DEPARTMENT OF MENTAL HEALTH
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LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

24 June 17, 2025

EDWARD YEN
EXECUTIVE OFFICER

June 17, 2025

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTH'S MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2025-26
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2025-26.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for FY 2025-26 as attached. The MHSA Annual Update has been certified by the Director of Mental Health (Director), or designee, and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The MHSA Annual Update for Fiscal Year (FY) 2025-26 builds upon the DMH-approved MHSA Two-Year Program and Expenditure Plan for each MHSA component. For FY 2024-25 DMH submitted a Two-Year Plan in order to align the County with the State Department of Health Care Services (DHCS) timeline for MHSA plans.

The Two-Year Program and Expenditure Plan contains a summary of MHSA FY 2023-24 programs, including clients served by MHSA programs and program outcomes. Additionally, the Annual Update describes DMH's ongoing Community Program Planning (CPP) and progress towards continued implementation of existing programs.

Board adoption of the MHSA Annual Update is required by law and necessary for DMH to submit the Annual Update for FY 2025-26 to the Mental Health Services Oversight and Accountability (MHSOA) Commission and DHCS. Additionally, WIC Section 5848 requires the following: 1) the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the Director, or designee, and the A-C attesting that the County has complied with all fiscal accountability requirements as directed by DHCS, and that all expenditures are consistent with the MHSA requirements; 2) a draft MHSA Three-Year Program and Expenditure Plan and Annual Updates 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; and 3) the Los Angeles County Mental Health Commission (MHC) conducts a Public Hearing on the draft MHSA Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In accordance with these requirements, DMH, on March 7, 2025, posted the MHSA Annual Update on its website for 30 days for public comment. MHC also convened a Public Hearing on April 10, 2025, where DMH presented the Annual Update, addressed public questions, and MHC voted to recommend the MHSA Annual Update for FY 2025-26.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's North Star 1, Make Investments that Transform Lives via Focus Area Goal A, Healthy Individuals and Families and Focus Area Goal C, Housing and Homelessness; and County's North Start 3, Realize Tomorrow's Government Today via Focus Area Goal A, Communication and Public Access.

FISCAL IMPACT/FINANCING

DMH utilizes the budget process to appropriate the MHSA funds for use during the respective fiscal year. Sufficient funding is included in DMH's Operating Budget for FY 2025-26 for this action.

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. More specifically, AB 1467 amended the WIC, requiring each county mental health program to prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates, to be adopted by the board of supervisors and submitted to the MHSOA Commission. AB 1467 also amended the WIC, requiring that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be certified by the Director and the A-C. The Director's certification attests to the stakeholder participation and compliance with MHSA non-supplantation provisions as required by AB 1467. Additionally, the Code was amended to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be circulated for public review and comment and that a public hearing be conducted at the close of the comment period.

The MHSOA Commission provided direction through a memo dated April 24, 2015, to all California counties to complete MHSA Annual Updates, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the Director and A-C.

The public hearing notice requirements referenced in WIC Section 5848(a) and (b), have been

satisfied and are recorded in the MHSA Annual Update for FY 2025-26. Additionally, DMH has complied with the certification requirements referenced in WIC Section 5847(b)(8) and (9). Compliance has been recorded in the MHSA Annual Update for FY 2025-26 via a signed MHSA Fiscal Accountability Certification Form.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2025-26 will ensure compliance with the MHSA, as amended by AB 1467, and allow for uninterrupted access to vital mental health services.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:RH:KN:RR:SK:FJM:atm

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel
Auditor-Controller

MHSA ANNUAL UPDATE

Fiscal Year 2025-26

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Posted for Public Review

March 7, 2025

TABLE OF CONTENTS

I. INTRODUCTION

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

LACDMH 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) as shown below:

MHSA Component	Approval Dates
Community Services and Support (CSS) Plan	February 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	September 27, 2009
Innovation 1 - Integrated Clinic Model, Integrated Services Management Model, Integrated Mobile Health Team Model and Integrated Peer-Run Model	February 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
Innovation 2 - Developing Trauma Resilient Communities through Community Capacity Building	May 28, 2015
Innovation 3 - Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions (Renamed to Help@Hand)	October 26, 2017
Innovation 4 - Transcranial Magnetic Stimulation	April 26, 2018
Innovation 5 - Peer Operated Full Service Partnership	April 26, 2018
Innovation 7 - Therapeutic Transportation	September 26, 2018
Innovation 8 - Early Psychosis Learning Health Care Network	December 16, 2018
Innovation 9 - Recovery Supports for Conservatees	September 26, 2018
True Recovery Innovation Embraces Systems that Empower (TRIESTE) *Revised as Hollywood 2.0	May 23, 2019 May 27, 2021
Interim Housing Multidisciplinary Assessment & Treatment Teams	March 7, 2023
Children's Community Care Village	November 17, 2023

II. DIRECTOR'S MESSAGE

DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

February 19, 2025

Dear Community Partners,

I am honored to share the Los Angeles County Department of Mental Health's (LACDMH) Fiscal Year 2025-26 Annual Update, a report on outcomes and expenditures for Fiscal Year 2023-24 and a look ahead to programming in Fiscal Year 2025-26. This past year has been a pivotal year for our department and the communities we serve. This year's plan represents the first annual update to our final Mental Health Services Act 2-Year Plan, an effort shaped through comprehensive reviews and collaboration with our valued stakeholders. Together, we are laying the foundation for a stronger and more responsive mental health system in Los Angeles County.

This year has been transformative for mental health policy in California. The passage of Proposition 1 underscores the State's commitment to addressing housing insecurities and changes program priorities for our Mental Health Services Act funds. In this context, LACDMH has finalized this year's annual update while preparing for the implementation of the Behavioral Health Services Act (BHSA), set to begin in July 2026.

Looking ahead, we are excited to launch our Community Planning Process with our Substance Abuse Prevention and Control (SAPC) partners in early 2025 to develop our first BHSA Integrated Plan. As we move forward, LACDMH is dedicated to engaging and informing our community, providers, and clients on the changes BHSA will bring.

Reflecting on Fiscal Year 2023-24: A Year of Change and Progress

Programmatic Highlights

Our work this year has been guided by a commitment to address the most pressing needs in our community and to expand access to care for all:

- In alignment with our mission, we have significantly increased housing resources to provide stability and dignity for individuals and families facing mental health challenges.
- Our Homeless Outreach and Mobile Engagement (HOME) teams have grown to connect even more unhoused individuals with critical resources and care to improve their wellbeing.

- The Interim Housing Outreach Program (IHOP) launched this year, filling a vital gap by partnering with housing providers. This innovative program ensures that hard-to-reach individuals receive the support they need to transition to stability and comprehensive care.
- We continued to support children and youth's mental health through partnerships with community based organizations (CBOs) to provide culturally responsive resources and services to youth.
- We continued to strengthen our Prevention programming such as our Promotores program that raises awareness about availability of services through outreach, engagement, and linking underserved cultural and linguistic communities to much needed care.
- We strengthened and enhanced the array of outpatient services and Full Service Partnership operations to address the most critical needs of our County's diverse communities.

Acknowledging Our Partners

None of this progress would be possible without our invaluable partners. To our providers, CBOs, and all those who work tirelessly to meet the needs of our diverse populations in Los Angeles County, we extend our deepest gratitude. Your dedication, expertise, and compassion are the backbone of our shared mission to create a healthier and more equitable community.

Looking Ahead

LACDMH is committed to scaling our services and infrastructure to meet the growing demand for mental health support. This Annual Update reflects our ongoing dedication to transparency, collaboration, and innovation. As we embark on this next phase, we look forward to continuing to work together to build a stronger mental health system that addresses the unique needs of every community in Los Angeles County.

Thank you for your partnership and unwavering commitment to this vital work. Together, we are making a difference.

With gratitude,

Lisa H. Wong, Psy.D.
Director

III. EXECUTIVE SUMMARY

PREFACE

In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million. The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness. MHSA funds an array of services that starts with prevention and integrates it into a comprehensive system of care to treat the whole person, with focus on wellness, recovery and resilience so that we may keep individuals out of hospitals, off the streets, and out of the jails.

Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for MHSA programs and expenditures. The Plan provides an opportunity for the Los Angeles County (County) - Department of Mental Health (LACDMH) to review its existing MHSA programs and services to evaluate their effectiveness. The Plan also allows LACDMH to propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available. It is through this Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders. Any changes made to any MHSA program must comply with MHSA regulations, as well as relevant State requirements.

PLAN LAYOUT

This Plan describes the programs that are funded by MHSA and is organized by the five MHSA components (Community Services and Supports; Prevention and Early Intervention; Innovation; Workforce Education and Training; and Capital Facilities and Technological Needs).

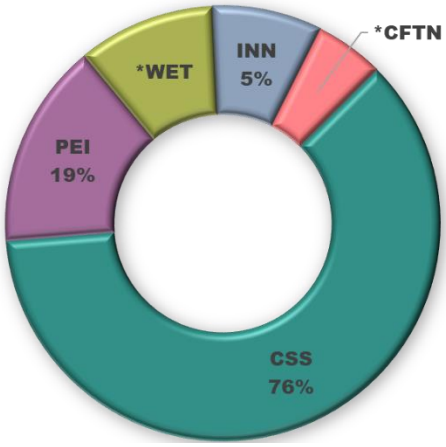
The information within this report is structured in the following sections:

- *MHSA Overview*
- *Development of the Annual Update*
- *Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2023-24 for programs previously approved.

IV. MHSA OVERVIEW

The Mental Health Services Act (MHSA) was enacted in January 2005 following the passage of Proposition 63 in late 2004. The Act imposes a 1% income tax on personal income in excess of $1.0 million to provide resources that will greatly improve the delivery of community-based mental health services and treatment across the State.

WIC Section 5891 states that MHSA revenues may only fund mental health services, and MHSA programs and activities. MHSA addresses a broad continuum of county mental health services for all populations: children, transition-age youth, adults, older adults, families, and underserved. MHSA specifies five required components that support county mental health systems.



Community Services and Supports (CSS)

- Mental health services and supports for children and youth, transition age youth, adults, and older adults
- Permanent supportive housing for clients with serious mental illness

Prevention and Early Intervention (PEI)

- Services to engage individuals before the development of serious mental illness or at the earliest signs of mental health struggles

Workforce and Education Training (WET)*

- Enhancement of the mental health workforce through continuous education and training programs

Innovation (INN)

- Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system, thereby increasing access to underserved communities, promotion of interagency collaboration, and the overall quality of mental health services
  - Accounts for 5% of the total MHSA allocation

Capital Facilities and Technological Needs (CFTN)*

- Building projects and improvements of mental health services delivery systems using the latest technology

**Transfers of CSS funds to WET and/or CFTN are permitted in accordance with MHSA guidelines and completed annually.*

V. DEVELOPMENT OF THE ANNUAL UPDATE

A. MHSA Requirements

WIC Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan and Annual Updates for MHSA programs and expenditures. Counties must also submit Annual Updates reflecting the status of their programs and services, as well as any changes.

WIC Section 5848 states the mental health board shall conduct a public hearing on the draft Three-Year Program and Expenditure Plan at the close of the 30-day comment period.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days of Board of Supervisor adoption.

MHSOAC is mandated to oversee MHSA-funded programs and services through these documents, and evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

The Los Angeles County submitted a COVID Extension Form for Fiscal Year 2020-21, which extended the Three Year Program and Expenditure Plan for Fiscal Years 2017-20 to include Fiscal Year 2020-21. This placed Los Angeles County on a track to submit a Two Year Program and Expenditure Plan for Fiscal Years 2024-25 through 2025-26, adopted by the Board of Supervisors on May 21, 2024.

B. County Demographics

a. Los Angeles County Population

The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. Serving as the local mental health plan in an area with almost 10 million residents, LACDMH ensures access to quality mental health care through its provider network composted of directly operated clinic sites, contracted clinic sites, and co-located sites. These sites provide an array of programs and services to County residents within and beyond the physical clinic facilities in more than 85 cities within its boundaries.

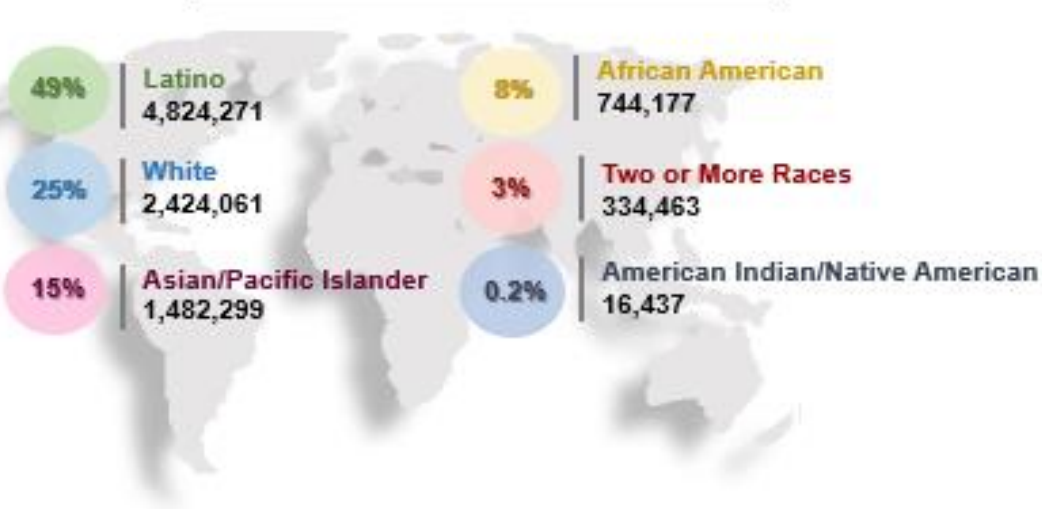
County residents represent one of the most diverse populations. This diverse racial and ethnic makeup are spread across approximately 4,000 miles that the County serves based on eight County defined Service Area (SA) boundaries.

The following data is taken from the American Community Survey, US Census Bureau and Hedderson Demographic Services, 2024.

Figure 1. Map of Los Angeles County Service Areas

The Antelope Valley area, or SA 1, consists of two legal cities, or 3.9% of all cities in Los Angeles County. SA 1 is the largest geographical but the least densely populated. SA 2, the San Fernando area, consists of 11 legal cities, or 22% of all cities. SA 2 is the most densely populated. The San Gabriel Valley area, or SA 3, consists of 30 legal cities, or 17.6% of all cities. SA 4 is the county's Metro area and consists of two legal cities, or 11.5% of all cities. SA 4 has the highest number of individuals experiencing homelessness within its boundaries. SA 5 represents the West and comprises five legal cities or 6.5% of all. The South, or SA 6, consists of five legal cities, or 10.3% of all cities. It has the highest poverty rate in the county. The East, or SA 7, consists of 21 legal cities, or 12.9% of all cities. SA 8 is the South Bay area and consists of 20 legal cities, or 15.4% of all cities in Los Angeles County.

Figure 2. Population by Race/Ethnicity



The next two tables provide the breakdown by race/ethnicity based on the Service Areas.

Table 1. Population by Race/Ethnicity and Service Area 2023

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,872	15,853	223,233	1,351	96,065	16,244	414,618
Percent	14.9%	3.8%	53.8%	0.33%	23.2%	3.9%	100.0%
SA 2	77,627	255,868	865,630	3,061	856,516	82,681	2,141,383
Percent	3.6%	11.9%	40.4%	0.14%	40.0%	3.9%	100.0%
SA 3	52,334	538,251	813,972	2,741	285,284	44,625	1,737,207
Percent	3.0%	31.0%	46.9%	0.16%	16.4%	2.6%	100.0%
SA 4	59,507	187,993	528,780	1,994	288,515	38,935	1,105,724
Percent	5.4%	17.0%	47.8%	0.18%	26.1%	3.5%	100.0%
SA 5	33,025	93,606	108,032	893	373,099	41,042	649,697
Percent	5.1%	14.4%	16.6%	0.14%	57.4%	6.3%	100.0%
SA 6	221,130	22,553	693,571	1,215	29,619	20,343	988,431
Percent	22.4%	2.3%	70.2%	0.12%	3.0%	2.1%	100.0%
SA 7	36,783	125,538	951,551	2,387	128,019	21,358	1,265,636
Percent	2.9%	9.9%	75.2%	0.19%	10.1%	1.7%	100.0%
SA 8	201,899	242,637	639,502	2,795	366,944	69,235	1,523,012
Percent	13.3%	15.9%	42.0%	0.18%	24.1%	4.5%	100.0%

Table 2. Population by Race/Ethnicity and Service Area

Race/Ethnicity	Highest	Lowest
African American	SA 6	SA 5
Asian/Pacific Islander	SA 3	SA 1
Latino	SA 7	SA 5
Native American	SA 2	SA 5
White	SA 2	SA 6
Two or More Races	SA 2	SA 1

In addition to the racial and ethnic diversity, LACDMH also serves residents across their lifespan. The following figures and tables below provide a snapshot of the population breakdown by age group based on the Service Areas.

Figure 3. Population by Age Group

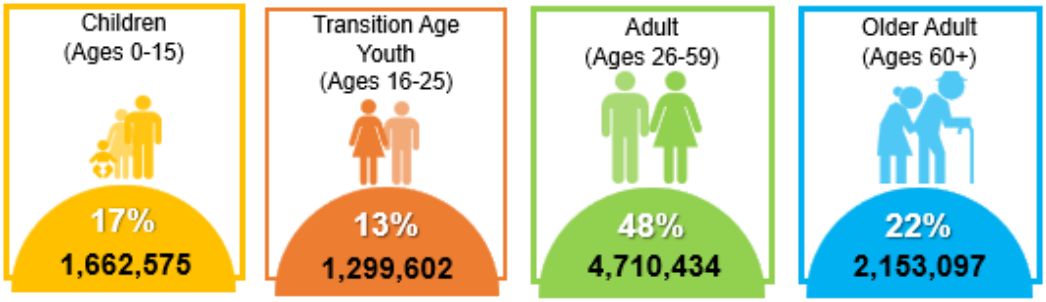


Table 3. Population by Age Group and Service Area

Service Area (SA)	Age Group				
	Children 0-15	TAY 16-25	Adults 26-59	Older Adults 60+	Total
SA1	90,115	63,983	178,859	81,661	414,618
Percent	21.7%	15.4%	43.1%	19.7%	100.0%
SA2	357,017	266,864	1,026,842	490,660	2,141,383
Percent	16.7%	12.5%	48.0%	22.9%	100.0%
SA3	278,571	231,369	790,600	436,667	1,737,207
Percent	16.0%	13.3%	45.5%	25.1%	100.0%
SA4	149,352	116,403	624,378	215,591	1,105,724
Percent	13.5%	10.5%	56.5%	19.5%	100.0%
SA5	83,195	84,240	330,469	151,793	649,697
Percent	12.8%	13.0%	50.9%	23.4%	100.0%
SA6	207,719	159,767	457,365	163,580	988,431
Percent	21.0%	16.2%	46.3%	16.5%	100.0%
SA7	232,855	183,177	585,248	264,356	1,265,636
Percent	18.4%	14.5%	46.2%	20.9%	100.0%
SA8	263,751	193,799	716,673	348,789	1,523,012
Percent	17.3%	12.7%	47.1%	22.9%	100.0%

Table 4. Population by Age Group and Service Area

Age Group	Highest	Lowest
Children (0-15)	SA 2	SA 5
Transition Age Youth (16-25)	SA 2	SA 1
Adults (26-59)	SA 2	SA 1
Older Adults (60+)	SA 2	SA 1

Figure 4. Population by Gender

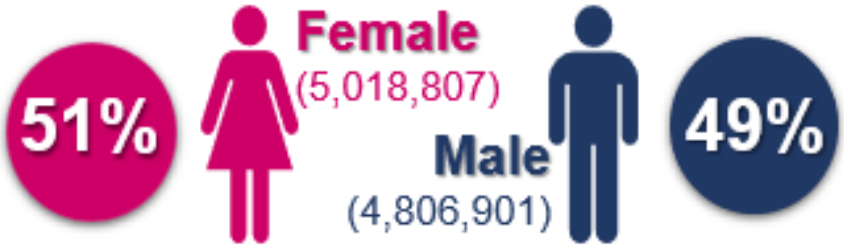


Table 5. Population by Gender and Service Area

Service Area (SA)	Male	Female	Total
SA1	204,135	210,483	414,618
Percent	49.2%	50.8%	100.0%
SA2	1,050,129	1,091,254	2,141,383
Percent	49.0%	51.0%	100.0%
SA3	841,873	895,334	1,737,207
Percent	48.5%	51.5%	100.0%
SA4	559,403	546,321	1,105,724
Percent	50.6%	49.4%	100.0%
SA5	313,077	336,620	649,697
Percent	48.2%	51.8%	100.0%
SA6	479,731	508,700	988,431
Percent	48.5%	51.5%	100.0%
SA7	617,750	647,886	1,265,636
Percent	48.8%	51.2%	100.0%
SA8	740,803	782,209	1,523,012
Percent	48.6%	51.4%	100.0%

b. Medi-Cal Population

This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, age and gender. Approximately 40% of the Los Angeles County Population is enrolled in Medi-Cal.

The following data is taken from the California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

Figure 5. Medi-Cal Population by Age Group

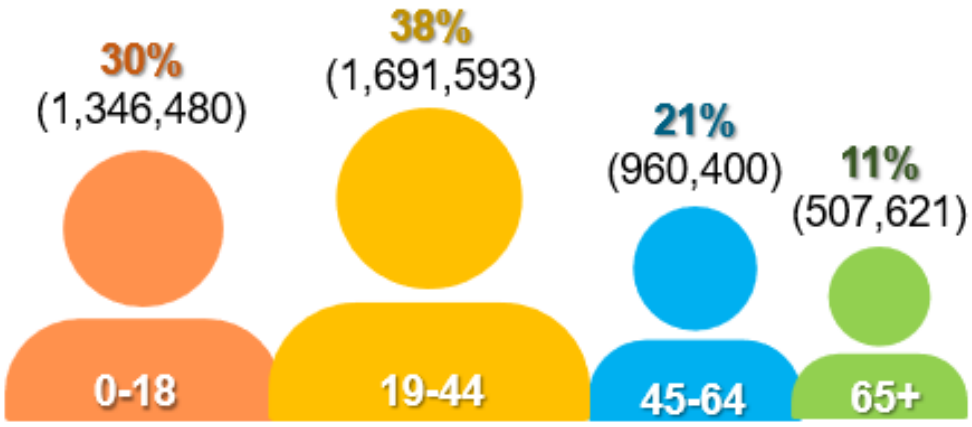


Figure 6. Race/Ethnicity Distribution Medi-Cal Population

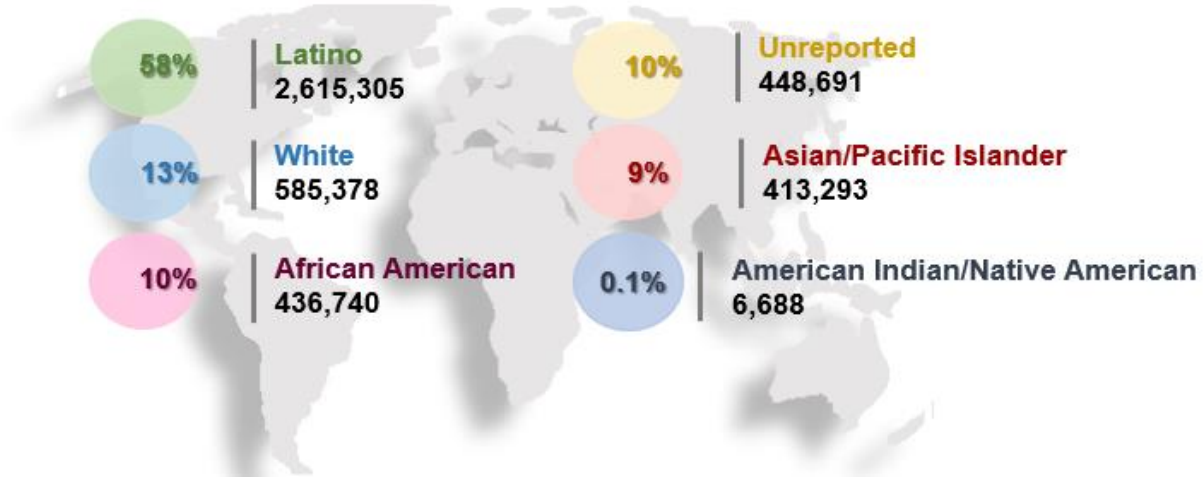
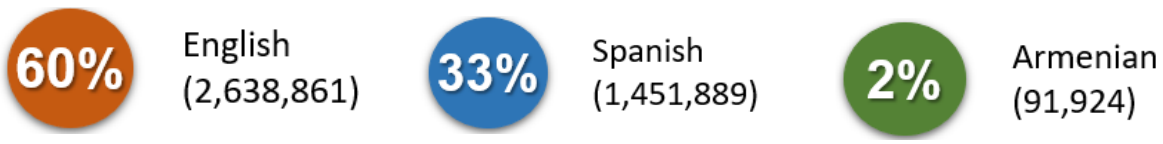


Figure 7. Top 3 Primary Languages for Medi-Cal Population



c. Los Angeles Homeless Services Authority's 2024 Greater Los Angeles Homeless Counts

Los Angeles Homeless Services Authority (LAHSA) is a City of Los Angeles and County of Los Angeles Joint Powers Authority and is the lead agency for Los Angeles Continuum of Care (CoC). LAHSA manages local, State and Federal funding for homeless services and resources.

The following information is taken from the LAHSA website, 2024 Homeless Count & System Key Performance Indicator Dashboard.

Figure 8. Los Angeles County Homeless Count

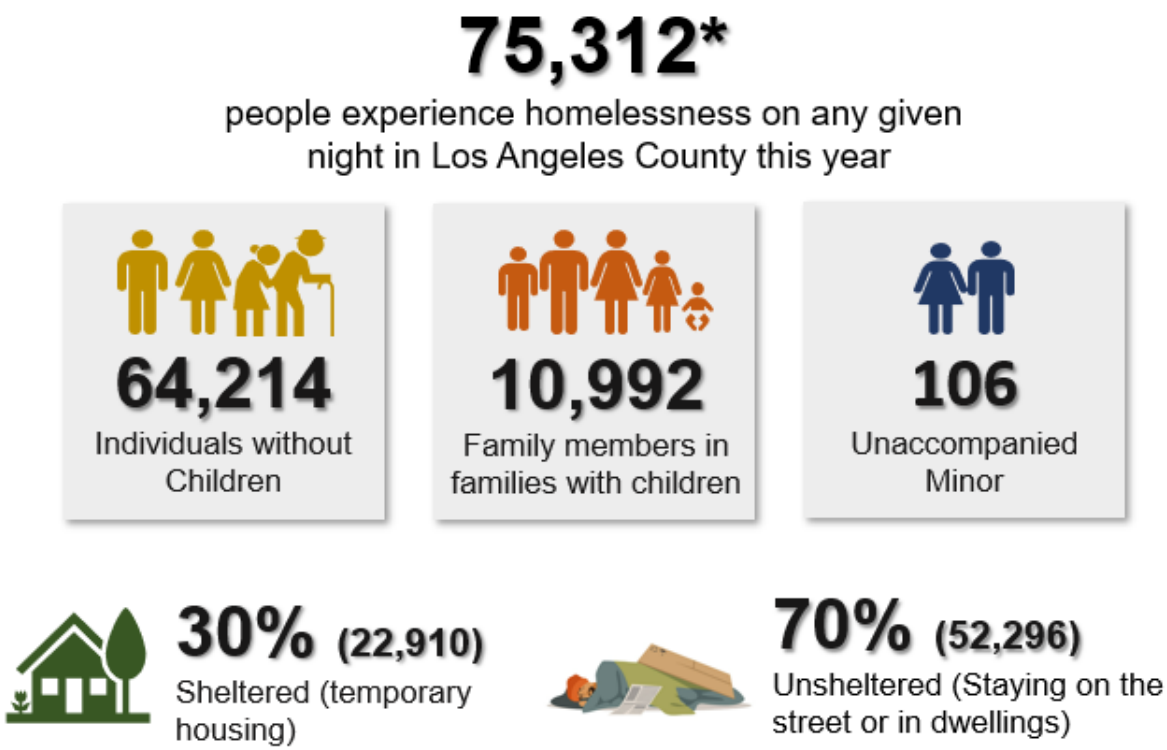


Figure 9. Three Year Trend for Sheltered versus Unsheltered Individuals Experiencing Homelessness

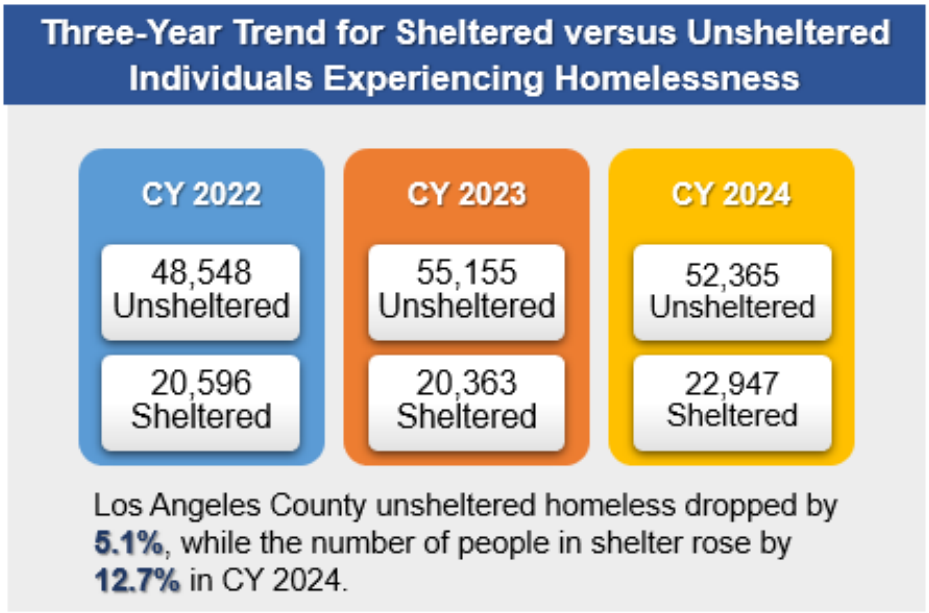
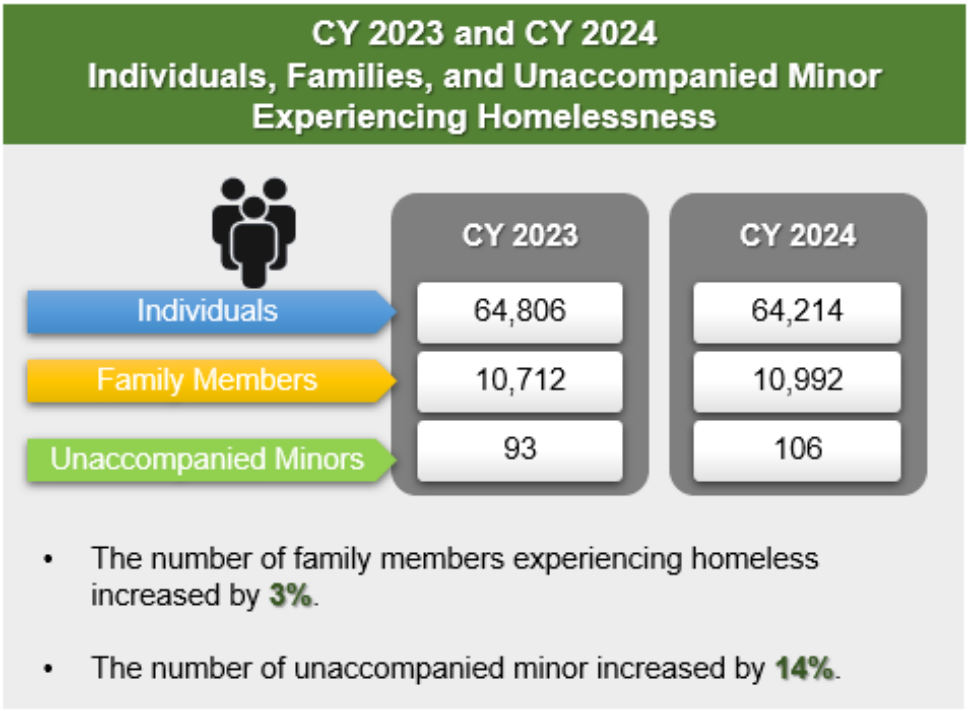


Figure 10. CY 2023 and 2024 Individuals, Families, and Unaccompanied Minor Experiencing Homelessness



The following figures do not include data for the cities of Glendale, Pasadena or Long Beach. These cities have established their own Continuum of Care (CoC) respectively. CoC is responsible for CoC governance and managing funding from HUD.

LAHSA estimates that 71,201 people experience homelessness on any given night.

Figure 11. 2024 Homeless Count – Los Angeles Continuum of Care

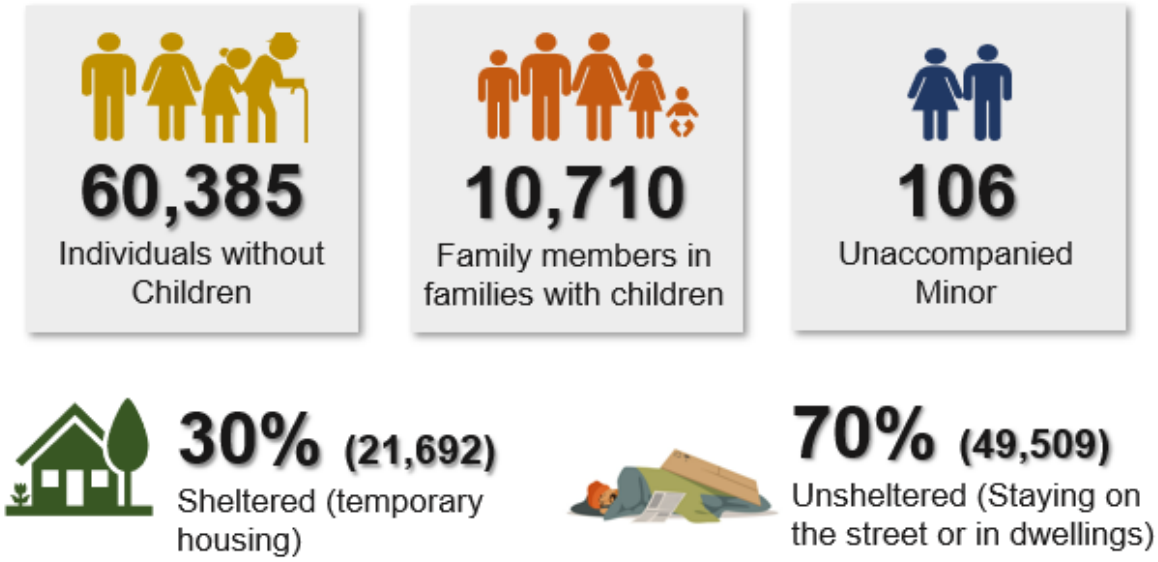
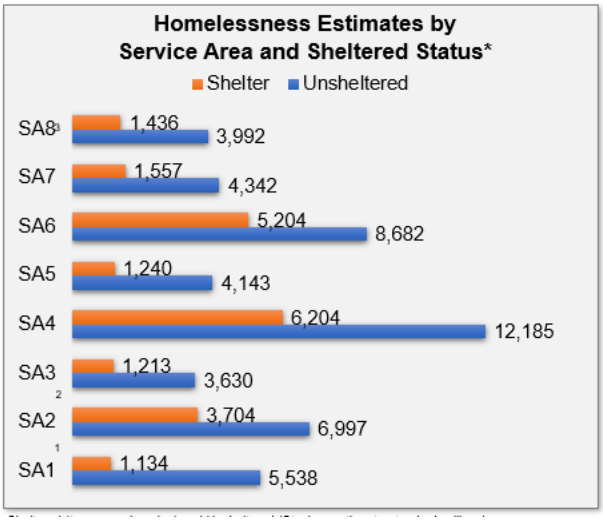


Figure 12. Service Areas Homeless Estimates – Los Angeles Continuum of Care



Highest Service Areas with People Experiencing Homelessness

	Sheltered	Unsheltered	Total
SA4	6,204	12,185	18,389
SA6	5,204	8,682	13,886
SA2	3,704	6,997	10,701

Figure 13. Gender – 2024 Homeless Count

Gender	Total	Percentage
Man (Boy if child)	**46,416**	65%
Woman (Girl if child)	**23,157**	33%
More than one gender	1,374	2%
Non-Binary	107	0.15%
Transgender	62	0.09%
Different Identity	35	0.05%
Questioning	31	0.04%
Culturally Specific Identity	19	0.03%

Data was self-reported by people experiencing homelessness in the Los Angeles CoC.

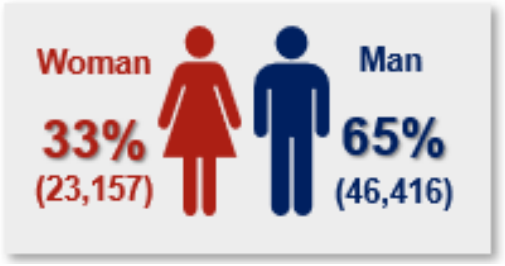


Figure 14. Age Group – 2024 Homeless Count

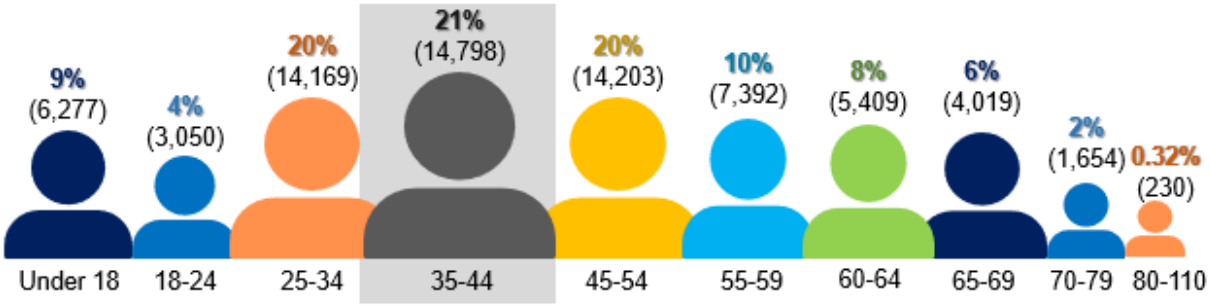


Figure 15. Race/Ethnicity Group – 2024 Homeless Count

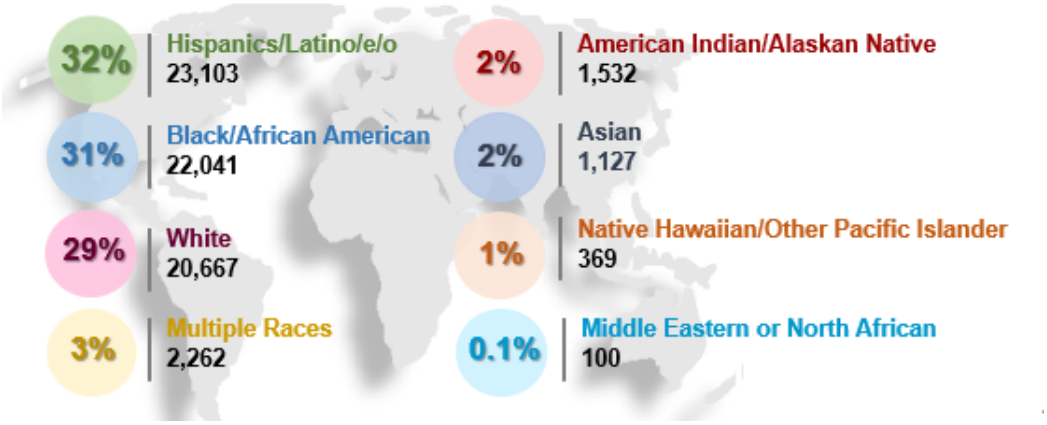
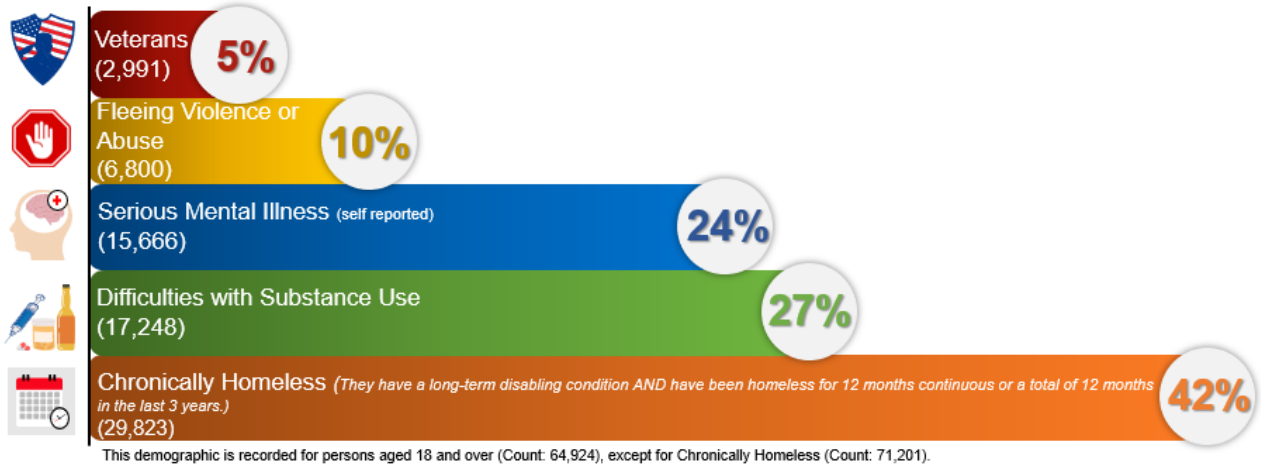


Figure 16. Persons Experiencing Homelessness – 2024 Homeless Count



d. County's Capacity to Implement Mental Health Services

Practitioners speaking a non-English threshold language most commonly spoke Spanish (84%), followed by Korean (2.84%), Tagalog (2.3%), Mandarin (1.77%), Armenian (1.72%), and Chinese (1.46%).

Practitioners Fluent and Certified in Non-English Threshold Languages, February 2025

Languages	Sum of Fluent	Sum of Certified	Sum of Total	% of Other Language Practitioners	% of All Practitioners
Arabic	63	14	77	0.78%	0.33%
Armenian	146	24	170	1.72%	0.73%
ASL	31	3	34	0.34%	0.15%
Cambodian	45	6	51	0.52%	0.22%
Cantonese	82	18	100	1.01%	0.43%
Chinese	134	10	144	1.46%	0.62%
Farsi	104	9	113	1.15%	0.49%
Hmong	2	0	2	0.02%	0.01%
Korean	254	26	280	2.84%	1.20%
Mandarin	155	20	175	1.77%	0.75%
Russian	79	12	91	0.92%	0.39%
Spanish	7546	740	8286	84.03%	35.60%
Tagalog	202	25	227	2.30%	0.98%
Vietnamese	102	9	111	1.13%	0.48%
Grand Total	**8945**	**916**	**9861**	**100.00%**	**42.36%**

Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served.

Languages	% of Other Language Practitioners	Percent of Population Enrolled in Medi-Cal	Percent of Clients Served in Outpatient LACDMH Clinics FY 2022-23
Arabic	0.78%	0.10%	0.08%
Armenian	1.72%	2.1%	0.61%
ASL	0.34%	------	-------
Cambodian	0.52%	0.2%	0.33%
Cantonese	1.01%	1.0%	0.26%
Chinese	1.46%	0.04%	0.05%
Farsi	1.15%	0.4%	0.31%
Hmong	0.02%	------	-------
Korean	2.84%	0.8%	0.38%
Mandarin	1.77%	1.2%	0.30%
Russian	0.92%	0.7%	0.16%
Spanish	84.03%	32.8%	14.16%
Tagalog	2.30%	0.2%	0.11%
Vietnamese	1.13%	0.7%	0.26%

Los Angeles County is an incredibly diverse community, with 13 threshold languages and has recorded over 35 self-reported ethnicities from individuals seeking services.

Strengths that impact the Los Angeles County Department of Mental Health's (LACDMH) ability to meet the needs of our clients include the diversity of our provider network. The Department has more than 800 service delivery sites with 78% Legal Entity providers and 22% Directly Operated. This is in addition to the many Community Based Organizations we fund to deliver Prevention services. Many of our Legal Entity Providers, Community Based Organizations and some Directly Operated sites have a mission to serve specific underserved populations that are racially and ethnically diverse and offer services and a workforce to meet their goals. Provider examples include Pacific Asian Community Services and United American Indian Involvement (UAII).

LACDMH has committed to expanding the number of providers who can deliver services tailored to the needs of our racially and ethnically diverse populations by implementing an Incubation Academy, providing funding and training for smaller Community Based Organizations to grow skills and capacity needed to become a Legal Entity provider. There are more than 20 CBOs in the current cohort most offering services to meet the needs of specific cultural communities.

To ensure voice and advocacy for underserved communities, LACDMH a Cultural Competence Committee stakeholder group and seven Underserved Cultural Community (USCC) groups made up of stakeholders which include persons with lived experience and community members. The seven groups include: Latino, African/African Heritage, American Indian/Alaska Native, Eastern European/Middle Eastern, LGBTQIA2-S, and Access for All, and advocacy group for individuals

with disabilities. The Department has also developed a Faith Based Leadership stakeholder group recognizing the role the many different faiths play in our local communities.

Each of these stakeholder groups contribute to service development and service accountability through active participation in the stakeholder process, engagement of their local communities, and development of annual projects intended to address the needs of their respective communities.

The Department has also invested in Community Health Promoters with a program titled the United Health Promoters. This program has trained community team members from specifical cultural groups (API, Black/African Heritage, Latino, etc.) to engage community members in the community to provide education and linkage.

Workforce shortage remains a primary challenge for the Department in meeting the needs of the racially and ethnically diverse populations it serves, as well as in implementing new programs. Los Angeles County is facing a statewide shortage of service professionals, including those interested in working in the public mental health sector. DMH is actively expanding its recruitment efforts to attract a diverse workforce. Last fiscal year, DMH launched the "Do Worthwhile Work" campaign, which specifically targets racially and ethnically diverse communities. This year, the Department is investing in a statewide media campaign aimed at youth, including those as young as middle school students, to raise awareness and offer guidance about careers in public mental health. Additionally, the Department continues to offer recruitment programs including the Pathways to Health program, offering high school students opportunities to explore mental health careers through a partnership with Charles Drew University, as well as the DMH Stipend Program, offering new clinician graduates from underserved/underrepresented communities with bilingual capacities a financial incentive to commit to work withing LA County public mental health. DMH also continues to provide training and support to community members with lived experience who are interested in becoming peer providers in the public mental health sector. To further expand recruitment efforts, DMH has increased its presence at both local and national conferences, to engage mental health professionals interested in working in public mental health. These events provide a valuable platform for connecting with potential recruits and raising awareness about career opportunities within the Department.

C. Community Planning Process

The Los Angeles County Department of Mental Health (DMH) organized and implemented a Community Planning Process (CPP) that engaged a broad range of MHSA stakeholders to gather a broader range of input regarding its MHSA programs and services, with special attention to the identification of unmet needs and service gaps and how to best address the mental health needs of populations within respective geographies across Los Angeles County.

Planning meeting dates and agendas as well as MHSA postings are made available to Stakeholders via email and the DMH website.

Community Planning Team

The Community Planning Team (CPT) is the diverse, multi-stakeholder entity responsible for agreeing on recommendations for the MHSA Three-Year Plan. Consisting of over 100 members, the CPT structure embodies three central commitments to a community-driven community planning process:

- A commitment to including a broad range of community and systems stakeholders. For this CPT, 92% (92 out of 100) of the members represent community voices, non-governmental organizations, and service provider networks.
- A commitment to robust representation of people with lived experience, by establishing a minimum threshold of 20%-to-30% of the total CPT being people with lived experience as consumers, clients, family members, caregivers, and peers. (This threshold is a floor, not a ceiling; the percentage can be higher.)
- A commitment to mirror as much as possible the demographic and cultural diversity of Los Angeles County.

Based on recommendations from DMH stakeholders and management, the CPT includes five categories with a corresponding number of representatives:

Stakeholder Categories	Representatives
1. Community Leadership Team	30
2. Community Stakeholder Groups	41
3. County Departments	19
4. Education System	5
5. Government/Quasi-Government Agencies	5
Total:	**100**

The following is a breakdown of stakeholder groups and the number of representatives per stakeholder group.

Stakeholder Category 1

Community Leadership Team

Community Leadership Teams are comprised of Co-Chairs from the Services Area Leadership Teams (SALTs) and the various Underserved Cultural Communities (UsCCs)

Service Area Leadership Teams (SALT)	Representatives
1. Service Area Leadership Team 1	2
2. Service Area Leadership Team 2	2
3. Service Area Leadership Team 3	2
4. Service Area Leadership Team 4	2
5. Service Area Leadership Team 5	2
6. Service Area Leadership Team 6	2
7. Service Area Leadership Team 7	2
8. Service Area Leadership Team 8	2
Total	**16**

Underserved Cultural Communities	Representatives
1. Access 4 All	2
2. American Indian/Alaska Native	2
3. Asian Pacific Islander	2
4. Black and African Heritage	2
5. Eastern European/Middle Eastern	2
6. Latino	2
7. LGBTQIA2-S	2
Total	**14**

Stakeholder Category 2

Community Stakeholders

Community Stakeholders: Presented in alphabetical order, these stakeholders include three types: (a) mental health planning, advisory, and advocacy bodies; (b) service providers supporting different consumer populations; and (c) people working within specific roles in the system (i.e., Peer Specialists, Community Health Workers / Promotoras, etc.).

Community Stakeholder Groups	Representatives
1. Assoc. of Community Human Service Agencies (ACHSA)	1
2. Community Health Workers / *Promotoras*	2
3. Cultural Competency Committee	2
4. Faith-Based Advocacy Council	2
5. First 5 Los Angeles	1
6. Health Neighborhoods (1 per Health Neighborhood)	18

Community Stakeholder Groups	Representatives
7. Housing/Homelessness	1
8. Los Angeles County Mental Health Commission	2
9. National Alliance for Mental Illness (NAMI)	2
10. Peer Advisory Council	2
11. Peer Specialists	2
12. Service Providers (Non-ACHSA)	2
13. Unions (1 per union)	4
14. Veterans	2
15. Youth Mental Health Council	2
Total	**45**

Stakeholder Category 3

County Departments
These County entities play a critical role collaborating with DMH to deliver services and supports to consumers, clients, family members, and caregivers.

County Departments	Representatives
1. CEO - Anti-Racism, Diversity & Inclusion	1
2. CEO - DOJ Compliance	1
3. CEO – Homeless Initiative	1
4. Department of Aging and Disability	1
5. Department of Children and Family Services	1
6. Department of Fire / First Responders	1
7. Department of Health Services	1
8. Department of Health Services – Housing for Health	1
9. Department of Justice, Care & Opportunities	1
10. Department of Military and Veterans Affairs	1
11. Department of Public Health	1
12. Department of Public Health – Substance Abuse Prevention & Control	1
13. Department of Public Social Services	1
14. Department of Youth Development	1
15. Libraries	1
16. Parks and Recreation	1
17. Probation	1
18. Public Defender	1
19. Sheriff	1
Total	**19**

Stakeholder Category 4

Education System
These K-12 school districts and institutions of higher education are critical partners in the delivery of mental health services and workforce development strategies.

Education	Representatives
1. Los Angeles Unified School District	1
2. Los Angeles County Office of Education	1
3. Los Angeles Community College District	1
4. California State University	1
5. University of California	1
Total	**5**

Stakeholder Category 6

City Governments / Quasi-governmental Agencies
These agencies are city governments with their own health jurisdiction; or quasi-governmental entities that play critical planning, coordination, or resource management functions that impact mental health.

City Government/Quasi-Government	Representatives
Cities with Health Departments	
1. Long Beach	1
2. Pasadena	1
Quasi-Governmental	
1. LA Housing Alliance	1
2. LAHSA	1
3. Los Angeles County Regional Centers	1
Total	**5**

Community Planning Meetings

Presentation materials for the following meetings are located on the DMH public facing website: https://dmh.lacounty.gov/about/mhsa/announcements/

Meeting Information

Date	April 2, 2024 - Tuesday
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting / Online

Meeting Description

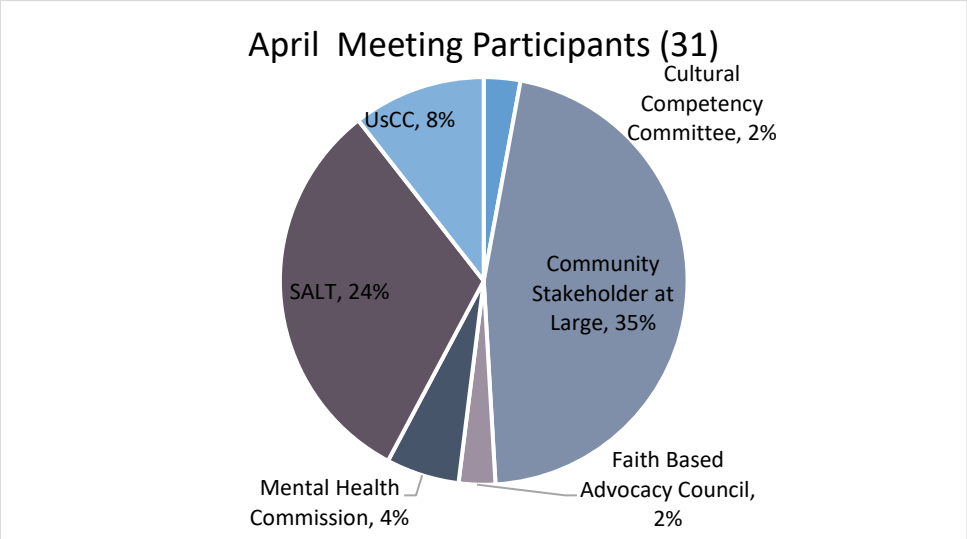
1. MHSA Foundational / Educational Video Development
MHSA stakeholders requested foundational videos be created that could educate the community about mental health, how to access mental health programs and services and ways to increase participation in community stakeholder groups. In response to this request, DMH identified film developer, Wondros, to develop a set of eight 5-minute videos.

2. Integration of Call Center for Mental Health and Substance Use Services
Currently, there are two telephone numbers being used for:

- DMH Helpline
- Department of Public Health SAPC SASH Line

Effective July 1, 2024, a single 24/7 access support line will be used for both Mental Health and Substance Use Disorder Services. This integration will streamline processes for crisis dispatch, linkage to services, modernize technology (e.g. chat, email/text notifications), and to reduce time-to-care and coordination of services.

Stakeholder Description
Stakeholders represented the following wide range of participants:



Stakeholder Involvement

1. MHSA Foundational / Educational Video Development Discussion

Members of the CPT brainstormed and shared their ideas to develop topics for each video based on their experience and knowledge. It was agreed the topics of the videos should motivate people to:

- Access mental health resources
- Attend SALTs, UsCCs, and other MHSA community stakeholder groups
- Become more involved in a community stakeholder group

Topics suggested by CPT members: Participants broke into teams based on Service Area to brainstorm the type of video topics that would benefit their community, and later reported to the bigger group for further discussion. Below are the suggested topics provided by each group.

1.	Mental Health Issues are More than Mental Illness
2.	Cultural Awareness
3.	Availability and Accessibility of Resources (highlighting the available resources and the process on how to access them)
4.	Education on DMH Services and Programs Which are Culturally and Linguistically Appropriate
5.	Evaluation on Accessing Services and Programs Using Less Stigmatizing Languages
6.	Community Involvement Highlighting SALTs, UsCC, etc.
7.	Crisis vs Emergency: Crisis and Intervention

2. Integration of Call Center for Mental Health and Substance Use Services

Stakeholders were provided with several options to be used as the opening greeting for the newly combined Call Center and chose the following as their top three choices:

1.	Behavioral Health Recovery Services
2.	Helping Access to Recovery and Treatment (HART)
3.	Mental Health and Substance Use Help Line

Although the stakeholders identified their top three choices, they also raised concerns that many of the suggested greetings contained words that could be considered stigmatizing, e.g., crisis, recovery, and treatment, and may be perceived as a threatening message that will discourage people to reach out and get help. As a result of this concern, participants broke into small groups to brainstorm a more appropriate and non-stigmatizing suggestions and recommended the following:

- Los Angeles County Helpline for Mental Health and Substance Use Services
- Link (one word that just means linkage to services and other help)
- Linkage to Recovery and Treatment (LRT)
- Behavioral Health Resource Services (BHRS)
- Behavioral Health Assistance Services Helpline (BHASH)

The general consensus among CPT membership is that while the greeting is important, ensuring increased accessibility to mental health services is the priority goal of the Call Center.

Meeting Evaluation Data

Upon the conclusion of each MHSA CPT meeting, participants are provided with a QR code and asked to complete a brief evaluation survey. Their responses are captured below:

75% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.

100% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was he**l**pful.

Comments collected included:

- "Meeting has clear purpose and focused discussion."
- "Interaction and dialogue create better understanding."
- "Overall, I love attending this meeting."

Meeting Information

Date	May 7, 2024-Tuesday, May 24, 2024-Friday
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

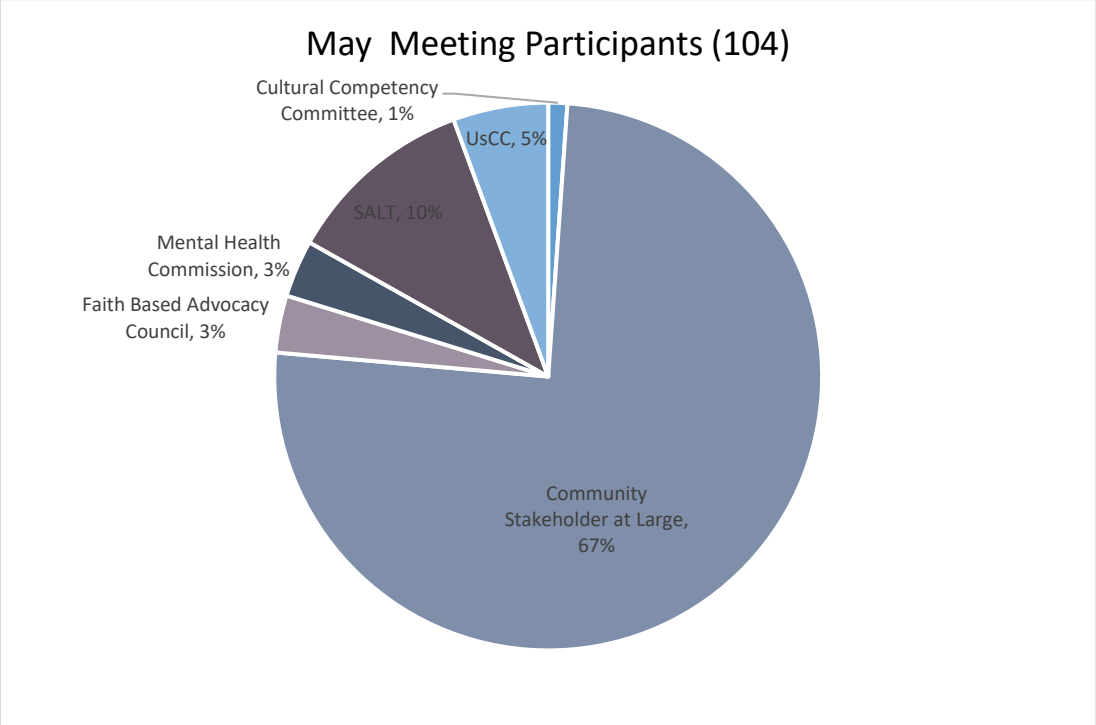
Meeting Description: May 7, 2024
Data and Accountability 101: Introduction to Results Based Accountability (RBA)

This meeting aimed to provide training on "Data and Accountability 101: Using Results Based Accountability". It is a foundation-building session for the beginners who are just starting their journey in the field of "accountability".

The MHSA Two Year Plan for FY 2024-25 and 2025-26 is currently under review by the Los Angeles County Board of Supervisors.

Upon final approval of MHSA 2-Year Plan, planning process will be shifted to implementation. Stakeholders being the authors of the 2-Year Plan will have the opportunity to monitor its implementation, but they need to be equipped with the tools to efficiently and effectively work on this task. While waiting for its approval, the Los Angeles County Department of Mental Health (LACDMH) provided stakeholders with a training on the Result Based Accountability (RBA) to be used as a tool to establish a common approach to supporting and monitoring the implementation of the MHSA Two-Year Plan and making sure that there is accountability.

Stakeholder Description
Stakeholders represented the following wide range of participants:



Stakeholder Involvement

Public funding has always been the center of criticisms not only from policy makers, but also amongst community stakeholders.

Stakeholders raised the following concerns:

- Lack of transparency and accountability.
- Lack of information and data on results.
- If data is available, it is difficult to access.
- If data is accessed, data is not easy to comprehend.

All these issues may lead to decreased or even lose public trust.

The LACDMH collaborated with community stakeholders and built a partnership with them based on trust. Stakeholders assist DMH in the planning, implementation, and monitoring of the MHSA Three-Year Program and Expenditure Plan. DMH recognizes there is a variety of challenges to developing and implementing quality mental health services and programs and therefore provided a training focused on introducing strategies and identifying solutions.

The training was provided to equip the community stakeholders with knowledge and skills on the framework that is being utilized by FSP, to monitor the results, activities, and resources embedded in the MHSA Three-Year Program and Expenditure Plan.

Stakeholders found the training very useful. Each individual exhibited strong interest and eagerness to learn as they fully participated in the discussions and activities provided by the trainer.

The data samples and illustrations listed below were presented to the stakeholders for analysis:

- Population Result: Indicator
- Performance Result: Measure
- Cause and Effect Relationships

Individual and group activities were conducted during the second part of the training to apply the theories learned and to evaluate stakeholders' understanding of RBA.

Stakeholders were able to distinguish the relationship between cause and effects and express detailed analysis on the data samples provided.

The MHSA Community Planning facilitator complimented participants on their ability to grasp complex ideas and concepts following a pop quiz to test their understanding of the meeting materials presented.

Training

The majority of this meeting focused on "Data and Accountability 101" training using the following format:

A. Result Based Accountability: Disciplined Approach

A common-sense and disciplined way of thinking and taking action to improve following:

- The quality of life in communities, cities, and counties.
- The performance of programs, agencies, and service systems.

B. Result Based Accountability: Focused on Results

- **ENDS** refer to the specific conditions of well-being (i.e., results) we want for populations or program participants (e.g., safety, physical health, mental health, financial security, etc.).
- **MEANS** refer to the strategies (e.g., programs, services, intervention, policy changes, etc.) to achieve the desired ENDS.

Meeting Evaluation Data

Upon the conclusion of each MHSA CPT meeting, participants are provided with a QR code and asked to complete a brief evaluation survey. Their responses are captured below:

- 62% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 79% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Comments collected included:

- "Good information."

- “Very informative. I learned a lot.”
- “I have the opportunity to engage with the community to share information and ideas.”
- “Love the interaction with the team.”
- “Meeting provided with a better understanding of the MHSA services.”
- “Hope to keep the meetings hybrid.”

Meeting Information: May 24, 2024

Meeting Evaluation Data

- 82% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 82% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

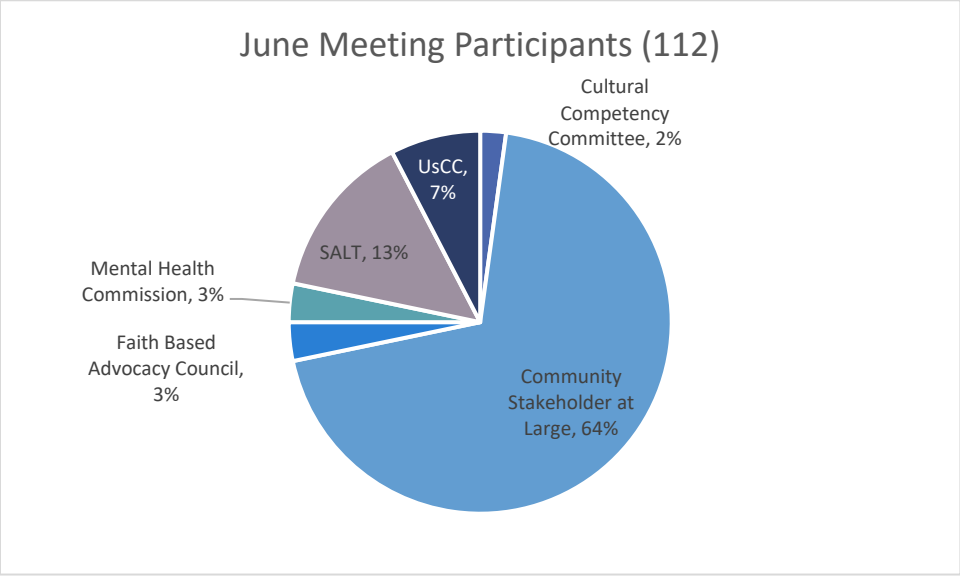
Comments collected included:
- “Great examples!”
- “Great presentation!”

Meeting Information

Date	June 4, 2024-Tuesday, June 28, 2024-Friday
Time	9:30 A.M. – 12:30 P.M.
Location	St. Anne’s Conference Center In-Person Meeting/ Online

Meeting Description: June 4, 2024
The meeting was focused on: Reviewing the design of Full Service Partnerships (FSP) to set the foundation for the “Data Accountability 201” session for the next CPT meeting.

Stakeholder Description
Stakeholders represented the following wide range of participants:



Stakeholder Involvement
As the implementation of the FY 2024-25, 2025-26 MHSA 2-Year Plan approaches, the Los Angeles County Department of Mental Health (LACDMH) continues to support the community stakeholders in transitioning from a planning role to a monitoring role.

Last month, Result Based Accountability (RBA) was introduced to community stakeholders. It is the framework to help community stakeholders monitor the implementation by gauging the performance result.

MHSA allotted a high percentage of funding for Full-Service Partnership (FSP). The FSP framework will be used in the implementation of the FY 2024-25, 2025-26 MHSA 2-Year Plan.
In this meeting, an FSP presentation was provided to stakeholders highlighting its objectives, the services offered, the eligibility criteria, the population the program serves, the referral process, etc. Providing this background will improve participant understanding of FSP and related services overall which will in turn all them to easily read and analyze the actual performance data presented in the future.

The following bullet points reflects stakeholder understanding of FSP:

- FSP is a service to help the community
- FSP helps individuals to regain their independence
- It offers a one-stop-shop to obtain services
- It provides services to individuals with serious mental challenges and substance abuse, and those experiencing homelessness and victims of domestic violence

In addition to the above information, DMH Executive Management emphasized that services are voluntary.

Questions and Answers:
Community Stakeholders asked the following questions to LACDMH Program Manager III Alejandro Silva, the head of FSP program:

1. Who pays for services provided by LACDMH?
Answer: Medi- Cal is being billed for the services provided to clients.

2. Can undocumented individuals receive mental health services?
Answer: Yes. There is MHSA fund allotted for undocumented people.

3. Does LACDMH provide services to adults with private insurance.
Answer: Individuals with private insurance should go to their private providers. However, if they show up at any DMH clinic, services will be provided. DMH bills their private insurance.

4. Does FSP accept referrals from individuals or caregivers who believe that a person needs services from FSP?
Answer: Yes. The referral will be thoroughly reviewed by Service Area Navigation Team, and if does not meet the requirements, the client will be referred to the most appropriate level of services needed.

5. Can a person in jail enroll in FSP?

Answer: No. They are already receiving services from jail. However, the Department of Health Services (DHS) or the Public Defender refers the individual to FSP program. FSP provides transportation, and makes sure that client has his medication, a place to live, and food to eat upon his/her release.

6. Can a person make a self referral?
Answer: No. A family member can refer by contacting the Service Area Navigator. It was noted and clearly explained that FSP has very specialized services with particular design and many requirements that may not fit everyone. Those who do not qualify will be linked to appropriate resources.

Meeting Evaluation Data

Upon the conclusion of each MHSA CPT meeting, participants are provided with a QR code and asked to complete a brief evaluation survey. Their responses are captured below:

Meeting: June 4, 2024

- 78% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 87% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants found that the preparation and execution of the meeting were perfectly organized. They liked that thoughtful and intentional approach to ensure that everything is understandable. They were happy that everyone was given the opportunity to give their opinion.

Comments collected included:
- "Our voice was being heard."
- "Very educational."
- "Good discussion."
- "Good, printed materials."

Meeting: June 28, 2024

- 69% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 64% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants recognized that the meeting/training provided good, detailed information. They were able to have their questions answered. Subject matter was very well explained.

Comments collected included:
- "Good information."
- "Information explained in detail"."
- "Able to get questions answered."

Meeting Information

Date	July 9, 2024-Tuesday, July 26, 2024-Friday
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

Meeting Description: July 9, 2024

The meeting was focused on:

- MHSA- Related Update
- Reviewing and analyzing Full Service Partnerships (FSP) data to begin applying Results Based Accountability tools and concepts.

MHSA- Related Update

1. **Foundational Videos**
   The filming of the 5-minute foundational videos to educate the community about mental health, how to access mental health programs and services and ways to increase participation in community stakeholder groups will start in September 2024.

2. **Transitioning from Mental Health Services Act (MHSA) to Behavioral Health Services Act (BHSA)**
   BHSA work groups will be created by August 2024 to work on effective transitioning of MHSA to BHSA.

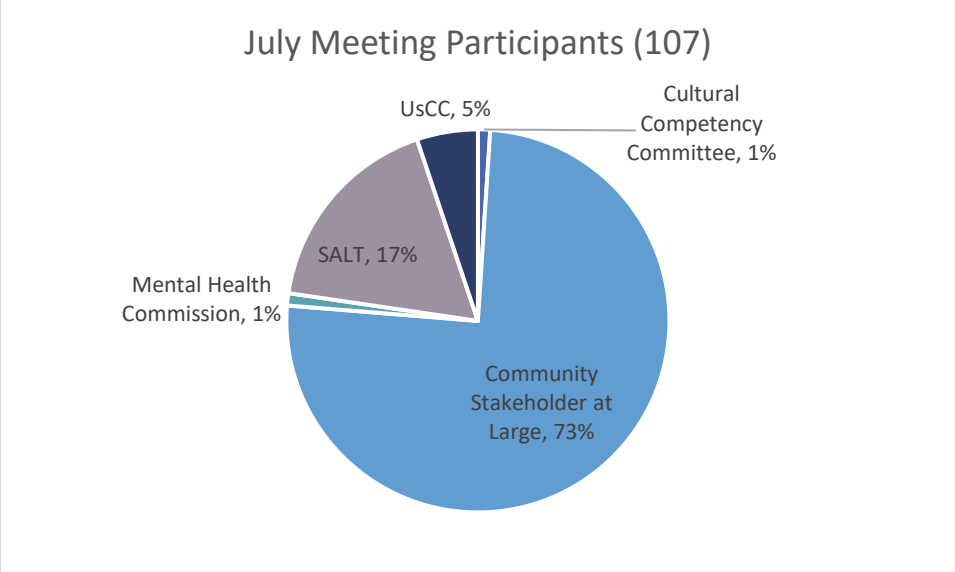
3. **Transportation**
   Effective July 9, 2024, transportation is provided to help facilitate the commute of the Community Planning Team (CPT) meeting participants from each Service Area (SA). This may also extend to Commission meeting attendees. Antelope Valley and Lancaster from SA1 were the first ones benefited from this program, and the Los Angeles County Department of Mental Health (LACDMH) is working to expand this service to other locations starting from those living in the remote areas.

4. **Beyond the Walls**
   Starting September 2024, a quarterly meeting will be launched at the libraries in all Service Areas to educate the community about mental health, and LACDMH's services and programs available for them. These meetings will be held on Saturdays or evenings at each Service Area to reach out to those community stakeholders who are unable to attend the regularly scheduled meeting.

5. **Client Activity Fund (CAF), Co-Chairs Orientation, and Stipend**
   In order to get paid for CAF or stipend, participant needs to attend the orientation that is being held annually. Last orientation was held on July 17, 2024, and another one coming up in December 2024. Detailed information will be provided to participants soon.

6. **Additional Accommodation**
   Additional accommodation will be provided if requested. Attendees should inform the Department of Mental Health (DMH) of the accommodation needed 2 weeks prior to the scheduled meeting.

Stakeholder Description
Stakeholders represented the following wide range of participants:



Stakeholder Involvement

The MHSA Two Year Program and Expenditure Plan developed in 2023 with multi-stakeholder groups input and recommendations is now in the implementation process. As its implementation begins, the Department of Mental Health (DMH) continues to provide training to stakeholders to prepare them for their new role of monitoring the program. In this training, the stakeholders were given an opportunity to review, interpret, and analyze data. Participants provided intelligent analysis of the data presented and asked their questions for some clarifications. Everyone exhibited interest in learning and stayed focused during the entire presentation.

Training

FSP Data: Review and Analysis

The Full Service Partnership (FSP) received the highest budget from the MHSA funding, and it will continue under the newly passed BHSA. The framework of the FSP will be used in the implementation and monitoring of the MHSA 2-Year Plan.

In the previous presentation, the stakeholders were informed of FSP objectives, services offered, eligibility criteria, population, program serves, referral process, etc. With the knowledge obtained on how FSP works and performs, participants are now ready to get trained reviewing and analyzing the actual FSP data in preparation for their role of monitoring the implementation of the MHSA 2-Year Plan.

Several FSP data elements were presented to participants for their interpretation and analysis. The purpose was to train the participants on how to describe and interpret:

- Aggregated and Disaggregated Data

- Year One data trends

Description tells the story of what is happening while interpretation explains why it is happening. With that analogy, participants provided their description and interpretation for the different date presented below.

Participant Questions and Answers

1. How is DMH contracting relationship with legal entities?
   Response: DMH continues to partner with legal entities to provide needed services for clients. DMH continues to collect data to monitor the efficiency and effectiveness of programs and services provided to clients.

2. What is the best way to bring the information/updates to the community?
   Response:
   a. DMH continues to provide updates to the community through CPT, SALT, UsCC, and other community stakeholder meetings.
   b. DMH provides training to community stakeholders on how to capture updates.
   c. A training is provided to Co-Chairs on leadership and how convey updates to their SALT membership.
   d. Meeting recordings, flyers, and handouts are regularly posted at DMH website. Additionally, meeting recording can be sent directly to participants when requested.
   e. CART, language translations and ASL interpretations are also provided during the meetings.

3. Will BHSA provide services for incarcerated individuals?
   Response: No. Incarcerated individuals will not be provided services under the current BHSA guidelines. However, discussion on implementation of BHSA is currently in process, and there are possibilities of changes with its guidelines.

4. Are there any additional BHSA guidelines updates?
   Response: None, but individuals and community groups are encouraged to get involved in the planning process. The DMH will invite the Police and Sheriff Department to join the BHSA Planning and continue to partner and collaborate with them in dealing with mental illness.

Meeting Evaluation Data

Upon the conclusion of each MHSA CPT meeting, participants are provided with a QR code and asked to complete a brief evaluation survey. Their responses are captured below:

Meeting: July 9, 2024

- 69% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 86% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants found that the preparation and execution of the meeting were perfectly organized. They liked that thoughtful and intentional approach to ensure that everything is understandable. They were happy that everyone was given the opportunity to give their opinion.

Comments collected on what they like about the sessions:

- "We learned how to read the data, understand the breakdown, and how we can use them."
- "The interaction and Question and Answer were positive."
- "The training is always to learn about the program and the fact that is available to all."
- "The moderator recapped what was said and heard."
- "I attended via Teams but thought that the information provided was useful. Responses from attendees were brilliant, indicating an increasing level of understanding of the subject matter. "

Meeting: July 26, 2024

- **93%** found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- **100%** of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants recognized that the meeting/training provided good detailed information. They were able to have their questions answered. Subject matter was very well explained.

Comment collected:

- **"**Good meeting."
- "Good discussions."
- "Good explanations."
- "Had the opportunity to analyze data together."
- "I felt that the data interpretation lesson was taught at an accessible level, and the data selected to interpret for the exercise was interesting."

Meeting Information

Date	August 6, 2024-Tuesday, August 23, 2024-Friday
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

Meeting Description: August 6, 2024

The meeting was focused on:

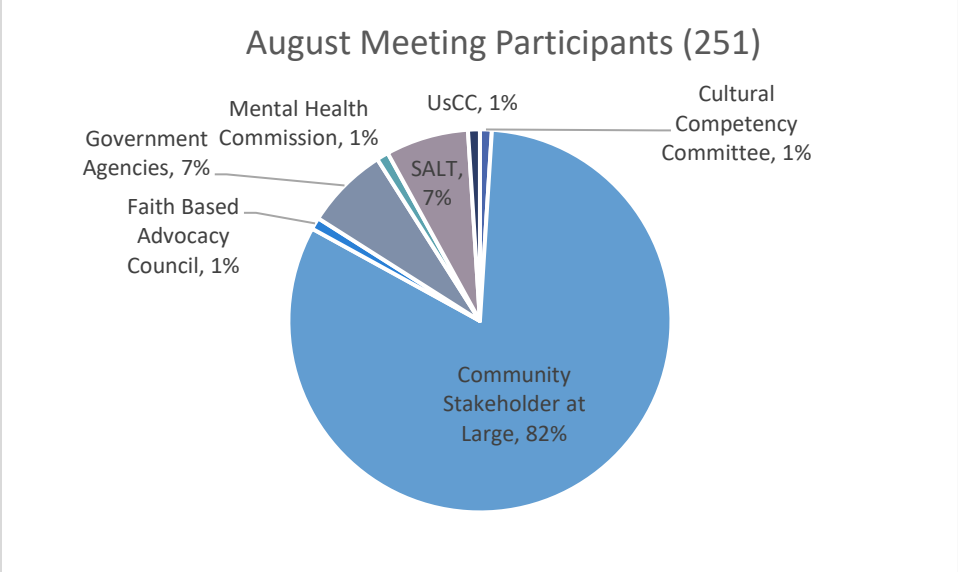
- MHSA- Related Update
- Discussion of outcomes for Full Service Partnerships (FSP) and Outpatient Care Services

BHSA Updates

- BHSA updates will be provided during the CPT monthly meetings
- BHSA Community planning kicks off in March 2025
- First sessions will be orientation to BHSA and the Needs Assessment

Stakeholder Description

Stakeholders represented the following wide range of participants:



Government agencies include CEO, Probation Department, DHS, DPH, JCOD, LAHSA, BOS, Fire Department, and Public Defender.

Questions and Answers/Suggestions

Provide more information about PRC.
Response: PRC is open to people and it is a place for individuals to participate in activities and connect with others. It is a place where people have voice.

Stakeholders Suggestions:

- Change PRC's name to, "Family Resource Center".
- Need a bigger space for PRC.

DMH Sr. Deputy Director Theion Perkins strongly agreed and stated, "I agree. We need a bigger PRC but it has to be approved by the CEO".

1. DMH needs to work with experience legal entities for all services such that of PRC.
   Response: from DMH Sr. Deputy: "We believe in partnership with legal entities, but DMH need start the program in each Service Area before having legal entities handle some."
2. How do you monitor legal entities?
   Response: DMH have benchmark and new Statement of Works (SOW) that clearly specify the deliverables legal entities need to comply.
3. How does DMH handle the impact of COVID trauma to youth and children?
   Response: DMH partners with schools to assist children and youth address the the trauma and other issues.
   - School districts and DMH staff educate and train each other on how to appropriately handle the trauma that youth and children are experiencing.
   - DMH Prevention Division also does their share to assist.
   - Children and parents in trouble. DMH is still working towards helping both children and parents experiencing hardships connecting. DMH is assisting the entire family.

4. Are there school based mental health program?
   Response: Yes, there are only five (5) districts initially.
5. How to approach the 60 and above population?
   Response: DMH is currently conducting analysis and assessment on what the best approach for the 60+ population. The department can expand and appoint a specialized lead to bring coherently across the system.
6. How does OCS apply the linguistic and cultural competency?
   Response: DMH does a lot of outreaching from different universities outside of California to hire ASL clinicians and bring people that can provide the needs of the clients.

Suggestions:

- Consider the family and faith components, and anything that can make services accessible to everyone.
- Youth leaders involvement.
- Connect with parents to educate them about mental health and provide assistance.
- Recognize the gap of the increasing number of clients and the shortage of clinicians.
- Acknowledging the suicide prevention and bullying are big problems among youths.
- Specialty mental health needs. Utilizing arts especially in PRC.
- FSP should provide funding for those individuals in jail.

Future Presentation Topics:

- "Substance Abuse and Crime". Some people commit crime to get help.
- "How to Improve the System?" The data is really helpful.
- "Foster Care: The True Problems are the Parents, Not the Children."

Meeting Evaluation Data: August 6, 2024

Upon the conclusion of each MHSA CPT meeting, participants are provided with a QR code and asked to complete a brief evaluation survey. Their responses are captured below:

- 75% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 96% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants found that the preparation and execution of the meeting were perfectly organized. They liked that thoughtful and intentional approach to ensure that everything is understandable.

Comments collected on what they like about the sessions:

- "Definitely on time!"
- "Liked the overview of the entire DMH including their specialty programs."
- "Learned a few things such as the distinction between FSP and OCS."
- "Thank you for defining the acronyms."

Meeting: August 23, 2024

- 75% found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- 91% of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants recognized that the meeting provided good detailed information. They were able to have their questions answered. Subject matter was very well explained.

Comments collected on what they liked about the sessions:

- "Very complex subject matter converted into a simpler explanation."
- "I appreciated the breadth of information covered in one session."
- "Lots of information! Very informative."
- "I like having the questions and answers after the presentation."
- "Very thorough presentation! Very clear, concise, and informative"
- "I appreciated the clear facilitation and presentation!
- "Very helpful to have information about FSP services planning, timelines, and changes."

Meeting Information

Date	September 10, 2024 – Tuesday / September 27, 2024 - Friday
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

Meeting Description:

1. MHSA- Related Update
2. Provide population-level data and service utilization information to begin mapping out mental health needs in Los Angeles County.
3. Identify key questions and additional data to prepare for the BHSA community planning process.

MHSA- Related Update

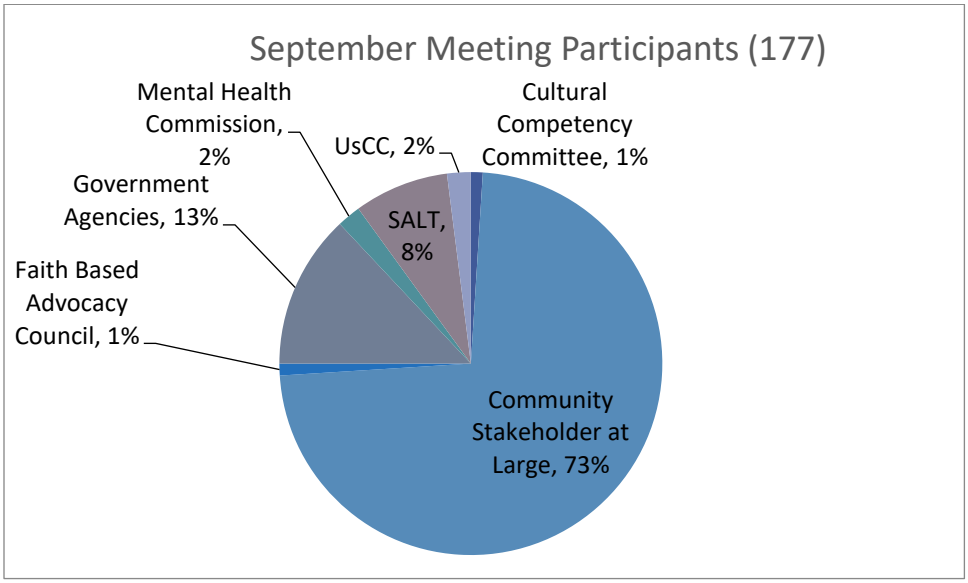
1. **Schedule of the MHSA Community Planning Team Meetings**
   A. Housing
      Friday, September 27, 2024, at 9:30 A.M.
   B. MHSA Program Updates on Housing, Linkages to Services, and Points of Engagement
      Tuesday, October 8, 2024, at 9:30 A.M.
   C. Prevention
      Friday, October 25, 2024, at 9:30 A.M.

2. **CPT Meetings in November and December 2024**
   There will be only one CPT meeting for November due to the upcoming election, and one meeting for December in observance of the holiday.

November 19, 2024, Tuesday at 9:30 A.M.- 12:30 P.M. – in person
December 9, 2024, Monday at 9:30 A.M.- 12:30 P.M. – in person

Stakeholder Description

The 177 stakeholders represented the following wide range of participants:



Meeting Information

Date	October 8, 2024
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

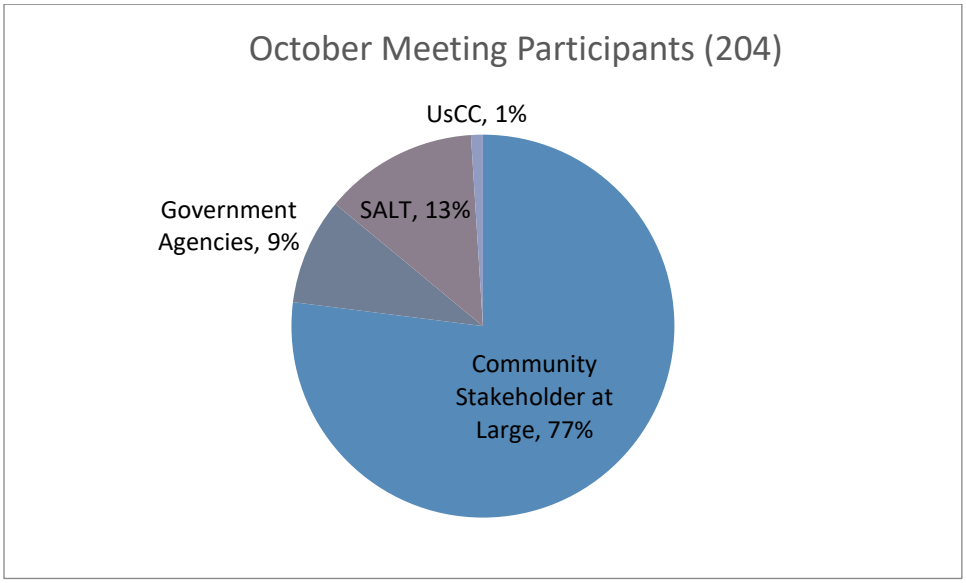
Meeting Description

The meeting was focused on:

1. Share MHSA-Related Updates.
2. Provide MHSA Program Updates on Housing, Linkages to Services, and Points of Engagement.
3. Describe Next Steps and Conduct Meeting Evaluation.
4. Provide information on the Behavioral Health Services Act (BHSA) Regulations for Prevention and respond to questions.

Stakeholder Description

Stakeholders represented the following wide range of participants:



Questions and Answers:

At the end of the presentation, attendees were invited to ask questions and/or clarifications. Many questions were received, and they were categorized into topics. Due to limited time, only a few questions were answered during the meeting. However, a "Frequently Asked Questions" (FAQ) was created to answer the rest of the questions raised by attendees. FAQ will be posted at the DMH website, and will also be provided to the CPT members/attendees.

Frequently Asked Questions (FAQ) for the BHSA Regulations for Prevention

The following are questions, comments and/or recommendations from the DMH Community Planning Team members and stakeholders who attended the virtual meeting on Friday, October 25, 2024. This document will be developed as a frequently asked questions (FAQ) regarding the presentation on the BHSA Regulations for Prevention.

FUNDING

1. Where is the funding for the Underserved Cultural Community (UsCC) projects coming from currently? Is it from Prevention Early Intervention (PEI) component?
    - Response: The funding for UsCC projects comes from the planning outreach engagement budget, it does not come from PEI and that will continue to be resource from that budget.
    - Yes, the UsCC groups will get that same funding for outreach engagement even after BHSA. There is no specific planning outreach budget identified under BHSA so, this is another one of those we will need to work with and engage the state on this. We see this as potentially fundable under BHSA, but this is going to be part of the planning processes and discussion. We will work to identify what we can fund and what we need to prioritize. This is a highly valued investment that's going to be part of the planning discussion. The department values the work of the UsCCs, however the

BHSA funding is still something that needs to be addressed during the upcoming planning process. The amounts and types of funding will be determined as we go through the BHSA planning process.

2. Will the UsCC groups still be funded and allowed as part of BHSA funding?
    - Response: There is no specific planning outreach budget identified under BHSA so we will need to work with and engage the state for clarification. We see this as potentially fundable under BHSA, but this is going to be part of the planning processes and discussion. As we work to identify what we can fund, and what we need to prioritize, the one thing we will say is this is a highly valued investment that's going to be part of the planning discussion. The work that's happening through the USCCs is not funded by PEI dollars, it is funded through another bucket of funding.
3. Regarding outreach and services to underserved communities, will Community Based Organizations (CBOs) have access to funding with the new BHSA? If so, what are ALL sources?
    - Response: Outreach services to underserved communities are potentially fundable under BHSA, but we still need to go through the planning process to figure out what kind of services and outreach activities will be conducted. When it comes to community-based organizations, there would still be an interest to partner with community-based organizations. We come back around to what departments identify what the plan has developed and with our stakeholders. The interest is still to work with community-based organizations, but this will depend on what gets prioritized through BHSA. The purpose of today is to share what we know so far, but a lot of decision-making and some of the details around how we can spend the dollars are still coming and that is the conversation we'll be engaging all of you in March.
4. Are the plans for investments regarding technology to help facilitate leveraging Application Programming Interface (APIs) to integrate systems between county and legal entities to assist with providing outcomes data more easily?
    - Response: Yes, it's really to make sure that we're making not just the exchange of information and outcomes easily but there is also a significant burden in terms of costs to do this kind of work. A lot of this is still unknown to the 58 counties in California. As MHSA and BHSA have varied differences including capital facilities and technology, we're going to have to wait to see what the final regulations are and what they allow for to be able to answer this and to see where the money could be available. The department has an interest in making sure that the outcomes data is exchanged effectively and efficiently between legal entities and the department, as we think it's a requirement for BHSA. The department has an interest in making things easier for providers. Our PEI outcome was built a long time ago. A lot of the instances have happened since then and with our new implementations, we have leveraged APIs and built website variations. As far as those updates and new requirements are concerned, it is always our goal to do that. We will need to figure out how to match and mirror the technology with the provider's capabilities. The emphasis on outcome data is only going to get stronger under BHSA and it is a shared interest. As more information rolls out, there will be more clarity around the next steps around this task.

5. At which point will legal entities know how their contracts are going to be impacted by the changes?

    - Response: Our analyst team is mapping our contracts that mention prevention, early intervention, and prevention and early intervention. We have identified them and are waiting for final guidance from the state about what early intervention will look like. Then we can align the prevention projects that we want to prioritize with the new early intervention requirements. As we learn more, we will be sharing that out and we are aware that contractors need time to plan. They have budget cycles just like our department has budget cycles. We are hoping to have the work and the results available as soon as we can.

6. Will BHSA Housing Intervention dollars be spent on operating subsidies for Permanent Supportive Housing (PSH) to ensure LA can utilize the upcoming Homekey+ funds?

    - Response: This is a brand new opportunity. This comes from the bond part of Proposition 1 and will be in discussion. We will have to come back to this as these questions. This helps us as we think about the planning process. Although we can't answer today, we really do appreciate being able to talk through them and hearing these questions now.

7. For current MHSA funds PEI projects, when will we know the decisions?

    - Response: This is not part of today's updates that we are focusing on. What we're focusing on now is the upcoming behavioral health services funding. Your question is about the current MHSA funds and that will be addressed at our November 19th meeting. We are going to focus on MHSA and then December as well. Let's reconnect on that one and come back to that at that time.

8. Will there be funding for CBOs and community outreach services mentioned?

    - Response: There is a commitment to continue working with community-based organizations during the BHSA planning process. Through the BHSA planning process we will determine which outreach services, what that means and how that will look.

9. California Advancing and Innovating Medi-cal (CalAIM) and how it will affect/impact BHSA?

    - Response: CalAIM is an initiative or a payment reform that began last fiscal year. CalAIM is already implemented, and it changed a lot of rules around servicing and payments that we made to providers and payments to ourselves. The intent was to try to incentivize services a little bit differently. They are both part of the same umbrella or group of initiative that is coming forth from the state to modernize behavioral health and an effort to incentivize. This is also a different way to reduce some of the burden of paperwork and administration and to refocus right now a lot of our mental health services. There is just a broad array of other initiatives that are taking part and BH Connect initiatives that are really looking to transform behavioral health payment reform and BHSA changes the allocations in how we spend our BHSA dollars. There has been an effort with CalAIM especially looking at some non-direct services. There are in lieu of services, some things like housing and some of these other connection

services are now covered by Medi-Cal that may not have been before. This also applies to MHSA right now. What is happening in CalAIM now that we can't do with MHSA changes the priorities and how we allocate the services. However, the same services are eligible under MHSA and BHSA.

10. Any CBOs part of the BHSA planning meetings or committees?
    - Response: Yes, they are open to CBOs, community partners, clients and family members.

SERVICES

1. Why are hot meals not being used in prevention and early intervention?
    - Response: We don't have board authority or board approval to use PEI funding for food. We're not allowed so when we host training or community events, you know, with our PEI funding, we're not allowed to provide. So, for some of you maybe we're looking at our early intervention services.
2. How are you going to ensure the services that will be provided under BHSA are going to be culturally relevant to our various communities? For example, Eye Movement Desensitization and Reprocessing (EMDR) is more effective for the Black and African communities versus Trauma Focus Cognitive Behavioral Therapy.
    - Response: One of our goals as a department that you've probably seen is a commitment to focus and intentional evaluation of services from an equity lens. We are looking at our cultural roots within Los Angeles County. We are looking at the groups of individuals that may employ underserved or unserved people and trying to make sure we're doing outreach into those communities. We are trying to ensure we have practices and trained clinicians through our LA DMH directly operated clinics but also that our legal entity providers are trying to match the clinicians that are hiring with the clients that they're serving. BHSA brings an increased focus on diversity of our work force to match the diversity of our communities. During the planning process, you'll hear us talk about the equity tool that's available through the county CEO's office. Dr. Taguchi and her team and members of my team have been meeting regularly to look at how we're developing an equity tool for LA County DMH to use. This will be the common starting place for the department in planning and developing new services. We will be able to see what the highest risk communities are and which are the most underserved communities, and which practices are effective with those communities. We will be doing a very intentional equity driven internal process and then you'll hear that a lot in the upcoming planning process.
3. Why is EMDR not an approved DMH EBP under MHSA? Will it be a DMH approved EBP under BHSA?
    - Response: Over the years we have had requests to look at EMDR and we have looked at it. When we look at evidence-based practices (EBP) one of the things that we really try to focus on is consistent findings. Whatever we're supporting as a department we know that it has consistent findings related to the effectiveness and the impacted treatment. We have noticed that there's a lot of mixed research and some providers who have expressed interest; we are going to be working towards a pilot to really look

at how the program is impacting our communities. We don't have any specific dates, but we are in the process of looking at a pilot and looking at the impact of EMDR in our communities. It is important to note here that it focuses on African American communities, and we think what's important in LA county. We want to also look at how it's going to impact all of our communities. The pilot will begin, and we'll have more information on that.

4. How is Adverse Childhood Experiences (ACEs) going to be used in BHSA approaches?
    - Response: ACES is a tool we've been looking at, specifically what are the risk factors people have experienced, what are the tools that people can access to help them improve or turn or boost their internal resources. We continued to use ACEs. We heavily invested in our work with youth, and we know that ACEs impact our community as well throughout their life span. The priority for us looking at ACEs and impacting the trajectory of our community and advocating fiercely especially for our populations. You know the populations too because we know the impact of what can happen, and we want to make sure it's emphasized to all our stakeholders that we're very committed and prioritizing and omitting adverse childhood experiences as much as we can.
5. What are you going to do for children 0-13 under BHSA?
    - Response: ACEs approaches in tools are foundational to the work. Under BHSA, they are prioritizing 51% of our allocation will be for youth under the age of 26 and one of the prioritizations is working on interventions that deal with childhood trauma. So, ACEs is embedded in that and for the question about the 13 and under, it is a priority population under the age of 26. With early intervention for youth under 26 there is an emphasis on interventions with respect to childhood trauma. We offer many trainings in best practices, and we are very much committed today to supporting our youth and also our parents.
6. Will children with private insurance be excluded from accessing mental health services under BHSA Early Intervention like they have in the past?
    - Response: There's been a lot of investments around children and youth. We had school-based health and community schools. There are about 14 different programs that are wrapped up in one of the things that the governor has made clear is that the services are made responsible for what they're supposed to be doing and there are sanctions in the legislation. There are also reporting out requirements in the overall behavioral health reform plan, that road map, there are pieces in place to make sure that youth in schools get services. The managed care plan will be responsible for the population level prevention work. Schools have received funding and have an opportunity to become a provider, and services provided to individuals with private insurance for the private insurance company to have to pay for those services. This will not necessarily be through BHSA, but it will be through the governor's overall vision for behavioral health reform and some of those different packages that he's put into place over the past four years will continue to be set in stone whether it's managed care, individual insurance, mental health plan, etc.
7. In your presentation you mentioned, targeting "individuals in crisis" as part of early intervention, how are we defining "crisis" in this scenario?

- Response: Unfortunately, we're still trying to define “crisis”. We will take it back to the planning process so we can have that conversation during that planning process around what is the state recommending at the county level, and what are we recommending and what is our funding availability showing us. This is going to get a little complicated, but it will be finalized during planning.

8. Are Peer Supporters/Peer Specialists part of the interventions supported under BHSA? How? If not, why?
    - Response: Allowances for new types of services that are part of the governor's behavioral health reform plan, but we've spent a lot of time and energy in the states, invested a lot of money in certification of peer specialist. We do not anticipate peer specialist going away.
9. Why are there no beds for the Tay youth population?
    - Response: This is an integration division question.

TRAINING

1. Will trainings be made available to other agencies to become certified in some of these methods of delivering preventative services, like neurofeedback?
    - Response: Under BHSA, dollars are being taken and centralized at the state level. What we saw though there may be grants coming out to counties that allow us to train up agencies in various practices or community to find out best practices. The state is going to be standing at the center of excellence doing some of the training. We will need to wait and see to the extent we have money for training. We would take that conversation back to stakeholder and planning process to see if we want to prioritize the utilization of these funds.
2. Will there be another seminar speaking on Other Core Services? Similar like we did for FSP, Housing, and Prevention.
    - Response: Core service is a term we use to group together the community services and supports MHSA funded services that are not FSP and under the new BHSA. We covered housing, FSP, and today was early intervention. We have not covered behavioral health support services. We intend to come back and share more information. This is one area we've not heard a lot about at all because the state has really been focusing on defining these much bigger categories. We understand this is an elimination system, that includes our crisis and planning services. But yes, we would recommend for those that are interested in hearing more, there is a DHCS public listening session on behavioral health services and supports which should include early intervention but should also talk about the other range of service that is are available. The session is scheduled for November 4th from 3:00 p.m. to 4:00 P.M. We are going to put the DHCS stakeholder web page in the chat box, so folks are all welcome to listen in along with us. You have to register if you want to listen in.

REQUESTS

1. When will Dr. Byrd's slides be available?

- Response: Microsoft PowerPoint - Transformation-BHSA Prevention Presentation_10.15.2024 - Read-Only

BHSA Planning Process

1. Will there be more discussion around leveraging the dollars? Specifically, Claim expanding eligibility for certain activities funded through BHSA?

    - Response: As we get into the BHSA planning process, we can take a crack at figuring out how they might leverage from each other but that might be part of the planning process. There has been an effort with CalAIM especially looking at some non-direct services. There are in lieu of services, some things like housing and some of these other connection services are now covered by Medi-Cal that may not have been before. That also applies to MHSA right now. What is happening to CalAIM now will be that we can't do with MHSA changes the priorities and how we spend the funding and how we allocate the services.

Meeting Evaluation Data: October 8, 2024

- **78%** found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- **87%** of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants found that the preparation and execution of the meeting were perfectly organized. They liked that thoughtful and intentional approach to ensure that everything is understandable. They were happy that everyone was given the opportunity to give their opinion.

Comments collected included:

- "Our voice was being heard."
- "Very educational."
- "Good discussion."
- "Good printed materials."

Meeting Information

Date	October 25, 2024
Time	9:30 A.M. – 12:30 P.M
Location	Online

Stakeholder Involvement

The presentation was intended to provide information on the BHSA, updates on changes to MHSA programing outlined in statute, and receive comments and questions.

Participants were able to comment and ask questions at the end of the presentations.

Meeting Evaluation Data: October 25, 2024

- **69%** found the meeting time was used efficiently, questions were answered in a respectful manner, and ample opportunities were provided to safely express feelings and share views and opinions.
- **64%** of participants reported the meeting had a clear purpose and objectives, materials were relevant, and the information provided was helpful.

Participants recognized that the meeting/training provided good detailed information. They were able to have their questions answered. Subject matter was very well explained.

Comments collected included:

- "Good information."
- "Information explained in detail"."
- "Able to get questions answered."

Meeting Information

Date	November 19, 2024
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

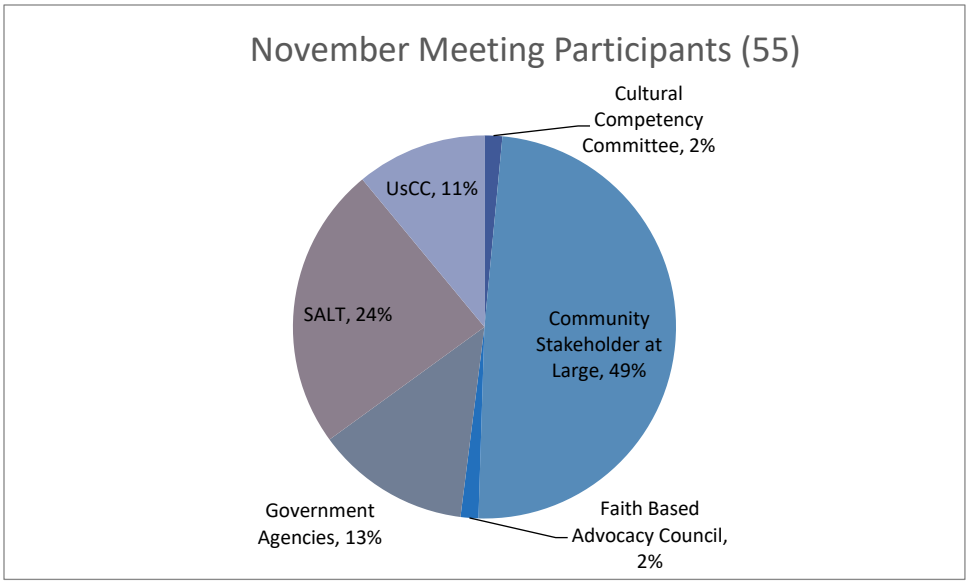
Meeting Description

This meeting aimed to:

1. Share brief updates on MHSA administrative items, including the 2025 meeting calendar.
2. Provide updates and gather questions on the following MHSA- funded programs:
    a. Alternative Crisis Services
    b. Workforce Education and Training
    c. Interim Housing Outreach Program (IHOP)
    d. Hollywood 2.0
3. Provide updates and receive feedback on:
    a. MHSA Innovations 7 - Therapeutic Transportation
    b. MHSA Innovations 8 - Early Psychosis Learning Network

Stakeholder Description

Stakeholders represented the wide range of participants summarized below.



Government agencies include CEO, Department of Rehabilitation, Fire Department, and Public Defender.

Presentation and Discussion

DMH executives conducted presentations on their respective MHSA programs including the data of each program's outcome. Stakeholders participated with the discussion and asked questions and further clarifications. They also shared their thoughts and provided recommendations to improve the services each program provides to clients and the community DMH serves.

The goal is to learn from the evaluation of the outcome to determine what is working and what is not working, and possible expansion of programs to other parts of the County.

MHSA Innovation and Feedback, and MHSA Innovation 7 & 8

1. **Hollywood 2.0 Pilot Project**
   Karla Bennett, LCSW, MH Program Manager II
2. **Innovation 7 – Therapeutic Transportation (TT)**
   Miriam A. Brown, Deputy Director, LCSW
3. **Innovation 8: Early Psychosis Learning Health Care Network - EPI-CAL**
   Samantha Wettimuny, Supervising Psychologist, Psy.D.

Meeting Information

Date	December 10, 2024
Time	9:30 A.M. – 12:30 P.M
Location	St. Anne's Conference Center In-Person Meeting/ Online

Meeting Description

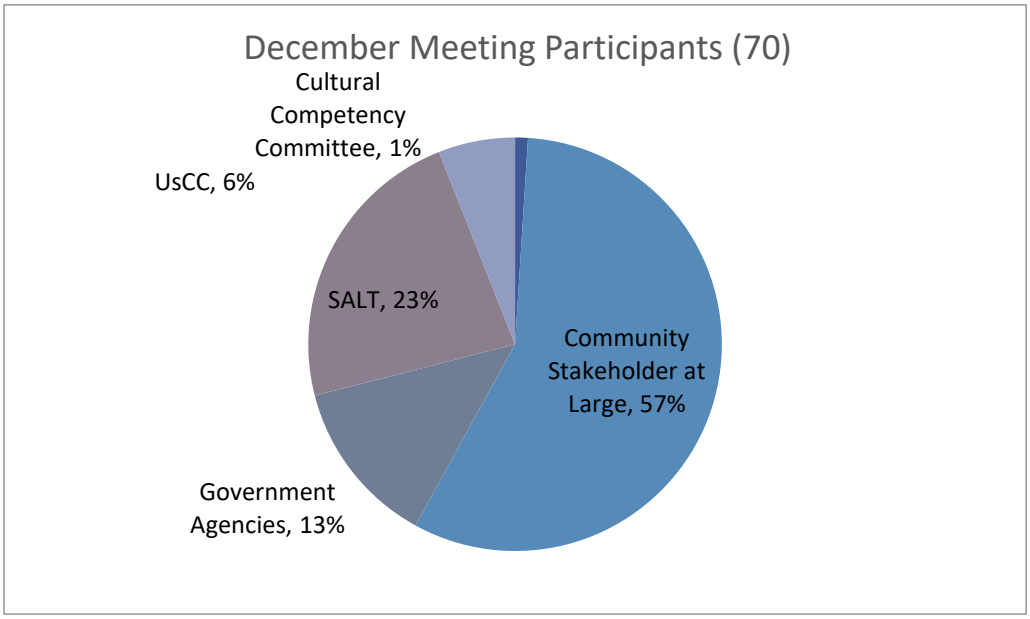
This meeting aimed to:

1. Share brief updates on MHSA administrative items.
2. Provide updates and gather questions on the following MHSA- funded programs:
    e. Prevention, Early Intervention, Stigma and Discrimination Reduction, and Suicide Prevention
    f. 988 Call Center
    g. School Threat Assessment Team
    h. Veteran Peer Access Network (VPAN)
3. Present the MHSA Mid-Year Adjustment for fiscal years 2024-25 through 2025-26 and gather feedback and questions.

The meeting started with the announcements, reminders, and general instructions. The facilitator, Dr. Rigo Rodriguez reminded attendees that the meeting is public and is being recorded. He instructed online attendees to use the chat box to write their questions, comments or recommendations as they do not have the access to speak. American Sign Language (ASL), Spanish and Korean Interpretation, and Communication Access Realtime Translation (CART) captioning were provided. Land Acknowledgment was read before the presentation started.

Stakeholder Description

Stakeholders represented the wide range of participants summarized below.



Meeting Information

Date	April 10, 2025
Time	9:30 A.M. – 12:30 P.M
Location	LACDMH Headquarters: 510 S. Vermont Ave., 9th floor, Conference Room, Los Angeles, 90020 In-Person Meeting/ Online

LACDMH completed the 30-day public posting and comment period and collection of submitted feedback for inclusion in the draft Annual Update before presented to the Board.
The public hearing meeting occurred on April 10, 2025, with Spanish and Korean translation. The agenda, presentations and transcripts are included in Appendix B. Stakeholders were notified about the event via email, Instagram and the DMH website.

During the meeting, stakeholders expressed interest in understanding the range of services available to different populations, particularly focusing on race and ethnicity, and sought information regarding unmet needs within these communities. They inquired about the referral criteria and process for accessing Restorative Care Services, aiming to clarify how clients are directed to these supports.

Further, concerns were raised about the number of clients involved in Full Service Partnerships (FSP), specifically noting the number of Transition Age Youth (TAY) and Department of Children and Family Services (DCFS) involved in these services. Stakeholders also questioned the timeline for the Department of Mental Health (DMH) to implement new training curricula for Mental Health Community Workers, beyond those outlined in the Workforce Education and Training (WET) plan.

Attention was also drawn to the upcoming end of the Intensive Mental Health Recovery Specialist Training Program, with questions about whether it will be funded through alternative sources and for how long. Additionally, there was interest in whether this program was intended as a pathway for promotion for county-employed Mental Health Community Workers at peer resource centers, which are expected to evolve into clubhouses.

Stakeholders asked for clarification on the status of unspent funds, questioning why funds are remaining unused, especially given the sizable total of $729 million, which they requested to be elaborated upon. They referenced the MHSA Annual Update, noting plans for FY 2025/26 to recruit and hire remaining IHOP staff, including DPH clinicians for inpatient Substance Use Disorder (SUD) treatment, and inquired about how many of these positions would be available to Community Workers. Moreover, they emphasized the importance of ensuring that full-time peer roles are paid and supported comparably to other IHOP staff.

In terms of engagement, stakeholders queried how outreach is conducted and what participation levels have been observed over the past five years. They also asked about staffing composition, specifically the ratio of clinical versus administrative staff, and sought updates on the progress of Innovation 8, requesting data on its success.

Further, they wanted to know the percentage of clients served who are involved in both mental health and substance abuse services, as well as the amount of funding spent prior to the implementation of BHSA. Finally, stakeholders asked when the Behavioral Health Commission (BHC) would receive current updates or actions regarding the unspent funds in the 2025-26 plan.

See Appendix C for the comments/recommendations submitted by the Behavioral Health Commission and Appendix D for LACDMH’s response.

VI. PROGRAMS AND SERVICES (BY COMPONENT)

This section provides FY 2023-24 outcome data and program information for existing MHSA programs and is organized by component: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technological Needs and Innovation.

Community Services and Supports (CSS)

As the largest component with 76% of the total MHSA allocation, CSS was designed with service categories that shape the integrated system of care for clients diagnosed with SMI. In FY 2023-24, approximately **162,836** unique clients received a direct mental health service through CSS.

The CSS component of the plan includes the following programs:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Crisis Services (ACS)
- Housing Services
- Linkage
- Planning, Outreach and Engagement Services (POE)

Table 6. CSS clients served by Service Area in FY 2023-24.

Service Area	Number of Clients Served*
SA1- Antelope Valley	12,330
SA2- San Fernando Valley	26,259
SA3- San Gabriel Valley	24,457
SA4- Metro Los Angeles	35,809
SA5- West Los Angeles	11,017
SA6- South Los Angeles	26,592
SA7- East Los Angeles	15,861
SA8- South Bay	32,567

*Clients served may have received services in more than one service area. Number of clients counted are for direct services and do not include outreach efforts.

The next few pages provide a summary of information for each CSS program.

Full Service Partnership (FSP)

Program Description: FSP programs provide a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness.

FSP services are provided by multi-disciplinary teams of professional and paraprofessional and volunteer providers who have received specialized training preparing them to work effectively with children and young adults (ages 0-20) and adults (ages 21+); FSP teams provide 24/7 crisis services and develop plans with the client to do whatever it takes within the resources available and the recovery plan agreed between the client and the FSP provider team to help clients meet individualized recovery, resiliency, and development and/or recovery goals or treatment plan; and FSP teams are responsive and appropriate to the cultural and linguistic needs of the client and their families.

Intended Outcomes: Reduce serious mental health systems, homelessness, incarceration, and hospitalization. Increase independent living and overall quality of life.

Key Activities:

- Outreach and engagement (provided to potential FSP clients prior to enrollment in a FSP program; used to build a relationship between the FSP program and potential client and to determine if the potential client is appropriate for FSP services) including outreach and engagement in community spaces such as libraries and parks.
- Clinical services (24/7 crisis response services; counseling and psychotherapy; field-based services; integrated treatment for co-occurring mental health and substance abuse disorder; case management to provide linkages to services to employment, education, housing and physical health care)
- Nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care)

FY 2023-24 Update:
As part of the previous Three-Year Plan, FSP programs and services were developed to provide comprehensive mental health services to clients requiring intensive treatment. Services are provided by a multi-disciplinary team based on a specific number of client slots. Services provided to clients enrolled in FSP may include, but are not limited to, 24/7 crisis response (in-person when needed); ongoing intensive mental health treatment; linkage to housing; employment services; and co-occurring mental illness and substance use treatment services. Adult FSP services aim to help clients who are enrolled in the program increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations. For those clients that are homeless, Adult FSP services will help them transition from street to home by providing immediate and ongoing assistance with securing and maintaining housing. Child/Young Adult (YA) FSP services include but are not limited to individual and

family counseling, 24/7 assessment and crisis services, Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS). The intent of these services is to help clients and/or families increase their ability to function at optimal levels. Existing FSP programs serve children and young adults between the ages of 0-20 and adults 21+.

In FY 2024-25, Legal Entity (LE) contracts will be amended to extend contracts through the end of FY 2025-26. In addition, LACDMH anticipates doing a re-solicitation process for Adult FSP that will align with the requirements set forth by the Department of Health Care Services (DHCS) and the Behavioral Health Transformation (BHT).

On March 5, 2024, California voters passed Proposition 1, which will modernize and reform the Mental Health Services Act (MHSA). This will require counties to provide specific programs such as Assertive Community Treatment (ACT), Forensic Assertive Community Treatment (FACT), High Fidelity Wraparound, Individual Placement and Support (IPS), and lower levels of FSP.

FY 2023-24 FSP Data and Outcomes

As of June 30, 2024, LACDMH had FSP slots as shown in the next table.

Table 7. FSP Slots

Program	Number of Slots
Child/Youth (includes Wraparound and Intensive Field Capable Clinical Services)	3,673
Adult (includes Assisted Outpatient Treatment and Homeless)	9,426

Table 8. FSP Summary: age group, average cost per client, unique clients served and total number of clients to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2025-26[2]
Children	$30,418	2,684	2,746
TAY	$23,019	2,281	2,277
Adult	$18,314	6,460	6,512
Older Adult	$16,026	1,619	1,656

[1]Cost is based on direct mental health services, not inclusive of community outreach services or client supportive services expenditures.
[2]FY 2025-26 total number to be served, reflects an average of the two prior fiscal years.

Figure 17. FSP Clients Served

Figure 18. FSP Clients Served by Age Group

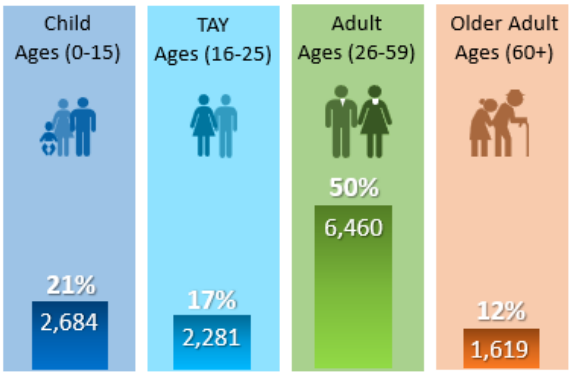


Figure 19. FSP Clients Served by Ethnicity Area

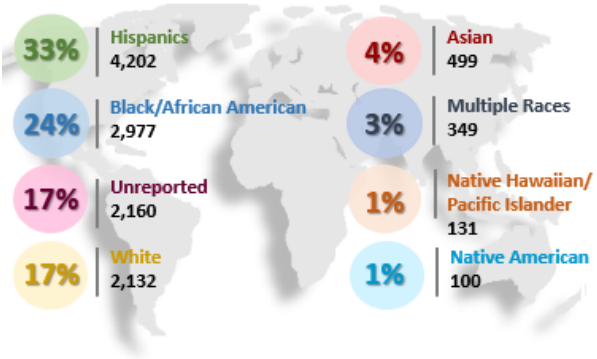
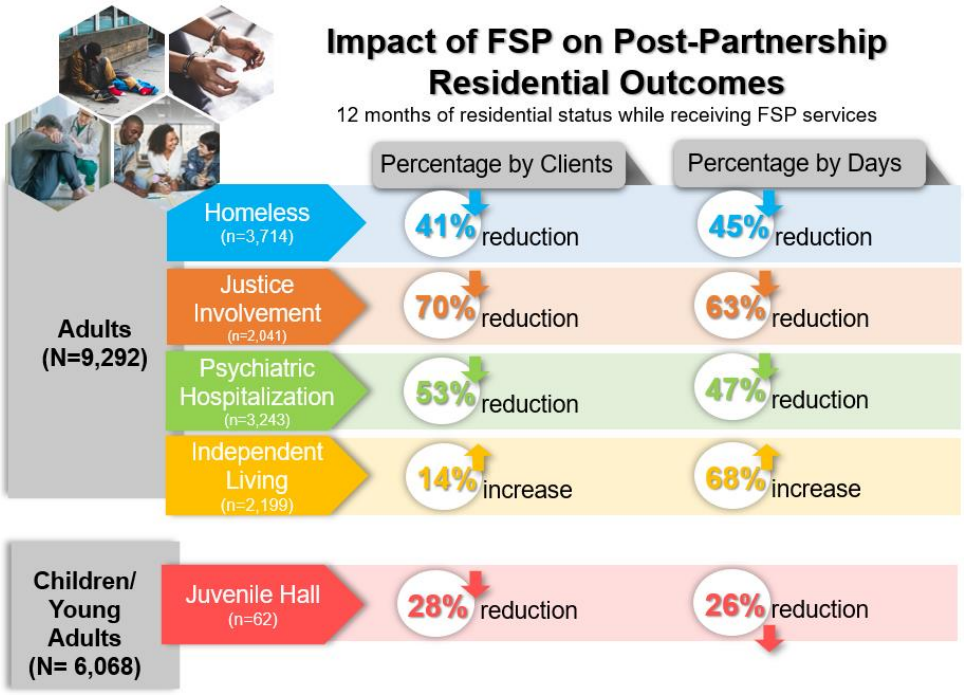


Figure 20. FSP Clients Served by Service

*Number of New Clients is a subset of Number of Clients Served

Service Area	Number of Clients Served	*Number of New Clients
SA1 – Antelope Valley	858	51
SA2 – San Fernando Valley	1,397	94
SA3 – San Gabriel Valley	1,565	113
SA4 – Metro	2,410	152
SA5 – West	745	38
SA6 – South	2,435	212
SA7 – East	1,444	107
SA8 – South Bay	2,387	159

Figure 21. FSP Residential Outcomes



Outcome data for clients with open outcomes in FY 2023-24 with a data cut off of 6/30/2024. Clients had a baseline sometime before 6/30/2023 and no disenrollment Key Event Change before 7/1/23 unless they also had a reestablishment that was active during FY 2023-24. Figures represent cumulative changes, inclusive of all clients served in FY 2023-24.

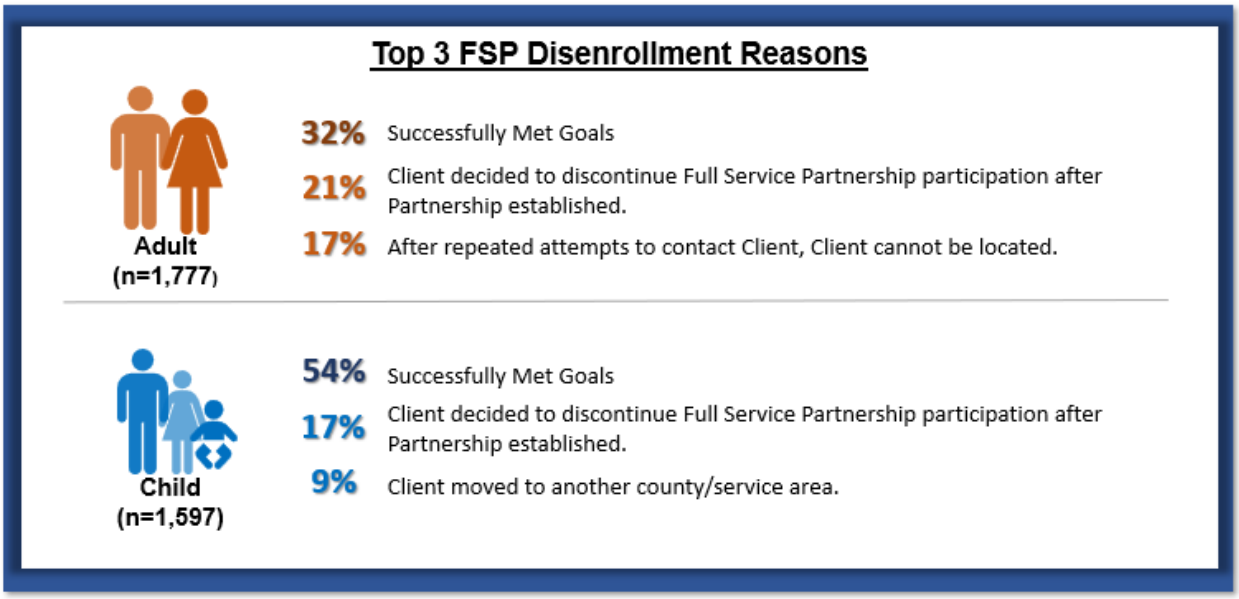
Disenrollment

FSP disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within 12 months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to FSP services for more than 12 months from date of last contact.

The reasons for disenrollment are as follows:

- Target population criteria not met.
- Client decided to discontinue FSP participation after partnership was established.
- Client moved to another county/service area.
- Client cannot be located after attempts to contact client.
- Community services/program interrupted – client will be detained or incarcerated in the juvenile or adult system for over 90 days.
- Community services/program interrupted- client will require residential/institutional mental health services - Institutions for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital
- Client has successfully met his/her goals such that discontinuation of FSP is appropriate; Client's needs can be met in a lower level of Care.
- Client is deceased.

Figure 22. FSP Disenrollment



Outpatient Care Services (OCS)

Program Description: Outpatient Care Services (OCS) provides a broad array of integrated community-based, clinic and/or field-based services in a recovery-focused supportive system of care. This system of care provides a full continuum of services to all age groups. As part of this continuum, clients can receive mental health services, which may include evidence based or community defined evidence-based treatment and supports in a timely manner in the most appropriate setting to meet their needs. Training and equipment are essential to support evidence-based practices and community defined evidence-based treatment. OCS is inclusive and strives to provide culturally sensitive and linguistically appropriate services to meet the needs of the diverse communities of Los Angeles County.

LACDMH believes that wellness, recovery, and peer services are essential to the entire continuum of care. Services provided are developed with an Anti-Racism Diversity and Inclusion (ARDI) lens. In addition, the LACDMH is integrating its Wellness teams into outpatient service sites. Peer Resource Centers remain as standalone services. Peer Resource Centers include peer support (individual and group), advocacy, linkage, social connections and supports.

OCS aims meet clients where they are to engage individuals in services and assist them in moving toward recovery and achieving self-determined, meaningful goals that promote connectedness, mental and physical wellbeing, and meaningful use of time. All age groups have access to core components of mental health services based on their level of engagement and commitment. These services include assessments, individual and/or group therapy, crisis intervention, case management, housing, employment support, peer support, co-occurring disorders treatment, medication support services (MSS) and Medication Assisted Treatment (MAT). The intensity, location (community/field or office/clinic) and duration of the service(s) depend on the individualized need of each client and will likely change over time. While most clients generally move from more intensive to less intensive services, some clients may need more intensive services for periods of time due to a variety of factors. These factors include, but are not limited to, the emergence or exacerbation of a severe mental illness; non-adherence to treatment recommendations; a substance use disorder; and exposure to trauma, violence, or external psychosocial stressors such as housing, employment, relationship, or legal problems. The primary goal of OCS to engage individuals in active participation in their treatment journey toward recovery.

Priority Population:

- Children (0-15), Comprehensive Services
- Transition Age Youth (16-25), Comprehensive Services, Enhanced Emergency Shelter Program, Supported Employment Individual Placement and Support (SEIPS), Probation Camps and Drop-in Centers
- Adults (24-59), Comprehensive Services
- Older Adults, Comprehensive Services, and Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) program

Key Activities:

- Clinical services (individual, group, and family therapy; crisis resolution/intervention; evidence-based treatments; medication support services, including MAT; outreach and

engagement which includes outreach and engagement in community spaces such as libraries and parks; co-occurring disorder services; screenings and assessments to determine level of care needs; and case management)

- Ancillary services (Peer Resource Centers; peer support; family education and support; linkage to various resources; housing services; and vocational and pre-vocational services).

FY 2023-24 OCS Data and Outcomes

Table 9. OCS Summary: age group, average cost per client, unique clients served and total number of clients to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2025-26[2]
Children	$6976	22,870	21,732
TAY	$4,982	20,126	20,291
Adult	$4,419	63,183	64,229
Older Adult	$4,510	18,034	18,170

[1]Cost is based on direct mental health services, not inclusive of community outreach services or client supportive services expenditures.
[2]FY 2025-26 total number to be served, reflects an average of the two prior fiscal years.

Figure 23. OCS Clients Served Group

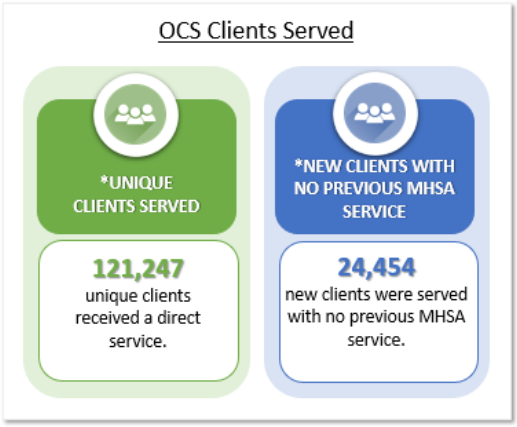


Figure 24. OCS Clients Served by Age

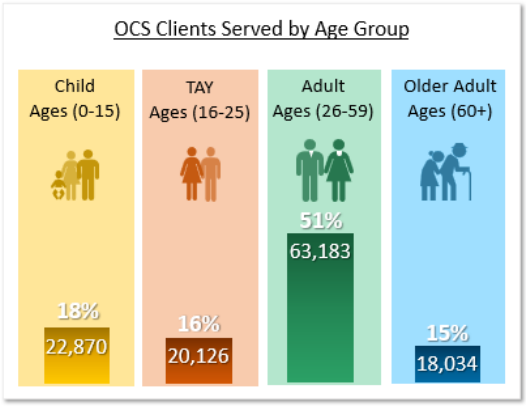


Figure 25. OCS Clients Served by Ethnicity

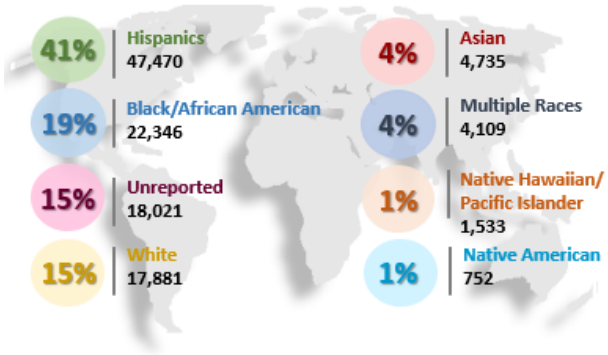


Figure 26. FSP Clients Served by Service Area

Service Area	Number of Clients Served	*Number of New Clients
SA1 – Antelope Valley	9,113	1,669
SA2 – San Fernando Valley	20,577	4,260
SA3 – San Gabriel Valley	15,010	2,905
SA4 – Metro	21,842	4,868
SA5 – West	6,971	1,247
SA6 – South	18,194	3,445
SA7 – East	11,388	2,140
SA8 – South Bay	22,228	4,450

*New Clients is a subset of Unique Clients Served

Changes or modifications for FY 2025-26:

The Department has adopted a level of care tool that will be implemented across the entire system, directly operated and contracted providers. Over the next year, the Department will develop and implement lower levels of Full-Service Partnership (FSP) programs, which will align with the level of care tool, providing consumers with a fluid continuum of care trajectory. As the Department continues to pivot to meet the needs of special populations, including people experiencing homelessness and/or justice involvement, and expanding field-based services and training to successfully engage and work with clients effectively in the field.

In addition, the Department will focus on age group specialization that require expertise in programming, engagement, and outreach. Age group leads will be identified to develop age-specific mental health treatment that offers therapeutic approaches and interventions tailored to address the unique psychological, emotional, and developmental needs of individuals at different stages of life.

Due to best practices, OCS requires initial in person services to establish mental and physical health baselines. The Department continues to provide telehealth as an option per consumer choice for on-going services. Where possible, telework is used as both a retention and access to care strategy and staff morale booster.

OCS will continue to create and expand programming around specialty mental health needs, such as eating disorders, perinatal/maternal mental health, men's/fatherhood mental health, and co-occurring mental health and substance use disorders. To enhance these efforts, champions have been enlisted in the areas of men's/fatherhood mental health, perinatal/maternal mental health, and LGBTQIA2S+ mental health.

Alternative Crisis Services (ACS)

Program Description:

Alternative 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., FSP and Assertive Community Treatment programs, housing alternatives, and treatment for co-occurring substance abuse. ACS serves individuals 18 years of age and older of all genders, race/ethnicities, and languages spoken.

In 2019, Countywide Resource Management integrated with the Managed Care Division and changed its name to the Intensive Care Division. It remains responsible for overall administrative, clinical, integrative, and fiscal aspects of programs that serve the most severely ill individuals with mental illness. This includes planning, developing, and implementing urgent care centers and enriched residential programs for these specialized populations. Also, it coordinates functions to maximize the flow of clients between various levels of care and community-based mental health services and supports.

LACDMH MHSA ACS programs:

- Psychiatric Urgent Care Centers
- Enriched Residential Services (ERS)
- Crisis Residential Treatment Programs (CRTP)
- Law Enforcement Teams (LET)
- Restorative Care Villages
- Psychiatric Mobile Response Teams (PMRT)
- 988 Crisis Call Center Services (also known as The 988 Suicide & Crisis Lifeline) – See the Suicide Prevention section for outcomes and program content.
- Therapeutic Transportation (Services began in FY 2024-25)

Intended Outcomes:

- Reduce utilization of psychiatric emergency rooms and inpatient acute psychiatry
- Reduce incarceration of persons with severe and persistent mental illness

Key Activities:

- Divert clients as appropriate to mental health urgent cares
- Divert clients as appropriate to Crisis Residential Treatment Programs
- Utilize mental health clinician teams in the fields as alternatives to crisis response

During FY 2023-24, the Department of Mental Health (DMH) added four (4) Crisis Residential Treatment Program (CRTP) facilities and one (1) on June 14, 2023. The total number of CRTP facilities is 19 (12 on county campuses and 6 in the community). To respond to urgent placement needs, DMH also approved 20 Single Case Agreements (SCAs) for the Enriched Residential Services (ERS) Program in FY 2023-24 and admitted 2 single cases to an ERS provider at the end of FY 2023-24.

In addition to adding treatment beds to the DMH network, the Department also focused on expanding its mobile crisis response services by holding hiring fairs and recruiting staff. DMH also

contracted with three (3) providers to assist in providing service countywide during evenings and weekends, with the ultimate goal of providing 24/7 services by December 2023.

By July 2024, Sycamores, Vista and Brain Health were all on board to provide Field Intervention Teams (FIT) services under their Mobile Crisis Outreach Teams (MCOT) contract across the Service Areas. In FY 2023-24, all MCOT providers began to provide services at 4 pm Monday through Friday and increased their teams to respond to calls in 60 minutes or less. MCOT teams are expected to provide services 24/7 during the week and holidays.

Also, DMH expanded their bed network to support clients requiring acute psychiatric services brought by law enforcement, ambulances and DMH staff, including FIT, Psychiatric Mobile Crisis Response (PMRT) and MCOT. In November 2023, DMH secured 42 guaranteed beds at four (4) hospitals including Mission Community Hospital, Adventist Health Glendale, LA Downtown Medical Center, and College Medical Center. This enabled them to secure a bed at one of the four hospitals through a DMH Provider Line and admit the patient directly.

DMH successfully hired Community Health Workers (CHW)/Peers and continued to fill vacancies on the PMRT teams as well as other crisis response teams: Law Enforcement Co-response Teams (LET), Therapeutic Transportation Teams (TTT) and School Threat Assessment Response Teams (START). In January 2024, DMH implemented a Therapeutic Transportation Pilot Project in Santa Monica consisting of a clinician, CHW, and driver. The team will handle calls through the 911 system for clients that are non-combative, non-agitated, and experiencing a mental health crisis. As a result of the multiple hiring fairs, lateral transfers and using the certified hiring list, PMRT was increased to 51 teams, a PMRT mid- and nocturnal shift were implemented to meet the needs of the community. Additionally, DMH was able to hire staff for the LET and START program. DMH continues to encounter difficulties in hiring and retaining staff because of the lack of telework options due to the nature of field work requiring in-person evaluation and assessment.

With the expansion of MCOT teams, PMRT teams, and other ACR programs, DMH was able to provide crisis services 24/7 by November 2023. DMH will continue to utilize overtime PMRT staff to fill gaps in coverage.

During FY 2023-24, LACDMH continued its investment in the development of Permanent Supportive Housing (PSH) PSH for homeless or chronically homeless individuals and families who are living with SMI or Serious Emotional Disturbances (SED).

Psychiatric Urgent Care Centers (UCC)

Psychiatric UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24-hours per day, 7 days per week. UCCs also provide case management for individuals experiencing psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Clients are permitted to stay in the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services.

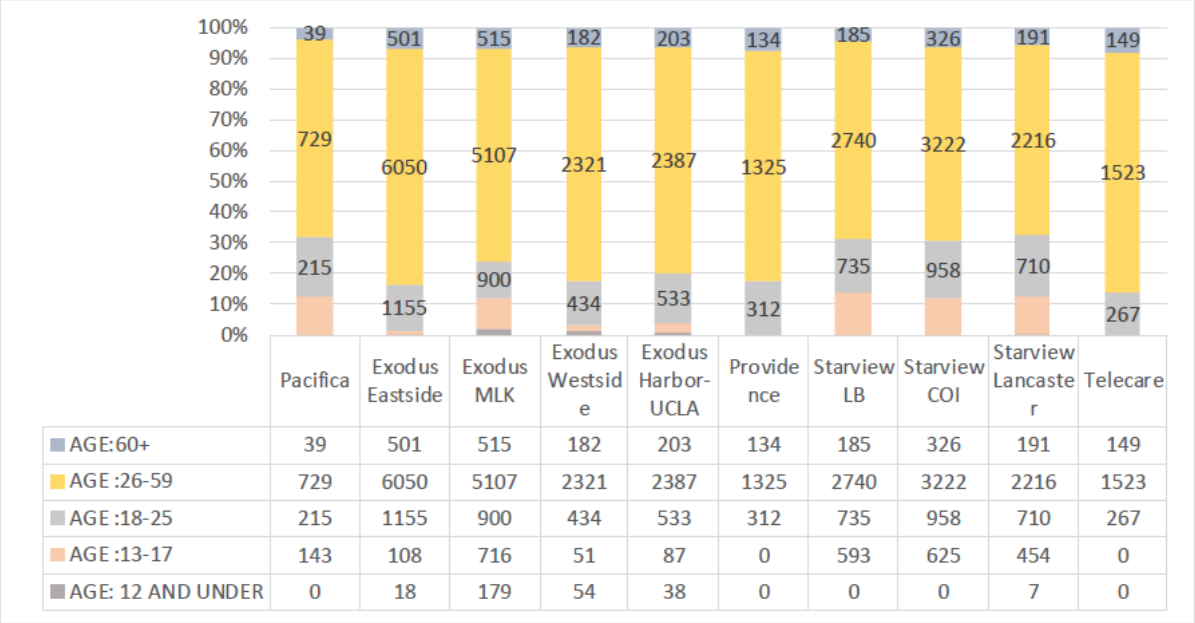
Table 10. Location of the Current UCCs

Urgent Care Center	Service Area	Location	Address	Phone
Starview High Desert	1	Lancaster	415 East Avenue I Lancaster, CA 93535	Ph: (661) 522-6770 Fax: (661) 723-9079
Behavioral Health UCC	2	San Fernando Valley	14228 Saranac Lane Sylmar, CA 91342	Ph: (747) 315-6108 Office: (747) 315-6100
Star View BHUCC	3	East – City of Industry/East San Gabriel	18501 Gale Ave. Ste. 100 City of Industry, CA 91748	Ph: (626) 626-4997
Exodus (Eastside UCC)	4	Downtown Los Angeles	1920 Marengo Street Los Angeles, CA 90033	Ph: (323) 276-6400 Fax: (323) 276-6498
Exodus (Westside UCC)	5	West Los Angeles	11444 W. Washington Blvd., Ste D. Los Angeles, CA 90066	Ph: (310) 253-9494 Fax: (310) 253-9495
Exodus (MLK UCC)	6	South Los Angeles	12021 S. Wilmington Ave., Los Angeles, CA 90059	Ph: (562) 295-4617
Exodus (Harbor UCC)	8	Harbor-UCLA/Torrance	1000 W Carson Street, Bldg. 2 South Torrance, CA 90502	Ph: (424) 405-5888
Providence Little Company of Mary OBHC[2]	8	San Pedro	1300 W. 7th Street San Pedro, CA 90732	Ph: (310) 832-3311
Star View BHUCC	8	Long Beach	3210 Long Beach Blvd. Long Beach, CA 90807	Ph: (562) 548-6565
Telecare (La Casa[1] MHUCC[2])	8	Long Beach	6060 Paramount Blvd. Long Beach, CA 90805	Ph: (562) 790-1860 Fax: (562) 529-2463
Pacifica Hospital of the Valley Behavioral Health UCC	2	San Fernando Valley	14228 Saranac Lane Sylmar, CA 91342	Ph: (747) 315-6108 Off: (747) 315-6100

[1] La Casa is an exception; it is not open 24-hours per day, 7 days a week. It is LPS-designated.
[2] MHUCC = Mental Health UCC; OBHC = Outpatient Behavioral Health Center.

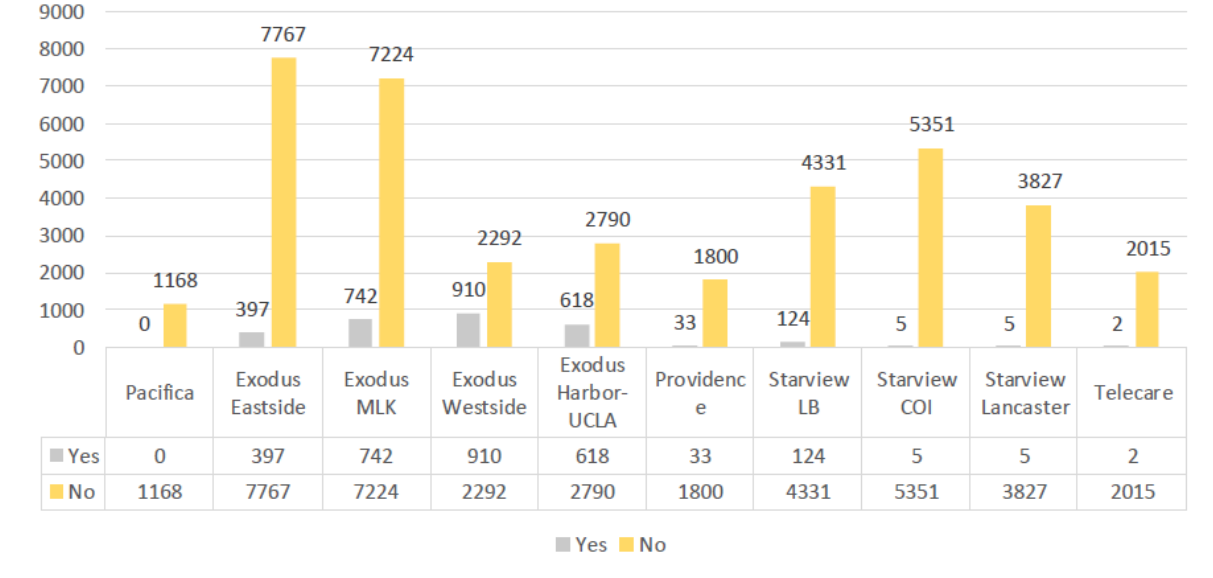
The following graphs provide an overview of FY 2023-24 outcomes of the UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 27. FY 2023-24 UCC New admissions by age group



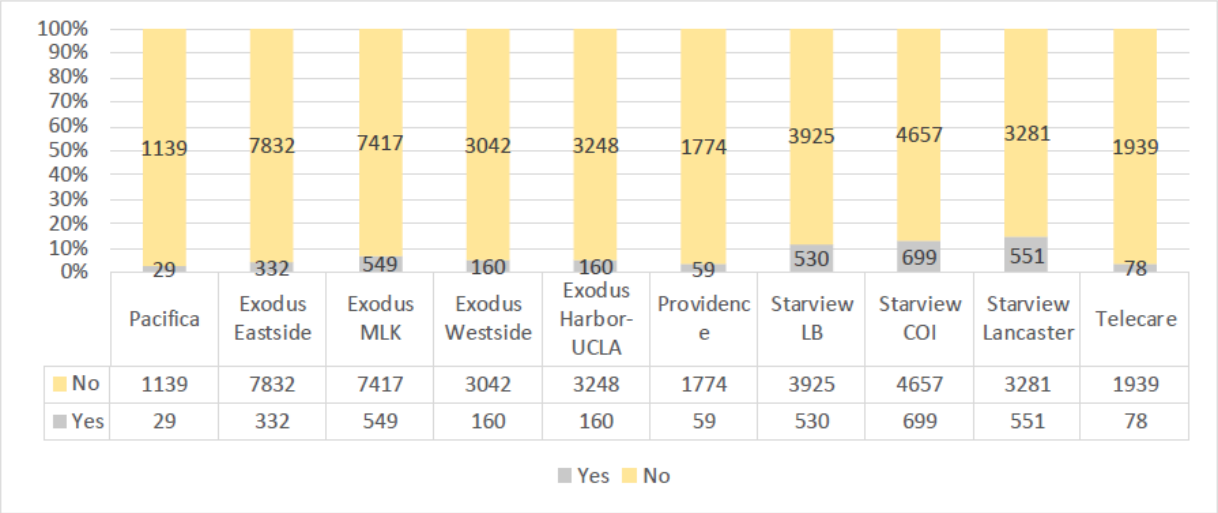
	Pacifica	Exodus Eastside	Exodus MLK	Exodus Westside	Exodus Harbor-UCLA	Providence	Starview LB	Starview COI	Starview Lancaster	Telecare
AGE:60+	39	501	515	182	203	134	185	326	191	149
AGE :26-59	729	6050	5107	2321	2387	1325	2740	3222	2216	1523
AGE :18-25	215	1155	900	434	533	312	735	958	710	267
AGE :13-17	143	108	716	51	87	0	593	625	454	0
AGE: 12 AND UNDER	0	18	179	54	38	0	0	0	7	0

Figure 28. Clients with a psychiatric emergency assessment within 30 days of an UCC assessment



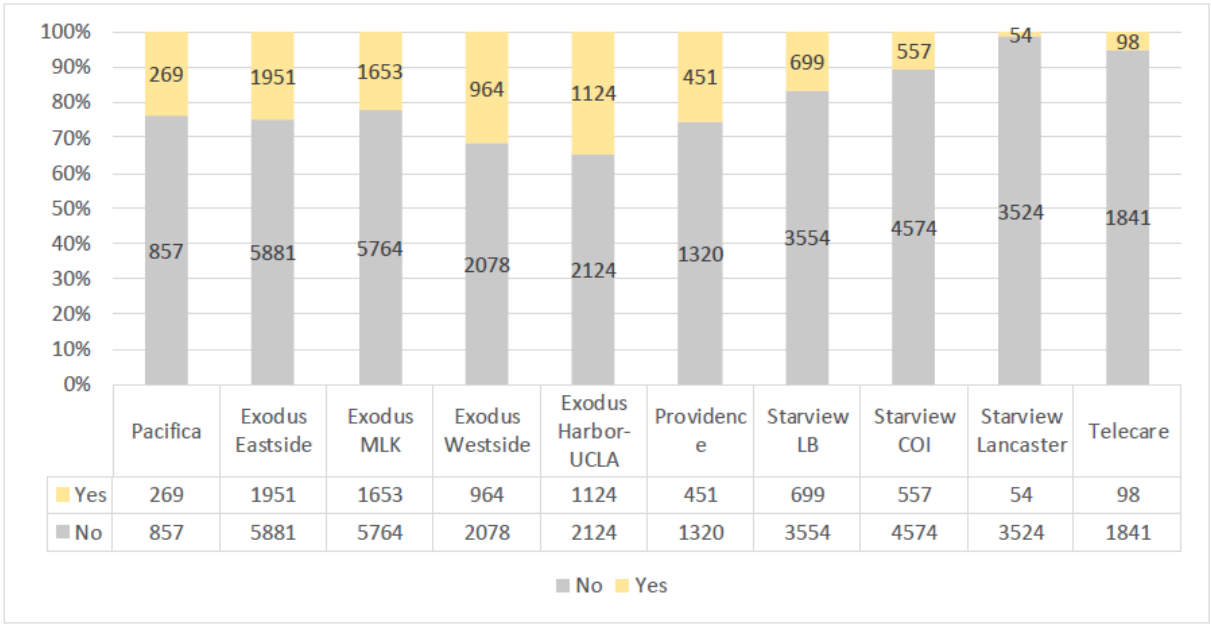
	Pacifica	Exodus Eastside	Exodus MLK	Exodus Westside	Exodus Harbor-UCLA	Providence	Starview LB	Starview COI	Starview Lancaster	Telecare
Yes	0	397	742	910	618	33	124	5	5	2
No	1168	7767	7224	2292	2790	1800	4331	5351	3827	2015

Figure 29. Clients returning to UCC within 30 days of prior UCC visit



	Pacifica	Exodus Eastside	Exodus MLK	Exodus Westside	Exodus Harbor-UCLA	Providence	Starview LB	Starview COI	Starview Lancaster	Telecare
No	1139	7832	7417	3042	3248	1774	3925	4657	3281	1939
Yes	29	332	549	160	160	59	530	699	551	78

Figure 30. Clients who were homeless upon admission to UCCs



	Pacifica	Exodus Eastside	Exodus MLK	Exodus Westside	Exodus Harbor-UCLA	Providence	Starview LB	Starview COI	Starview Lancaster	Telecare
Yes	269	1951	1653	964	1124	451	699	557	54	98
No	857	5881	5764	2078	2124	1320	3554	4574	3524	1841

Enriched Residential Services (ERS)

ERS is designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities, 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.

Table 11. Enriched Residential Services Facilities

Anne Sippi Clinic 5335 Craner Ave. North Hollywood, CA 91601 Ph: (818) 927-4045 Fax: (818) 927-4016	Bridges – Casitas Esperanza 11927 Elliott Ave. El Monte, CA 91732-3740 Ph: (626) 350-5304	Cedar Street Homes 11401 Bloomfield St. Bldg. 305 Norwalk, CA 90650 Ph: (562) 207-9660 Fax: (562) 207-9680
Telecare 7 4335 Atlantic Blvd. Long Beach, CA 90807 Ph: (562) 216-4900 Fax: (562) 484-3039	Normandie Village East– 1338 S. Grand Ave Los Angeles, CA 90015 Ph: (213) 389-5820 Fax: (213) 389-5802	Special Services for Groups (SSG) 11100 Artesia Blvd. Ste. A Cerritos, CA 9070 Ph: (562) 865-1733 Fax: (213) 389-7993
A&A Health Services of San Pablo 13956 San Pablo Ave. San Pablo, CA 94806 Ph: (510) 609-4040 Fax: (925) 725-4796	Percy Village 4063 Whittier Blvd., Suite #202 Los Angeles, CA 90023 (323) 268-2100 ext. 234 Fax (323) 263-3393 eFax 323-983-7530	A Brighter Day 407-409 W 103rd Street, LA, CA. 90003 Office: (213) 293-3213 Office: (888) 243-7412 eFax: (866) 815-5154

Crisis Residential Treatment Programs (CRTP)

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division. They are designed to improve the lives and adaptive functioning of those they serve. Those admitted to a CRTP can be expected to receive an array of services including self-help skills, peer support, individual and group interventions, social skills, community re-integration, medication support, co-occurring services, pre-vocational/ educational support, and discharge planning.

Table 12. List of current CRTPs

Hillview Crisis Residential 12408 Van Nuys Blvd., Bldg. C Pacoima, CA 91331 Ph: (818) 896-1161 x 401	**Didi Hirsch Excelsior House** DiDi Hirsch Comm. MH 1007 Myrtle Ave. Inglewood, CA 90301 Ph: (310) 412-4191 Fax: (310) 412-3942	**Exodus CRTP** 3754-3756 Overland Avenue Los Angeles, CA 90034 Ph: (424) 384-6130 Fax: (213) 265-3290
Gateways CRTP 423 N. Hoover Street Los Angeles, CA 90004 Ph: (323) 300-1830 Fax: (323) 664-0064	**Freehab (Teen Project) CRTP** 8142 Sunland Blvd., Sun Valley, CA 91352 Phone: (818) 582-8832 Fax: (818) 582-8836	**Safe Haven CRTP –** 12580 Lakeland Rd. Santa Fe Springs, CA 90670 Phone: (562) 210-5751
SSG Florence House CRTP 8627 Juniper Street Los Angeles, CA 90002 Phone: (323) 537-8979	**Valley Star LAGMC CRTP** 1774 Zonal Ave. Bldg. B Los Angeles, CA 90033 **Phone: (310) 221-6377**	**Valley Star MLK CRTP** 12021 Wilmington Ave. Los Angeles, CA 90059 Phone: (213) 222-1681
Telecare Olive House CRTP 14149 Bucher Ave. Sylmar, CA 91342 Phone: (747) 999-4232	**Telecare Citrus House CRTP** 7725 Leeds Street Bldg. D Downey, CA 90242 Phone: (562) 445-3001	**Telecare Magnolia House CRTP** 1774 Zonal Ave RTP, Bldg. D Los Angeles, CA 90033 Phone: (323) 992-4323
Central Star Rancho Los Amigos CRTP 7745 Leeds St. Downey, Ca 90242 Phone: (562) 719-2866	**Central Star Olive View CRTP** 14129 Bucher Ave. Sylmar, CA 91342 Phone: (818) 290-5308	**Valley Star Rancho Los Amigos CRTP** 7735 Leeds St. Downey, CA 90242 Phone: (562) 719-2865
Central Star LAGMC CRTP 1774 ZONAL AVE. BLDG. C Los Angeles, CA 90033 Phone: (310)221-6378	**Star View Rancho Los Amigos CRTP** 7755 Leeds St. Downey, CA 90242 Phone: (562) 719-2867	**Valley Star OV CRTP** 14119 BUCHER AVE. Sylmar, CA 91342 Phone: (818) 290-5307
Star View OV CRTP 14139 BUCHER AVE. Sylmar, CA 91342 Phone: (818) 290-5309		

Law Enforcement Teams (LET)

The countywide police and mental health co-responder teams consist of LACDMH staff working collaboratively with local police departments in Los Angeles County. The primary mission of LET is to assist patrol officers when responding to 911 calls involving persons with a mental illness. These crisis intervention services are aimed to reduce incarcerations, mitigate police use of force, and allow patrol officers to return quickly to patrol duties.

The County's diverse population requires compassionate and equitable intervention methods across the spectrum of care. LACDMH serves those most vulnerable and at-risk in our community through expanded personalized programs and collaboration with other County departments.

LET co-response teams consist of a law enforcement officer and a LACDMH mental health clinician who respond to 911 calls involving mental health crises. These teams ensure that the individuals in crisis receive appropriate, specialized care and safe transportation to the treatment

facilities. LET and LACDMH's Psychiatric Mobile Response Teams (PMRT) support one another as resources permit. Mental health clinicians have already been assigned to work with 40 of the 46 police departments throughout the County.

FY 2023-24 Outcomes

There were 11,674 incidents, of which 27.7% involved homeless individuals; 6.48% resulted in arrests; and 50.96% required hospitalizations.

Approximately 27% (N=3,178) of calls involved homeless individuals. Of MET (cities) 49.3% (N= 1,286) were homeless followed by Long Beach MET at 30.6% homeless. Of LAPD SMART calls

22.6% (N=1,042) involved homeless individuals followed by Sherif's MET calls at 16.5% homeless.

Overall, 50.96% (N=5,949) of all LET incidents resulted in an involuntary applications for further evaluation. Of these holds, 84.45% (N=5,024) were adults and 15.55% (N=925) were minors.

Approximately 6.5% (N= 756) of the calls resulted in an arrest, 2.9% (N=337) being misdemeanors and 3.6% (N=419) felonies. Of Sheriff's MET's incidents, 9.86% (N=358) resulted in arrest which was the highest arrest rate followed by MET (cities) at 6.64% (N=173) then LAPD SMART at 4.72% (N=218).

Psychiatric Mobile Response Teams (PMRT)

PMRT provides non-law enforcement-based mobile crisis response for clients experiencing a psychiatric emergency in the community. PMRT consists of LACDMH clinicians designated to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide food, clothing, or shelter for themselves. PMRT enables successful triage of each situation involving mentally ill, violent or high-risk individuals. PMRT provides caring, deescalating and less traumatizing approaches to crisis intervention—and whenever possible avoids outcomes that involve hospitalization, incarceration, or additional injury. PMRTs' tactics support clients and their families through trust and attention, and ultimately contribute to reducing stigma surrounding mental health and accessing help. This service includes coordination and the dispatch of response teams.

PMRTs also receive community calls that do not rise to the level of direct services; in these situations, staff provide information, referrals, and other kinds of alternative support. More than 23 entities send referrals to PMRT, making it a critical source of care and response across LA County.

FY 2023-24 Outcomes

Figure 31. FY 2023-24 Number of PMRT Incidents by Service Area – including non-dispatched

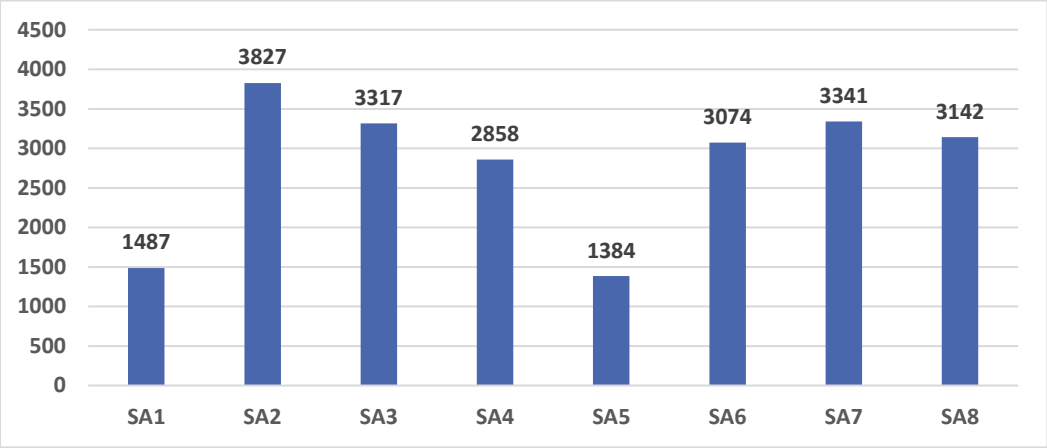


Figure 32. FY 2023-24 Number of PMRT Field Incidents by Service Area – excluding non-dispatched

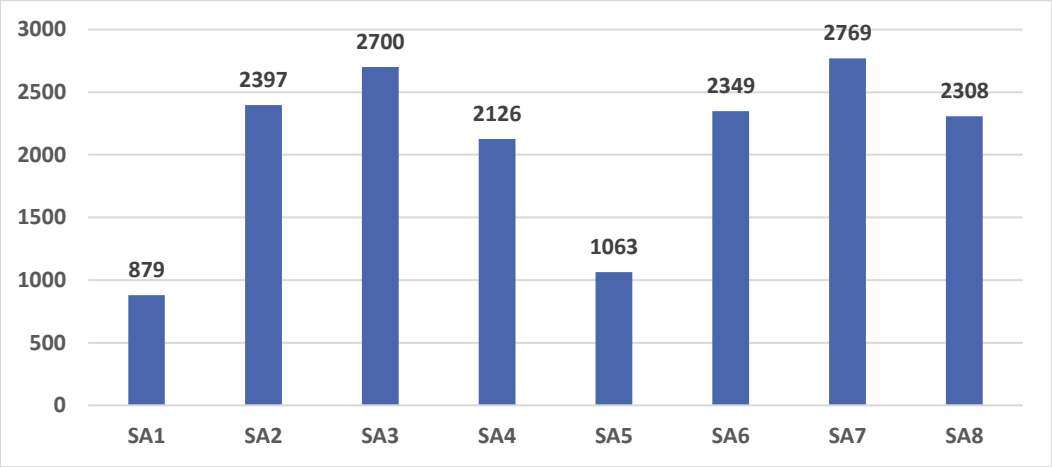


Figure 33. FY 2023-24 PMRT Daytime and After-hours Incidents – including non-dispatched

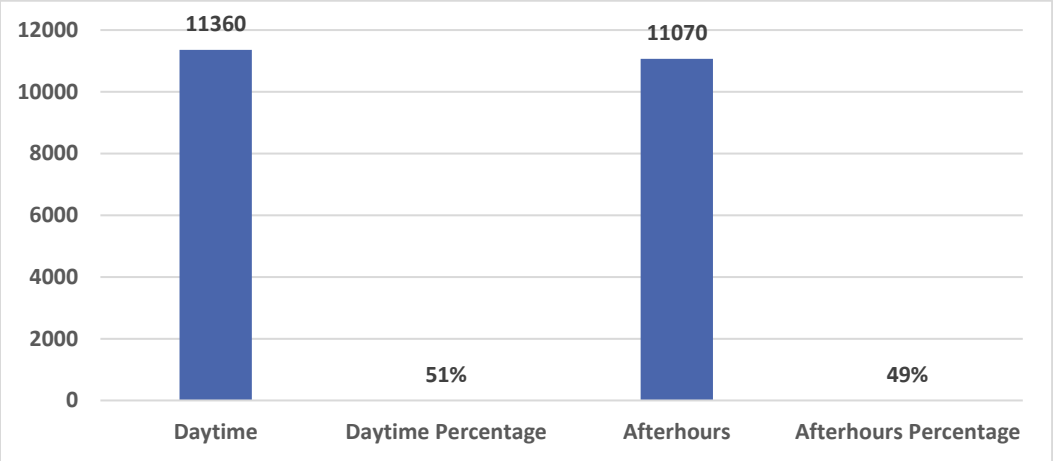


Figure 34. FY-2023-2024-PMRT Daytime and After-hours Field Visits – excluding non-dispatched

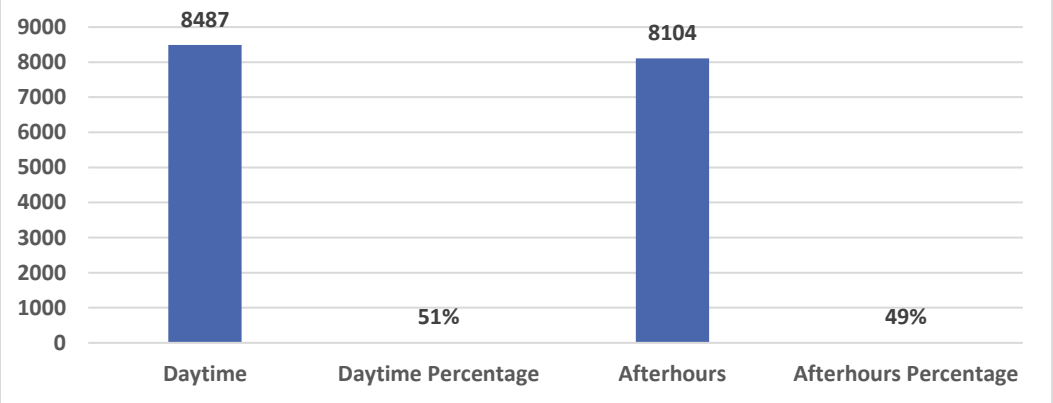


Figure 35. FY-2023-2024-Number of PMRT Incidents by Outcome – including non-dispatched

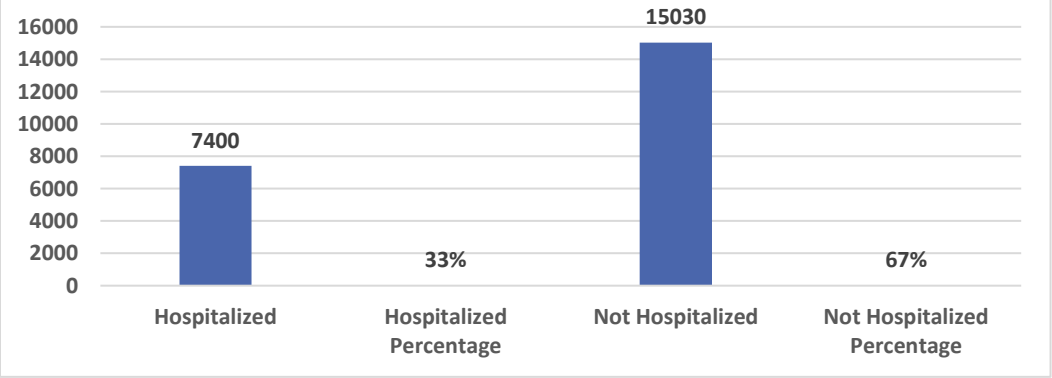


Figure 36. FY-2023-2024-Number of PMRT Field Visits by Outcome – excluding non-dispatched

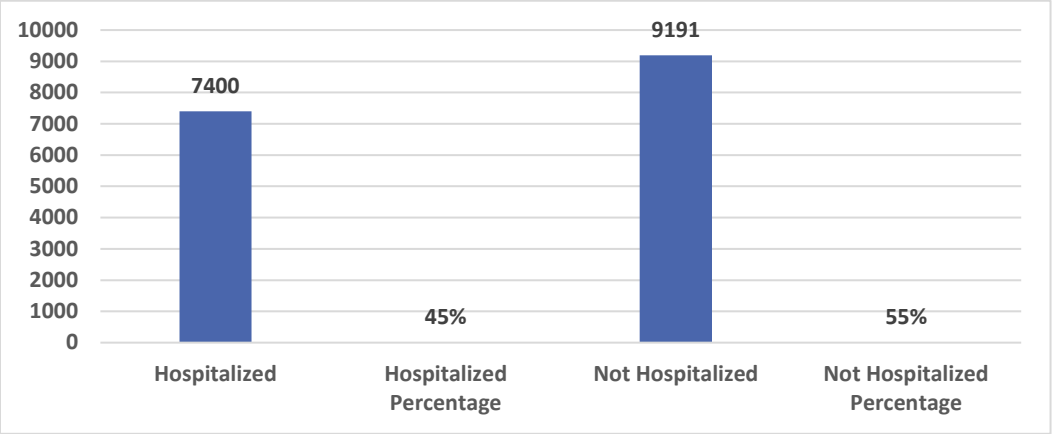


Figure 37. FY 2023-2024-Number of PMRT Incidents by Insurance Status - including non-dispatched

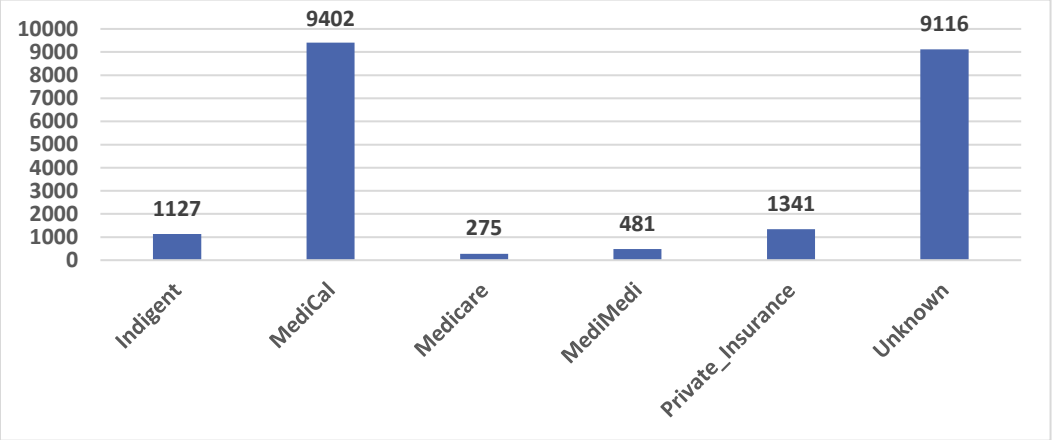


Figure 38. FY-2023-2024-Number of PMRT Field Visits by Insurance Status - – excluding non-dispatched

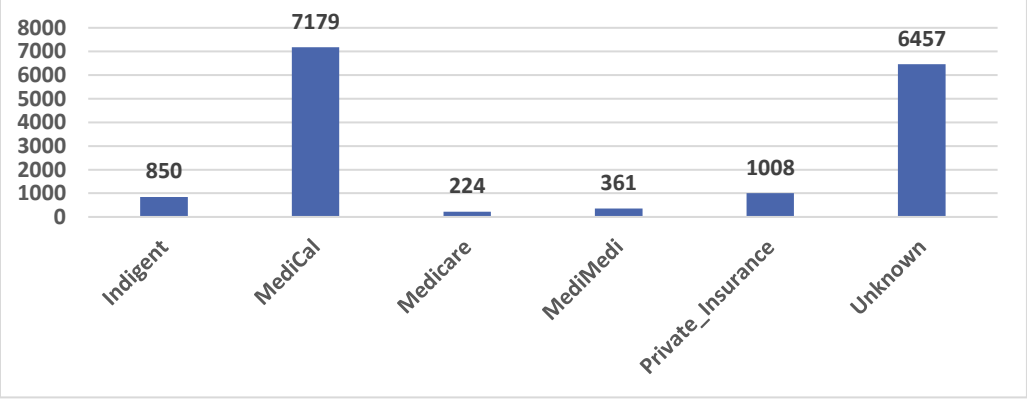


Figure 39. FY-2023-2024-Number of PMRT Incidents by Gender - including non-dispatched

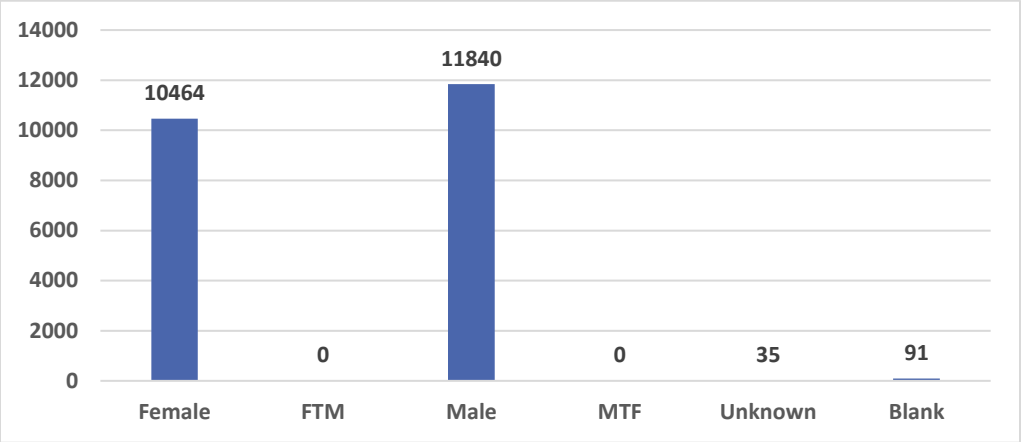


Figure 40. FY-2023-2024-Number of PMRT Field Visits by Gender – excluding non-dispatched

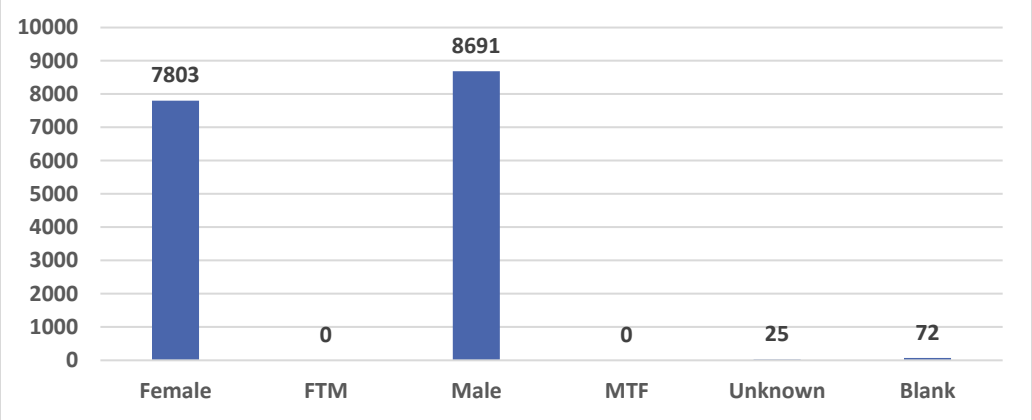


Figure 41. FY-2023-2024-Number of PMRT Incidents by Referral Source - including non-dispatched

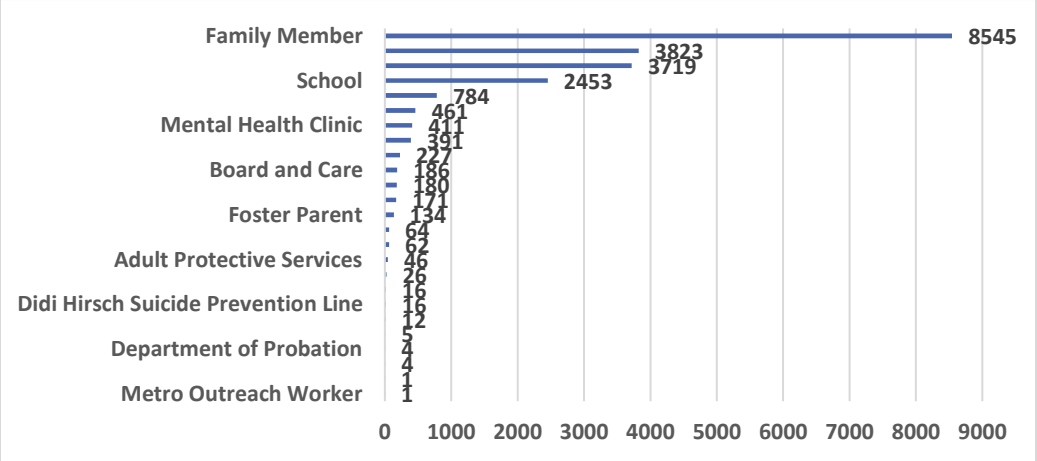


Figure 42. FY-2023-2024-Number of PMRT Field Visits by Referral Source – excluding non-dispatched

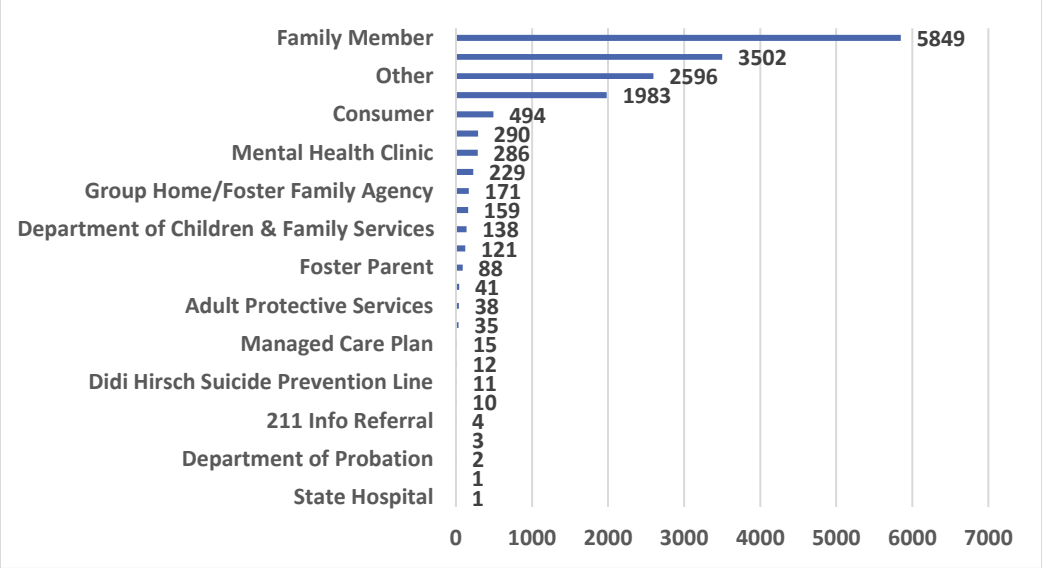


Figure 43. FY-2023-2024-Number of PMRT Incidents by Dispatch Time Category - including non-dispatched

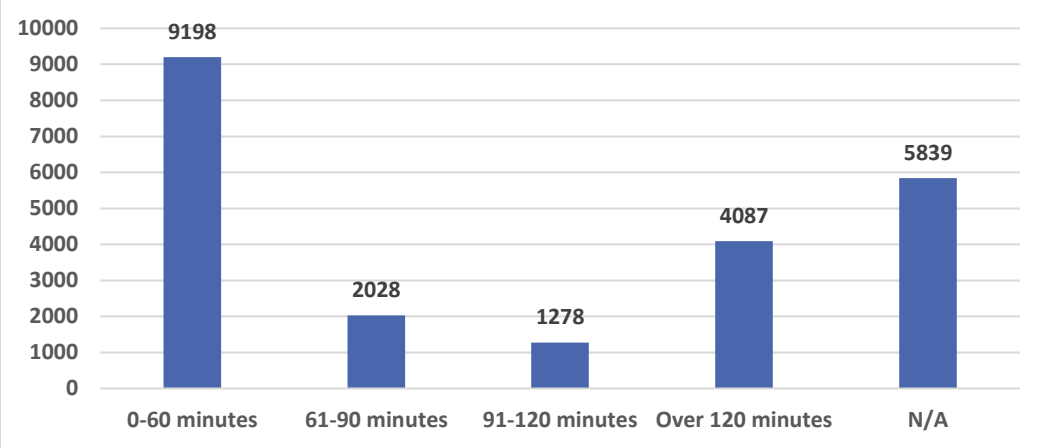


Figure 44. FY-2023-2024-Number of PMRT Field Visits by Dispatch Time Category – excluding non-dispatched

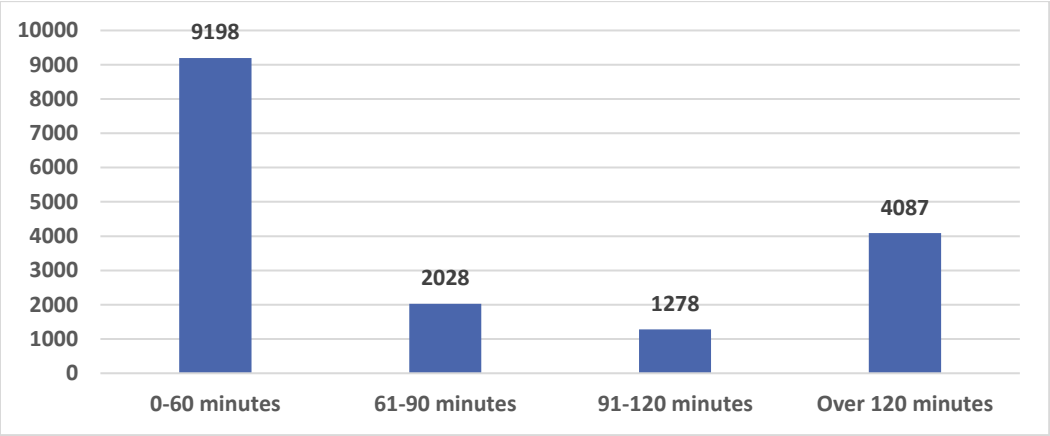


Figure 45. FY-2023-2024-Number of PMRT Field Visits by Call Duration - including non-dispatched

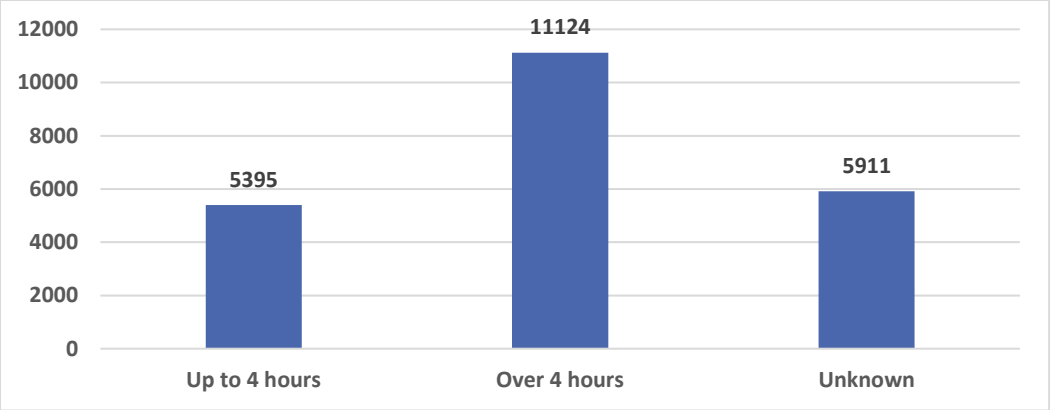


Figure 46. FY-2023-2024-Number of PMRT Field Visits by Call Duration – excluding non-dispatched

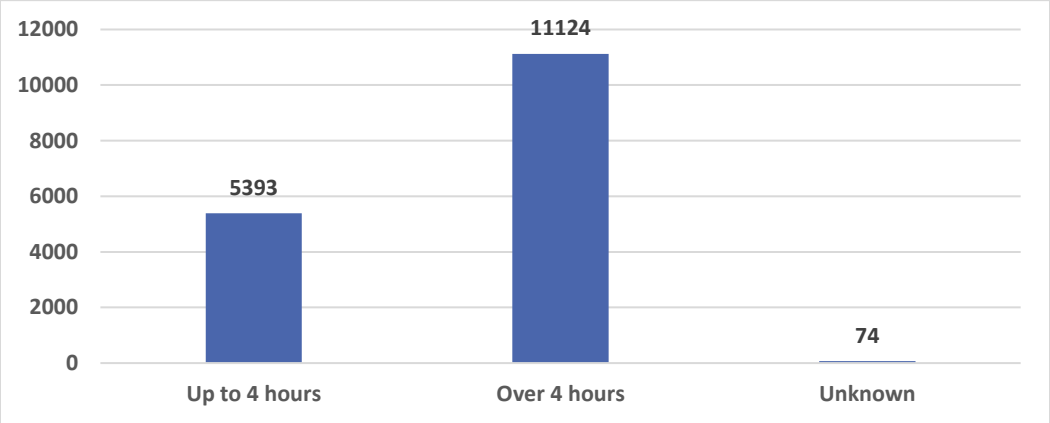


Figure 47. FY-2023-2024-Number of PMRT Requests by Age Group (0-20 v. 21+) - including non-dispatched

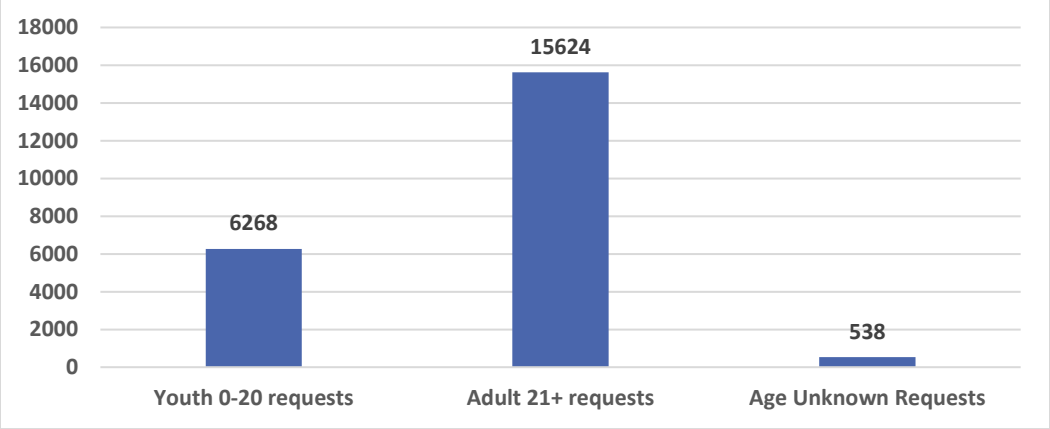


Figure 48. FY-2023-2024-Number of PMRT Requests by Age Group (0-20 v. 21+) – excluding non-dispatched

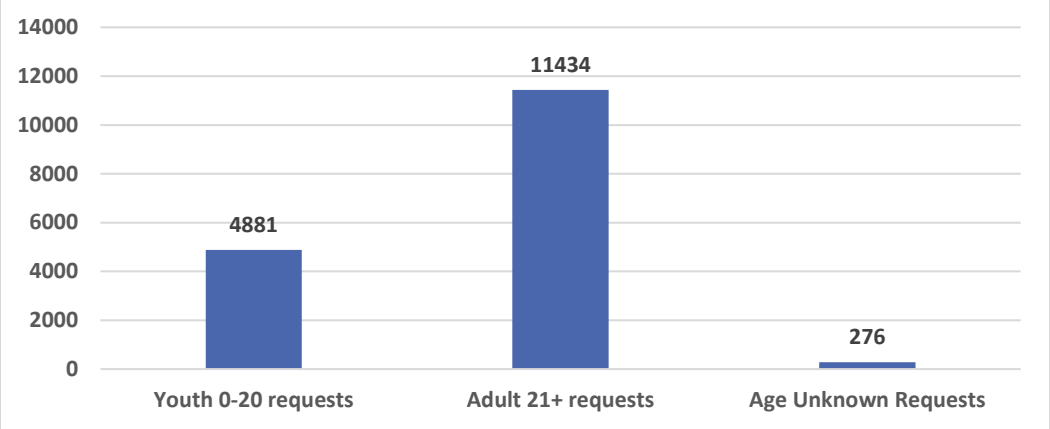


Figure 49. FY-2023-2024-Number of PMRT Requests by Age Group (0-17 v. 18+) - including non-dispatched

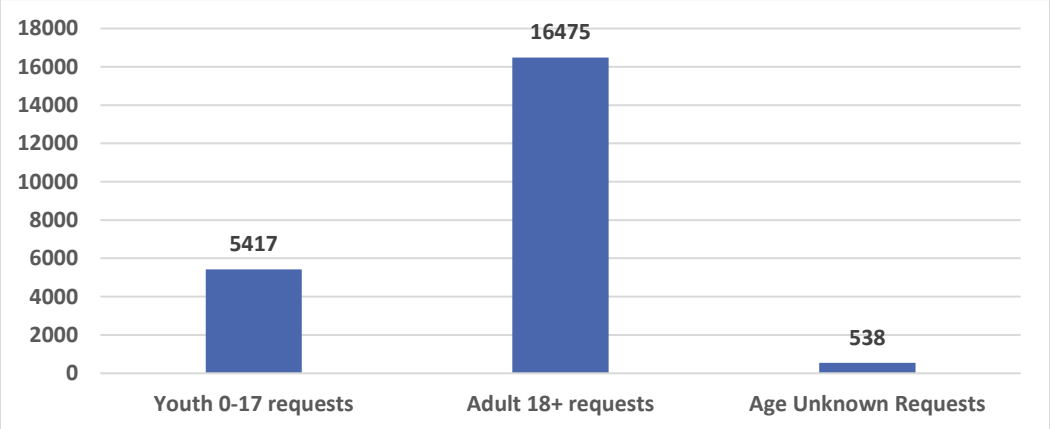


Figure 50. FY-2023-2024-Number of PMRT Incidents by Age Group (0-17 v. 18+) – excluding non-dispatched

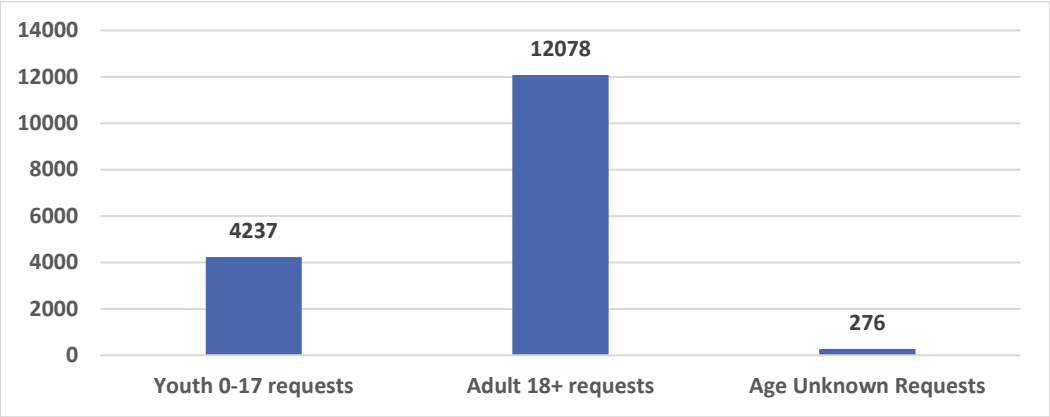


Figure 51. FY-2023-2024-Number of PMRT Requests by Housing Status - including non-dispatched

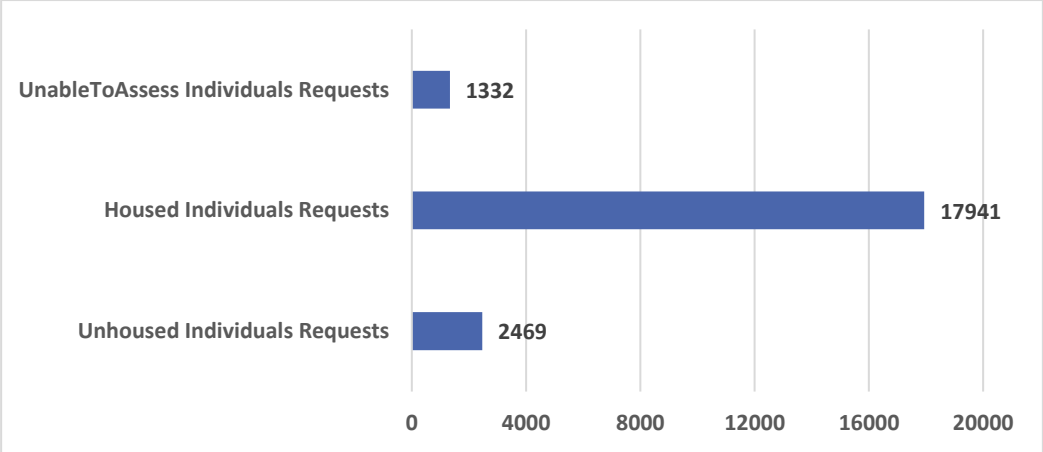


Figure 52. FY-2023-2024-Number of PMRT Field Visit by Housing Status – excluding non-dispatched

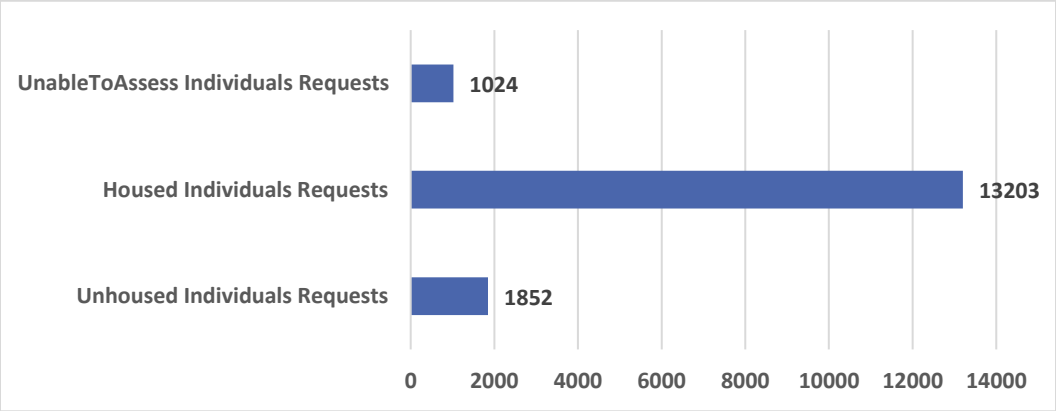


Figure 53. FY-2023-2024-Number of PMRT Field Visit Outcome for Individuals Aged 0-17 by 5585 Status - including non-dispatched

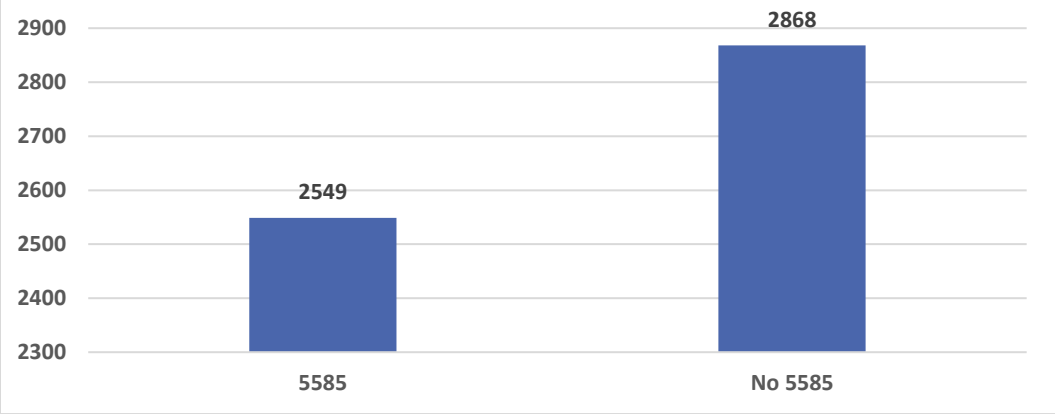


Figure 54. Number of PMRT Field Visit Outcome Individuals Aged 0-17 by 5585 Status – excluding non-dispatched

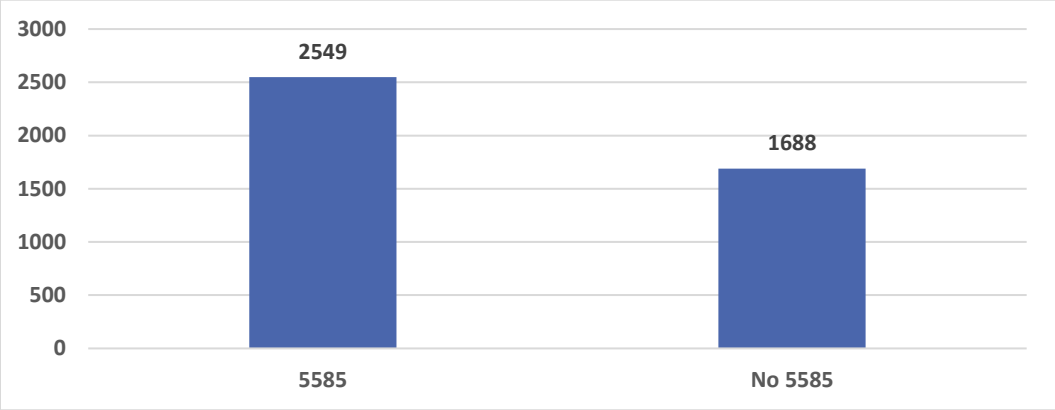
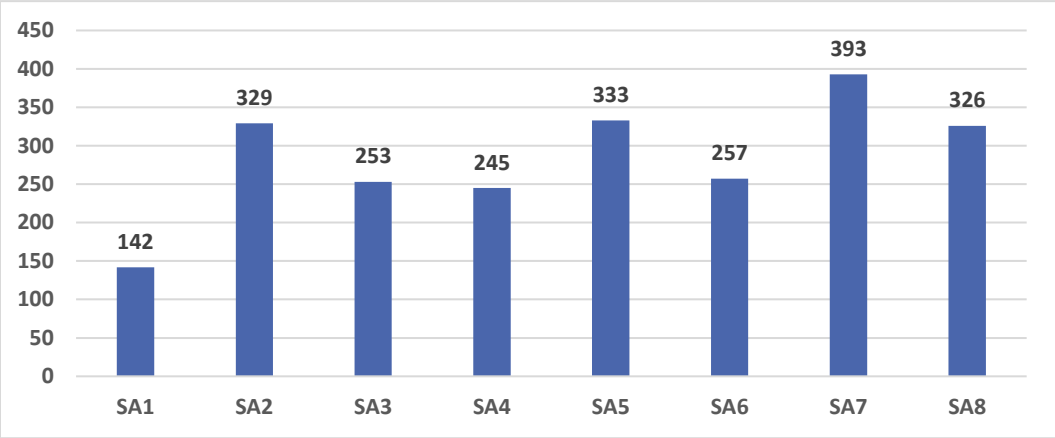


Figure 55. Mobile Crisis Outreach Team(MCOT) Incidents/Dispatched by Service Area



Alternative Crisis Services FY 2025-26

Another three CRTPs are scheduled to join our team in the coming months. Following MHSOAC grants to hospitals to open EmPATH units, DMH has been meeting with grant recipients to negotiate additional CSU capacity across various emergency departments. DMH continues to expand its network of CSUs. This includes the Children and Youth CSU on the MLK campus, the Olive View campus, and High Desert campus. These CSUs are currently being solicited and will open in the next Fiscal year. The construction of the CSU on High Desert will be completed in the fall of 2025, followed by its opening.

The following programs will continue in FY 25-26 and FY 26-27: Residential and Bridging Care (RBC) Program, Psychiatric Urgent Care Centers (UCC), Enriched Residential Services (ERS), Crisis Residential Treatment Programs (CRTP), Law Enforcement Teams (LET), Restorative Care Villages (RCV) and Psychiatric Mobile Response Teams (PMRT).

Housing

Program Description:

DMH provides a wide variety of housing resources and supportive services for individuals experiencing homelessness who have a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) including temporary housing, permanent housing, move-in assistance, eviction prevention and specialty mental health and housing case management services. DMH also administers funds that support capital development, capital improvements and operating subsidies.

Intended Outcomes

- Assist DMH clients who are homeless to obtain interim and/or permanent housing.
- Assist DMH clients living in permanent housing to retain housing.
- Increase the overall number of housing options including interim housing beds, permanent supportive housing (PSH) units, licensed residential care beds, other rental subsidies and housing resources available to DMH clients.

Key Activities

- Provide immediate interim housing and supportive services to DMH clients who are homeless to transition them from the streets or jails.
- Provide financial assistance to help DMH clients transition from incarceration or homelessness to permanent housing including assistance with rental subsidies, security deposits, utility deposits, furniture, household goods and eviction prevention.
- Provide specialty mental health, case management and housing retention services to DMH clients who are formerly homeless and living in permanent housing.
- Preserve the stock of Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs) in Los Angeles County by providing facilities with enhanced rates for DMH clients with complex needs and funding for capital improvements.
- Invest in the capital development of new PSH for individuals who are homeless and have a SMI/SED in partnership with the Los Angeles County Development Authority (LACDA) and through the use of No Place Like Home (NPLH) funding.

Manage the current portfolio of PSH that DMH has invested in to ensure that the intended population is served and that the resources are utilized.

Housing Programs Overview

The following DMH programs provided clients who were experiencing homelessness or at risk of homelessness with housing resources and supportive services in FY 2023-24:

- Capital Investments Program
- Housing Supportive Services Program
- Intensive Case Management Services Program
- Federal Housing Subsidies Unit
- Housing Assistance Program
- Housing for Mental Health Program
- Diversion, Reentry and Mental Health Program
- Enriched Residential Care Program
- Interim Housing Program
- Enhanced Emergency Shelter Program for Transition Age Youth (TAY)

The table below provides the client demographics found across these housing programs.

Table 13. Demographics of Clients Served Across Housing Programs

Age of Clients Across All Housing Programs		
Age Group	Number Served	Percentage
Children* (Ages 0-15)	11	0.1%
TAY (Ages 16-25)	1,032	8.9%
Adult (Ages 26-59)	7,164	61.7%
Older Adult (Ages 60+)	2,985	25.7%
Unknown/ Not Reported	412	3.6%
Total	11,604	100%

Gender of Clients Across All Housing Programs		
Gender	Number Served	Percentage
Additional Gender Category/Other	10	0.1%
Chose Not to Disclose	6	0.1%
Female	4,939	42.6%
Female-to-Male (FTM)/ Transgender Male/ Trans Man	16	0.1%
Genderqueer, Neither Exclusively Male nor Female	9	0.1%
Male	5,937	51.2%
Male-to-Female (MTF)/ Transgender Female/ Trans Woman	66	0.6%
Unknown/ Not Reported	621	5.4%
Total	11,604	100%**

Race and Ethnicity of Clients Across All Housing Programs ***		
Race and Ethnicity	Number Served	Percentage
Asian/Pacific Islander	321	2.8%
Black/African American	4,608	39.7%
Hispanic/Latino	2,441	21%
Multiracial/ Two or More Races	601	5.2%
Native American	94	0.8%
White	2,081	17.9%
Other	241	2.1%
Unknown/ Not Reported	1,217	10.5%
Total	11,604	100%

*While many DMH housing programs serve families experiencing homelessness, none target children directly. Rather, children counted in this and other Age distribution charts within the Housing section account for situations where either the child in the assisted family is the eligible DMH client or is being counted as the Head of Household due to their parent not being eligible for the housing resource.

**In this and other charts within the Housing section, sum of percentages may not total 100% exactly due to rounding.

***In this and other Race and Ethnicity distribution charts within the Housing section, granular race and ethnicity information is aggregated into the categories of Asian/Pacific Islander, Black/African American, Hispanic/Latino, Native American and White. In cases where a client reports multiple racial or ethnic identities, the client is categorized as Multiracial/Two or More Races. Clients who only report a racial or ethnic identity of Other Race or Other are categorized as Other.

As shown, DMH served a total of 11,604 unique clients across its housing programs in FY 2023-24. The majority of clients served were males and adults ages 26-59. Black/African American clients also represented the largest race/ethnicity group served, which aligns with Greater Los Angeles Homeless Count data from the Los Angeles County Homeless Services Authority (LAHSA) that has repeatedly shown a disproportionate representation of Black/African American people experiencing homelessness in Los Angeles County. This disparity, however, has reduced over the past several years from 40% of the homeless population identifying as Black/African American in 2017 to 31% in 2024. In contrast, LAHSA's Homeless Count has reflected an over 70% increase in Latinos experiencing homelessness between 2018 and 2023. Currently, DMH housing programs show an underrepresentation of Latino clients by comparison; although, many individuals represented in the data obtained their housing prior to 2018. Accordingly, DMH continues to work to address disparities as shifts occur in the demographics of the County's homeless population. A table outlining race and ethnicity distributions across various County populations is included below.

Table 14. Race and Ethnicity Across County Populations - FY 2023-24

Race and Ethnicity Across County Populations – FY 2023-24				
Race and Ethnicity	**Los Angeles County Population**	**LAHSA 2024 Greater Los Angeles Homeless Count**	**DMH Clients Served**	**DMH Housing Programs**
Black/African American	7.6%	31%	17.3%	39.7%
Asian/Pacific Islander	15.1%	2.1%	4.4%	2.8%
Hispanic/Latino	49.1%	43%	38.0%	21%
Native American	0.17%	2.2%	0.54%	0.8%
White	24.7%	29%	14.2%	17.9%
Multiracial/Two or More Races	3.4 %	3.2%	3.2%	5.2%
Other	N/A	N/A	8.9%	2.1%
Unknown/Not Reported	N/A	N/A	13.5%	10.5%

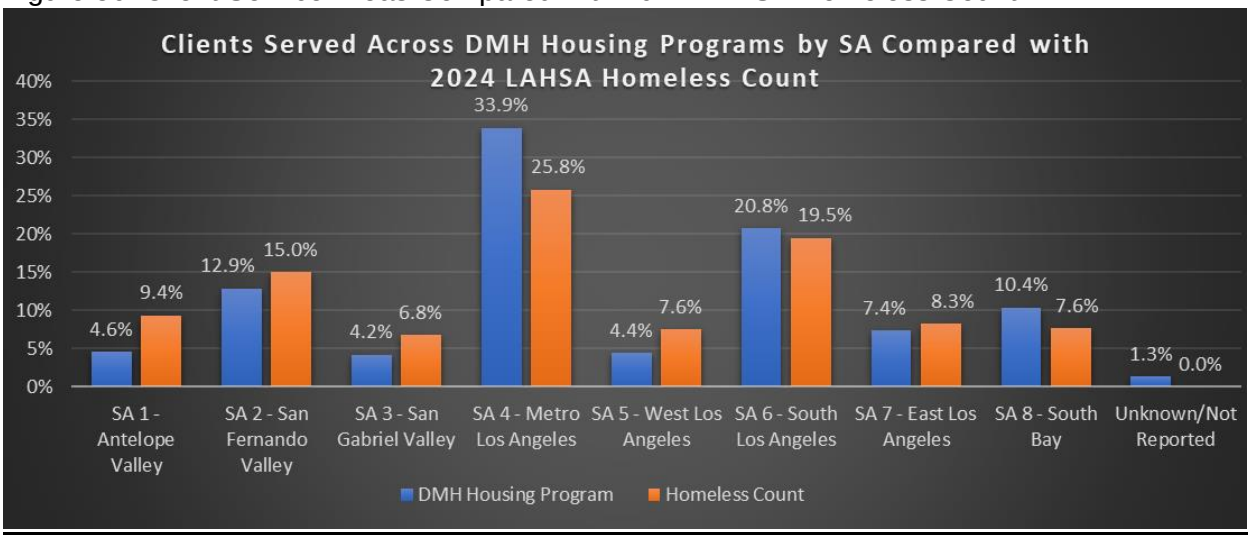
LAHSA Homeless Count data also serves as an interesting comparison point to Service Area data for DMH housing program clients. Despite some degrees of overrepresentation and underrepresentation, the Service Areas where clients were served were generally proportionate to the Services Areas where individuals experiencing homelessness were located. See table and figure below. In particular, Service Area 4, which has the highest concentration of DMH housing program clients, also has the highest concentration of individuals who are homeless – including those living in Skid Row - and housing and services tend to be concentrated there as a result.

Table 15. Clients Served Across DMH Housing Programs by Service Area

Service Area	Number Served	Percentage
SA 1 - Antelope Valley	413	4.6%
SA 2 - San Fernando Valley	1,159	12.9%
SA 3 - San Gabriel Valley	379	4.2%
SA 4 - Metro Los Angeles	3,038	33.9%
SA 5 - West Los Angeles	398	4.4%
SA 6 - South Los Angeles	1,869	20.8%
SA 7 - East Los Angeles	665	7.4%
SA 8 - South Bay	933	10.4%
Unknown/Not Reported	120	1.3%
Total	8,974*	100%

* Total is lower than the unique client count due to Service Area data not being available for all programs.

Figure 56. Client Service Areas Compared with 2024 LAHSA Homeless Count



Capital Investments Program

Since 2008, $1 billion in MHSA funding has been invested toward the development of project-based PSH in Los Angeles County for individuals and families who are experiencing homelessness and living with SMI or SED. The table below details these one-time capital investments and their corresponding amounts.

Table 16. DMH One-Time Capital Investments

DMH ONE-TIME CAPITAL INVESTMENTS (2008 – Present)		
Program Name	**MHSA Amount**	
No Place Like Home	$	744,903,877
Special Needs Housing Program/MHSA Housing Program	$	155,000,000
Mental Health Housing Program	$	103,300,000
Total	**$**	**1,003,203,877**

As of June 30, 2024, all $1 billion in MHSA funds have been committed. These commitments currently support 162 PSH developments and 4,564 PSH units as well as provide capitalized operating subsidies for 13 of these developments to help make the units affordable for individuals with limited income. Of the 162 PSH developments, 17 developments comprising 585 units were recommended for funding through the final NPLH solicitation that was released by LACDA on December 27, 2023 in partnership with DMH. DMH MHSA PSH units are intended to serve a wide range of populations as shown in the table below.

Table 17. Target Population of MHSA PSH Units

TARGET POPULATION	NUMBER OF MHSA PSH UNITS
Adults	2,958
Families	231
Older Adults	676
TAY	464
Veterans	235
Total	**4,564**

By the end of FY 2023-24, 110 of the 162 PSH developments had finished construction, resulting in 2,706 units being available for occupancy. DMH also managed dedicated units at another eight developments comprising 286 units. PSH units ranged in size from studio to four-bedroom apartments and provided housing for a total of 2,812 households throughout the fiscal year which included 127 minor children. An additional 35 MHSA-funded PSH developments comprising 1,273 units were in various stages of development but not yet ready for occupancy.

The table and figures below display the demographics of the clients that were residing in MHSA and other dedicated PSH units in FY 2023-24 as well as the location of the MHSA-funded developments and units by Service Area. Of note, while over half of all clients fell into the Adult age range, these numbers included individuals who were categorized as TAY at the time of their move-in and have since remained in PSH. Additionally, the data shows that over half of all clients resided in Service Areas 4 and 6, which aligns with the fact that these Service Areas have the highest number of individuals experiencing homelessness in the County according to the LAHSA Homeless Count.

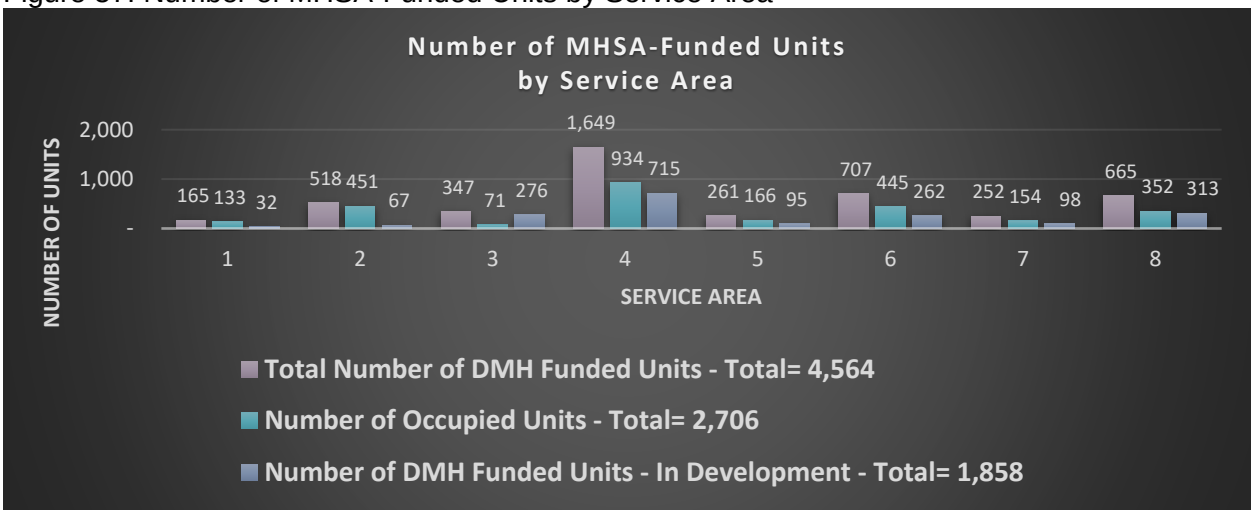
Table 18. Demographics of Clients Served in MHSA and Other Dedicated PSH Units

Gender of Clients Served in MHSA and Other Dedicated PSH Units		
Gender	Number Served	Percentage
Additional Gender Category/Other	1	0.0%
Chose Not to Disclose	1	0.0%
Female	1,179	41.9%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.0%
Male	1,450	51.6%
Male-to-Female (MTF)/Transgender Female/Trans Woman	17	0.6%
Unknown/ Not Reported	163	5.8%
Total	2,812	100%

Age of Clients Served in MHSA and Other Dedicated PSH Units		
Age Group	Number Served	Percentage
Children (Ages 0-15)	7	0.2%
TAY (Ages 16-25)	170	6%
Adult (Ages 26-59)	1,578	56.1%
Older Adult (Ages 60+)	908	32.3%
Unknown/ Not Reported	149	5.3%
Total	2,812	100%

Race and Ethnicity of Clients Served in MHSA and Other Dedicated PSH Units		
Race and Ethnicity	Number Served	Percentage
Asian/ Pacific Islander	42	1.5%
Black/ African American	1,198	42.6%
Hispanic/Latino	527	18.7%
Multiracial/ Two or More Races	133	4.7%
Native American	26	0.9%
White	495	17.6%
Other	56	2%
Unknown/ Not Reported	335	11.9%
Total	2,812	100%

Figure 57. Number of MHSA-Funded Units by Service Area



As previously reported, DMH's NPLH capital investment includes $100 million that has been set aside to develop PSH on each of the County's five medical center campuses as part of the Restorative Care Villages initiative. Construction on the first Restorative Care Village site, which will be located on the campus of LAC+USC, is now projected to start in late 2025. The proposed project includes 140 units that have been set aside to provide housing to individuals who are experiencing homelessness and have a SMI. DMH and LACDA are also continuing planning discussions for the next Restorative Care Village site, which will be located at Rancho Los Amigos - North Campus. It is anticipated that the Request for Proposals for this site, totaling $20 million, will be released in FY 2024-25.

Federal Housing Subsidies Unit

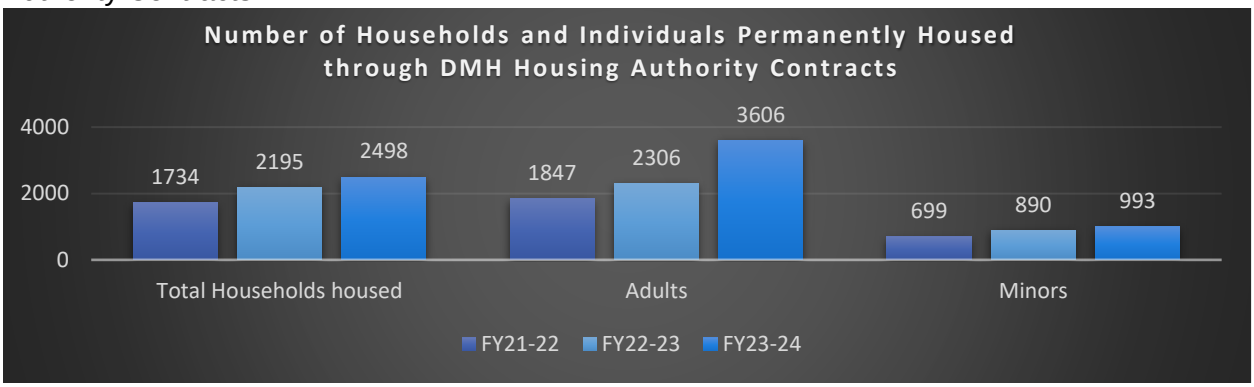
DMH maintained 16 contracts with the City and County of Los Angeles Housing Authorities during FY 2023-24, an amount that reflects the consolidation of two contracts. Overseen by the DMH Federal Housing Subsidies Unit, these contracts provided DMH with access to federal tenant-based subsidies, such as Continuum of Care (CoC), Tenant-Based Supportive Housing (TBSH) and Section 8, for DMH clients experiencing homelessness. These subsidies help to make rental units affordable for clients by limiting their share of the monthly rent to 30% of their income while the Housing Authority pays the remainder of the rent amount to the property owner.

DMH leverages MHSA-funded specialty mental health services to meet the service match requirements for its CoC subsidies. These services, which are delivered by DMH clinicians and case managers, provide clients with a comprehensive range of mental health support and housing assistance. This includes helping clients with completing housing applications and interviews, locating housing and maintaining their housing once they move in. While not all individuals receiving housing through Housing Authority contracts engaged in DMH mental health services during FY 2023-24, all individuals were receiving DMH mental health services at the time of lease-up in accordance with eligibility requirements.

During FY 2023-24, DMH Housing Authority contracts included 2,749 housing vouchers for DMH clients. These vouchers helped to provide housing to 2,498 households across all Service Areas,

which was a 14% increase from the previous fiscal year, and accommodated 3,606 individuals. This includes 2,613 adults and 993 minor children. A total of 346 households newly leased up during the fiscal year. The figure below details the growth experienced by the program over the last three years.

Figure 58. Number of Households and Individuals Permanently Housed through DMH Housing Authority Contracts



The FY 2023-24 housing retention rate for DMH clients in these federally-subsidized units was 95.5%. This included 12 clients who successfully graduated from the CoC program as they no longer needed the level of supportive services required by this program. These clients have now transitioned to the Housing Choice Voucher program for continued housing support, which does not require the same level of engagement with supportive services. The average length of stay for clients residing in housing using DMH federal tenant-based subsidies during the fiscal year was 5.67 years. While the longest tenure has reached over 25 years, 350 DMH clients or 14% have resided in housing using a DMH federal subsidy for a decade or more.

See table and figure below for the demographic distribution of the DMH clients served by FHSU as well as program tenure data. As previously mentioned, shifts over the last 5 years in the demographics of the homeless population may account for some of the differences in the race/ethnicity of the individuals served compared to the LAHSA Homeless Count given the long tenure of many clients using these Housing Authority resources. The low representation of Hispanic/Latino individuals may also be impacted by documentation requirements for Federal vouchers.

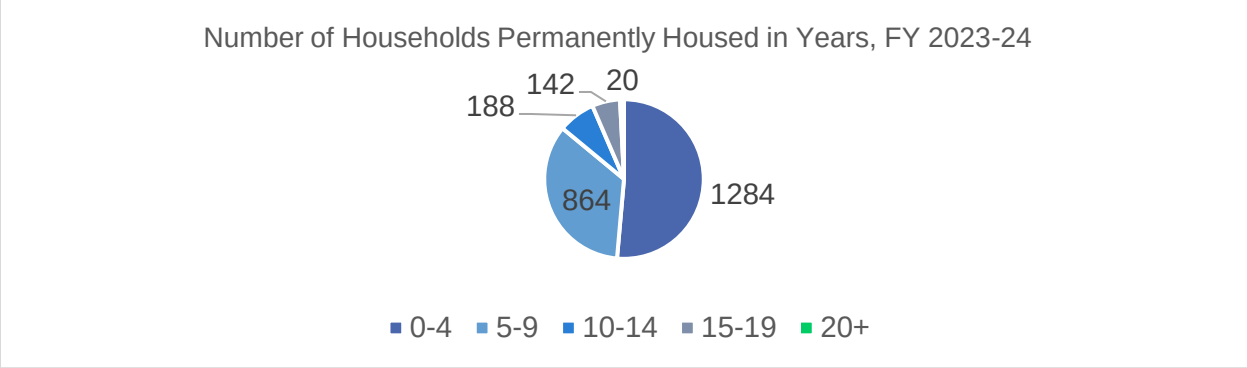
Table 19. Demographics of Clients Served by FHSU

Age of Clients Served by Federal Housing Subsidies Unit		
Age Group	Number Served	Percentage
Children (Ages 0-15)	1	0.0%
TAY (Ages 16-25)	71	2.8%
Adult (Ages 26-59)	1,630	65.3%
Older Adult (Ages 60+)	779	31.2%
Unknown/Not Reported	17	0.7%
Total	2,498	100%

Gender of Clients Served by Federal Housing Subsidies Unit		
Gender	Number Served	Percentage
Female	1,469	58.8%
Female-to-Male (FTM)/ Transgender Male/ Trans Man	2	0.1%
Male	1,007	40.3%
Male-to-Female (MTF)/ Transgender Female/ Trans Woman	3	0.1%
Unknown/Not Reported	17	0.7%
Total	2,498	100%

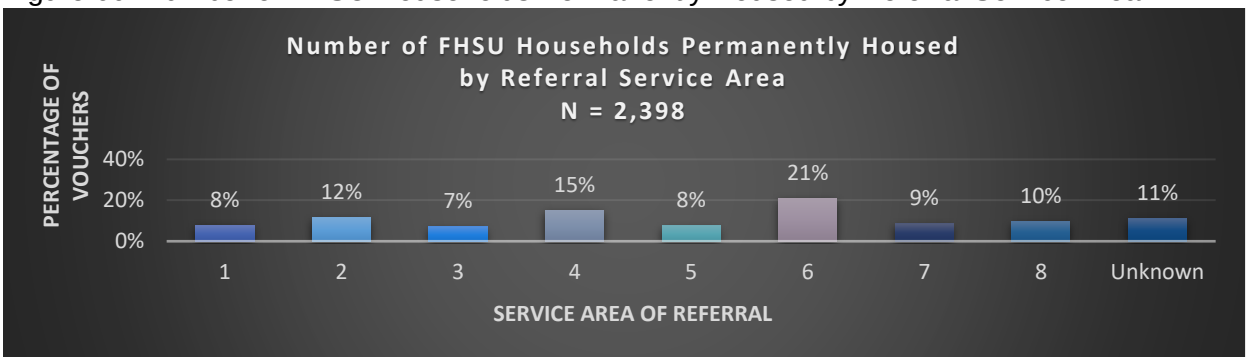
Race and Ethnicity of Clients Served by Federal Housing Subsidies Unit		
Race and Ethnicity	Number	Percentage
Asian/Pacific Islander	39	1.6%
Black/African American	1,253	50.2%
Hispanic/Latino	452	18.1%
Multiracial/ Two or More Races	142	5.7%
Native American	25	1%
White	442	17.7%
Other	48	1.9%
Unknown/Not Reported	97	3.9%
Total	2,498	100%

Figure 59. Number of FHSU Households Permanently Housed in Years



While not included in the overall Service Area data for DMH housing programs, the data below shows the Service Areas where households served by FHSU were homeless and receiving services at the time of referral to their housing resource. As noted, the highest number of clients utilizing federal vouchers were referred from Service Area 6 while the fewest number of clients utilizing federal vouchers were referred from Service Area 3. It is possible, however, that individuals located housing in a different Service Area from where they were referred.

Figure 60. Number of FHSU Households Permanently Housed by Referral Service Area



During FY 2023-24, DMH's Housing Authority contracts reached maximum financial capacity, which posed significant challenges to expanding the number of clients that could be housed using federal subsidies through these contracts. Despite these obstacles, DMH's strong working relationship and open communication with the Housing Authorities proved invaluable as we collaborated in closely monitoring utilization. Additionally, the FHSU played a crucial advocacy role for clients in several ways such as intervening on their behalf if required annual certification documents were missing due to hospitalization or family emergencies and ensuring that their housing subsidies were not terminated and remained in good standing through these circumstances.

Looking forward, the FHSU has a goal to fully utilize the vouchers allocated to DMH and to continue to advocate for clients to remain housed. FHSU will also continue to seek opportunities to increase the number of federal vouchers dedicated to DMH clients.

Supportive Services for Individuals in PSH

The DMH Housing Supportive Services Program (HSSP) used MHSA and local Measure H funds in FY 2023-24 to provide specialty mental health services onsite at project-based PSH locations including all sites with MHSA capital investments as well as at select tenant-based locations. HSSP services are delivered as part of an integrated care model in which DMH, Department of Health Services Housing for Health (DHS-HFH) and Department of Public Health Substance Abuse Prevention and Control (DPH-SAPC) partner to respectively provide mental health services, intensive case management services (ICMS) and substance-use focused Client Engagement and Navigation Services (CENS), as appropriate, to clients who are living in PSH. While the majority of ICMS services are funded by DHS-HFH using Measure H dollars, DMH also uses MHSA dollars to fund ICMS services at permanent housing locations with MHSA capital investments that opened prior to the start of Measure H.

The total number of individuals receiving HSSP services in FY 2023-24 was 4,141, and the total number of individuals receiving DMH-funded ICMS services was 1,259. As many clients received both HSSP and ICMS services, the unique client count between the two programs totaled 4,408. The tables below reflect demographic and Service Area information for these unique clients. The distribution of clients across Service Areas can be attributed to a variety of factors including where PSH inventory was available and whether the clients engaged in services.

Table 20. Demographics of Clients Served by HSSP and DMH-Funded ICMS

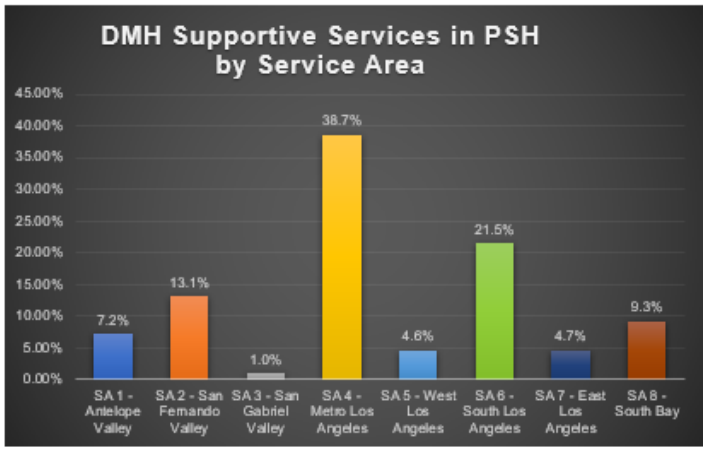
Age of Clients Served by HSSP and DMH Funded ICMS		
Age Group	Number Served	Percentage
Children (Ages 0-15)	6	0.1%
TAY (Ages 16-25)	256	5.8%
Adult (Ages 26-59)	2,621	59.5%
Older Adult (Ages 60+)	1,334	30.3%
Unknown/ Not Reported	191	4.3%
Total	4,408	100%

Gender of Clients Served by HSSP and DMH Funded ICMS		
Gender	Number Served	Percentage
Additional Gender Category/Other	2	0.0%
Chose Not to Disclose	1	0.0%
Female	1,894	43.0%
Female-to-Male (FTM)/Transgender Male/Trans Man	3	0.1%
Male	2,239	50.8%
Male-to-Female (MTF)/Transgender Female/Trans Woman	21	0.5%
Unknown/ Not Reported	248	5.6%
Total	4,408	100%

Race and Ethnicity of Clients Served by HSSP and DMH Funded ICMS		
Race and Ethnicity	Number Served	Percentage
Asian/Pacific Islander	69	1.6%
Black/ African American	1,850	42.0%
Hispanic/Latino	884	20.1%
Multiracial/ Two or More Races	229	5.2%
Native American	40	0.9%
White	779	17.7%
Other	102	2.3%
Unknown/ Not Reported	455	10.3%
Total	4,408	100%

Table 21. DMH Clients Receiving HSSP and DMH-Funded ICMS by Service Area

Service Area	Number Served	Percentage
SA 1 - Antelope Valley	318	7.2%
SA 2 - San Fernando Valley	576	13.1%
SA 3 - San Gabriel Valley	45	1.0%
SA 4 - Metro Los Angeles	1,705	38.7%
SA 5 - West Los Angeles	203	4.6%
SA 6 - South Los Angeles	947	21.5%
SA 7 - East Los Angeles	205	4.7%
SA 8 - South Bay	409	9.3%
Total	4,408	100%



Of those clients receiving supportive services at sites with MHSA capital investments, 92% retained housing. The following client success story shared by one of DMH's HSSP providers demonstrates the effectiveness of HSSP services and the collaboration with other partners to help clients remain in their homes.

"Client X has been an integral member of both the HSSP and ICMS teams since 2020. Like many of our members, he has faced challenges related to mental health, hoarding tendencies and substance use. However, with the unwavering support of his dedicated HSSP and ICMS teams, he has consistently passed his annual housing inspections. The teams have provided invaluable aid, helping him not only to clean and organize his living space but also to develop practical strategies for maintaining it. Although he continues to navigate these challenges, his

determination and the collaborative efforts of both teams have enabled him to achieve a more stable situation. Recently, he has also engaged in medication management, which appears to be contributing positively to his progress. His journey has been marked by ups and downs, yet he has shown remarkable resilience…"

Currently, however, the rate of new project-based PSH sites opening for occupancy is outpacing the number of HSSP providers available to serve those sites. Accordingly, the goal is to expand the network of contracted HSSP service providers over the coming year in order to deliver mental health services at more PSH sites and, thereby, increase the number of clients being served and supported with housing retention.

Housing for Mental Health

The Housing for Mental Health (HFMH) program uses MHSA funds to provide ongoing rental subsidies for highly vulnerable individuals with a SMI who are homeless and enrolled in a FSP program. HFMH rental subsides can be used for various types of permanent housing depending on the client's needs including tenant-based PSH, project-based PSH at one of eight partnering sites and licensed residential care facilities. As HFMH clients move into their units, program funds also pay for security deposits, utility assistance and household goods.

A total of 407 DMH clients were in permanent housing supported by HFMH rental subsidies at some point during FY 2023-24. Of those clients, 340 were FSP clients referred by DMH contractors. The remaining 67 were FSP clients with justice involvement referred by the DHS Office of Diversion and Reentry (ODR). In 2023, DMH began a new collaboration with ODR on implementation of a new program specifically providing housing resources and ICMS for DMH clients with justice involvement. The resulting Diversion, Reentry and Mental Health (DREAM) program is now responsible for administration of ODR-dedicated rental subsidies.

The tables below show the demographic and Service Area data for clients served by HFMH. The data includes both clients that were housed through HFMH as well as clients with open referrals that had not yet been housed, which totaled 451 clients.

Table 22. Demographics of Clients Served by HFMH

Age of Clients Served by Housing for Mental Health		
Age	Number Served	Percentage
Children (Ages 0-15)	1	0.2%
TAY (Ages 16-25)	9	2%
Adult (Ages 26-59)	323	71.6%
Older Adult (Ages 60+)	115	25.5%
Unknown/ Not Reported	3	0.7%
Total	451	100%

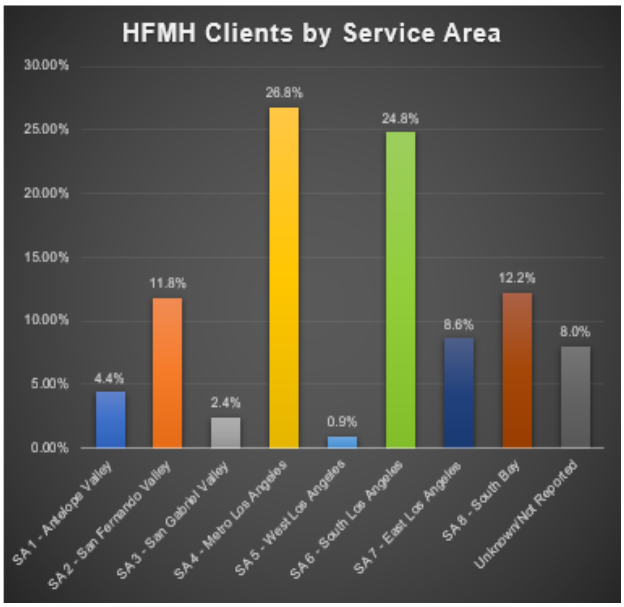
Gender of Clients Served by Housing for Mental Health		
Gender	Number Served	Percentage
Female	192	42.6%
Female-to-Male (FTM)/ Transgender Male/ Trans Man	1	0.2%
Male	255	56.5%
Unknown/ Not Reported	3	0.7%
Total	451	100%

Race and Ethnicity of Clients Served by Housing for Mental Health		
Race and Ethnicity	Number Served	Percentage
Asian/Pacific Islander	12	2.7%
Black/ African American	151	33.5%
Hispanic/Latino	97	21.5%
Multiracial/ Two or More Races	26	5.8%
Native American	2	0.4%
White	111	24.6%
Other	19	4.2%
Unknown/ Not Reported	33	7.3%
Total	451	100%

Table 23. HFMH Clients by Service Area

Service Area	Number Served	Percentage
SA 1 - Antelope Valley	20	4.4%
SA 2 - San Fernando Valley	53	11.8%
SA 3 - San Gabriel Valley	11	2.4%
SA 4 - Metro Los Angeles	121	26.8%
SA 5 - West Los Angeles	4	0.9%
SA 6 - South Los Angeles	112	24.8%
SA 7 - East Los Angeles	39	8.6%
SA 8 - South Bay	55	12.2%
Unknown/Not Reported	36	8%
Total	451	100%

Distribution across Service Areas can be attributed to the location of the PSH development, scattered site housing or licensed residential care facility.



The HFMH program has been fairly stable in the number of clients it has served over the years since there has been little fluctuation in the number of rental subsidies allocated and minimal turnover. During FY 2023-24, 49 individuals were newly referred to the HFMH program and 39 individuals newly moved into housing with HFMH rental subsidies. See table below for further details. As of June 30, 2024, the housing retention rate for HFMH was 93%, with 80% housed for at least two years and 68% housed for three years or more.

Table 24. HFMH Client Referrals and Move-Ins

HFMH HOUSING TYPE	TOTAL IN HOUSING	NEW REFERRALS	NEW MOVE-INS
Tenant-Based PSH	252	33	26
Project-Based PSH	147	12	13
Licensed Residential Care Facility	8	4	0
TOTAL	**407**	**49**	**39***

* Clients included in this total may have been referred to HFMH in FY 2023-24 or FY 2022-2023.

The HFMH program is made possible due to the collaboration of different partners that work together to provide housing and support. The DMH FSP contractors are paired with DHS-HFH contracted ICMS providers who serve as the lead for assisting clients through the housing application process. The nonprofit agency Brilliant Corners serves as the fiscal intermediary for the HFMH program and also provides supportive services to property managers and clients and assistance with housing location and lease negotiation in addition to rent payment. A Brilliant Corners Housing Coordinator maintains a minimum of quarterly contact with HFMH clients including those that are housed and not receiving mental health services. This helps to ensure that clients maintain some level of support even when no longer engaged in mental health services.

Below are some client experiences that have been shared with us from our HFMH partners.

- I work with a 25-year-old female client that is housed through HFMH along with her young son and boyfriend. When I met the client, she had an open court case and had to adhere to a diversion program in order to avoid being incarcerated. She was compliant with all court requirements and was discharged from the diversion program successfully. She was then identified to live independently using a HFMH voucher and through all her barriers, mental health diagnosis and being deaf, she has managed to live in her home for a year now. She takes care of her son and keeps her home maintained in an orderly manner. I believe she will continue to gain independence as her son gets older.

- This client came to our FSP program due to his homelessness and history of psychiatric hospitalizations. When he entered, he had lived on the street with his emotional support dog for a while. He attempted to move into a homeless shelter; however, he struggled to feel safe enough to stay indoors in a shelter setting due to his symptoms and ended up staying outside unsheltered for over a year. This client was awarded a HFMF voucher hoping that stable housing would help him feel safe enough to live indoors. After he obtained housing, his symptoms improved and he gained the ability to leave home without his emotional support dog. This HFMH voucher provided him with a sense of security, safety, hope for the future and desire to move on to live his life and allowed him to establish the independent living he always wanted. He is determined to keep his housing for life!

Housing Assistance Program

The Housing Assistance Program (HAP) uses MHSA and other funds to assist DMH clients in directly-operated and contracted programs who are homeless or at risk of homelessness with the costs associated with moving into housing. This includes security deposits, utility deposits and household goods. Additionally, HAP provides short-term rental assistance and resources for eviction prevention due to financial hardships. For clients that are served by DMH directly-operated FSP programs, HAP also administers a portion of the related Client Supportive Services (CSS) funds.

In one such case, a single mother of three fell ill and lost her job after being unable to provide a physician's note to her employer following a week's absence. As a result, she could not pay her rent and received a three-day eviction notice. Thanks to the assistance provided by the HAP program, she was able to receive eviction prevention support and remain in her home.

During FY 2023-2024, HAP supported 562 households with 937 financial assistance requests. Of note, requests for eviction prevention assistance saw an increase of 83% over the prior fiscal year. The tables below provide information on the types and quantity of services rendered and the demographics of those served.

Table 25. HAP Service Summary

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Security Deposits	312
Utility Deposits	24
Household Goods	400
Rental Assistance	168
Eviction Prevention	33
Total	**937**

Table 26. Demographics of Clients Utilizing HAP Resources

Age of Clients Utilizing HAP Resources		
Age	Number Served	Percentage
Children (Ages 0-15)	2	0.4%
TAY (Ages 16-25)	22	3.9%
Adult (Ages 26-59)	416	74%
Older Adult (Ages 60+)	116	20.6%
Unknown/ Not Reported	6	1.1%
Total	562	100%

Gender of Clients Utilizing HAP Resources		
Gender	Number Served	Percentage
Additional Gender Category/Other	1	0.2%
Female	312	55.5%
Female-to-Male (FTM)/Transgender Male/Trans Man	1	0.2%
Genderqueer, Neither Exclusively Male nor Female	1	0.2%
Male	237	42.2%
Male-to-Female (MTF)/Transgender Female/Trans Woman	3	0.5%
Unknown/ Not Reported	7	1.2%
Total	562	100%

Race and Ethnicity of Clients Utilizing HAP Resources		
Race and Ethnicity	Number Served	Percentage
Asian/Pacific Islander	12	2.1%
Black/ African American	299	53.2%
Hispanic/Latino	105	18.7%
Multiracial/ Two or More Races	30	5.3%
Native American	9	1.6%
White	59	10.5%
Other	7	1.2%
Unknown/ Not Reported	41	7.3%
Total	562	100%

Diversion, Reentry, and Mental Health

DMH and ODR partnered to launch the DREAM program in October 2023, which provides interim housing, licensed residential care and permanent housing as well as ICMS services for individuals who are homeless and have SMI and justice involvement. Court cases are resolved early by diverting clients out of jail and into housing and connecting them to a DHS ICMS provider as well as a DMH FSP or general outpatient program for mental health services.

During FY 2023-24, a total of 158 DMH clients were supported by DREAM. Of these clients, 54 were transferred from the HFMH program whose MHSA funds for justice-involved clients were reallocated to DREAM. The remaining 104 clients were newly referred by ODR. DREAM serves clients countywide; however, currently 70% of clients being served are within Service Area 6. The tables below show the demographic and Service Area data of those served.

Table 27. Demographics of Clients Enrolled in DREAM

Age of Clients Enrolled in DREAM Program		
Age Group	Number Served	Percentage
TAY (Ages 18-25)	10	6.3%
Adult (Ages 26-59)	130	82.3%
Older Adult (Ages 60+)	12	7.6%
Unknown/Not Reported	6	3.8%
Total	158	100%

Gender of Clients Enrolled in DREAM Program		
Gender	Number Served	Percentage
Female	41	25.9%
Male	109	69%
Unknown/Not Reported	8	5.1%
Total	158	100%

Race and Ethnicity of Clients Enrolled in DREAM Program		
Race and Ethnicity	Number Served	Percentage
Asian/ Pacific Islander	2	1.3%
Black/ African American	59	37.3%
Hispanic/Latino	38	24.1%
Multiracial/ Two or More Races	11	7%
White	25	15.8%
Other	6	3.8%
Unknown/ Not Reported	17	10.8%
Total	158	100%

Table 28. Service Area of Clients Enrolled in DREAM

Service Area of Clients Enrolled in DREAM Program		
Service Area	Number Served	Percentage
SA 2 - San Fernando Valley	9	5.70%
SA 3 - San Gabriel Valley	1	0.60%
SA 4 - Metro Los Angeles	14	8.90%
SA 5 - West Los Angeles	3	1.90%
SA 6 - South Los Angeles	111	70.30%
SA 7 - East Los Angeles	10	6.30%
SA 8 - South Bay	10	6.30%
Total	158	100.00%

The average monthly growth rate for DREAM was 15%, with approximately 20 new clients being referred monthly. Once enrolled, the retention rate for DREAM clients was 97%. The table below details the types of housing to which DREAM clients were referred. This program will continue to ramp up in FY 2024-25.

Table 29. DREAM Client Summary

DREAM HOUSING TYPE	TOTAL IN HOUSING
Interim Housing (IH)	105
Permanent Supportive Housing	50
Licensed Residential Care Facility	3
Total	**158**

Enriched Residential Care Program

The Enriched Residential Care (ERC) program assists DMH clients to obtain and maintain housing at an ARF or RCFE when the additional supports provided by these facilities is needed to live successfully in the community. ARFs and RCFEs are unlocked licensed residential care facilities that provide residents with 24-hour care and supervision, medication management, three meals per day and assistance with activities of daily living. MHSA and other funds are used to pay for client rent at the ARFs and RCFEs as well as for Personal and Incidental (P&I) expenses should the client not have Supplemental Security Income (SSI) or other adequate income to pay for these items. DMH has also partnered with the DHS-HFH Countywide Benefits Entitlement Services Team (CBEST) program to assist ERC clients without income to apply for benefits for which they are eligible such as SSI. MHSA and other funds are also used to provide ARFs and RCFEs with an enhanced rate for the DMH clients they serve to help cover the costs of enhanced services that clients may require due to their higher acuity and complex needs.

In FY 2023-24, the ERC program served a total of 1,452 unique clients. Throughout the fiscal year, 470 clients were referred to the program and 523 clients moved into an ARF or RCFE with ERC financial support, some which were referred in the prior fiscal year. Overall, the ERC program housing retention rate was 81%. The tables below provide detail on the demographic distribution of the ERC clients served and the types of financial support that they received.

Table 30. Demographics of Clients Served by ERC

Age of Clients Served by Enriched Residential Care Program		
Age Group	Number Served	Percentage
TAY (Ages 18-25)	38	2.6%
Adult (Ages 26-59)	992	68.3%
Older Adult (Ages 60+)	395	27.2%
Unknown/ Not Reported	27	1.9%
Total	1,452	100%

Gender of Clients Served by Enriched Residential Care Program		
Gender	Number Served	Percentage
Female	468	32.2%
Female-to-Male (FTM)/ Transgender Male/Trans Man	2	0.1%
Male	936	64.5%
Male-to-Female (MTF)/ Transgender Female/Trans Woman	4	0.3%
Unknown/ Not Reported	42	2.9%
Total	1,452	100%

Race and Ethnicity of Clients Served by Enriched Residential Care Program		
Race and Ethnicity	Number Served	Percentage
Asian/ Pacific Islander	145	10%
Black/ African American	359	24.7%
Hispanic/Latino	375	25.8%
Multiracial/ Two or More Races	65	4.5%
Native American	8	0.6%
White	383	26.4%
Other	20	1.4%
Unknown/ Not Reported	97	6.7%
Total	1,452	100%

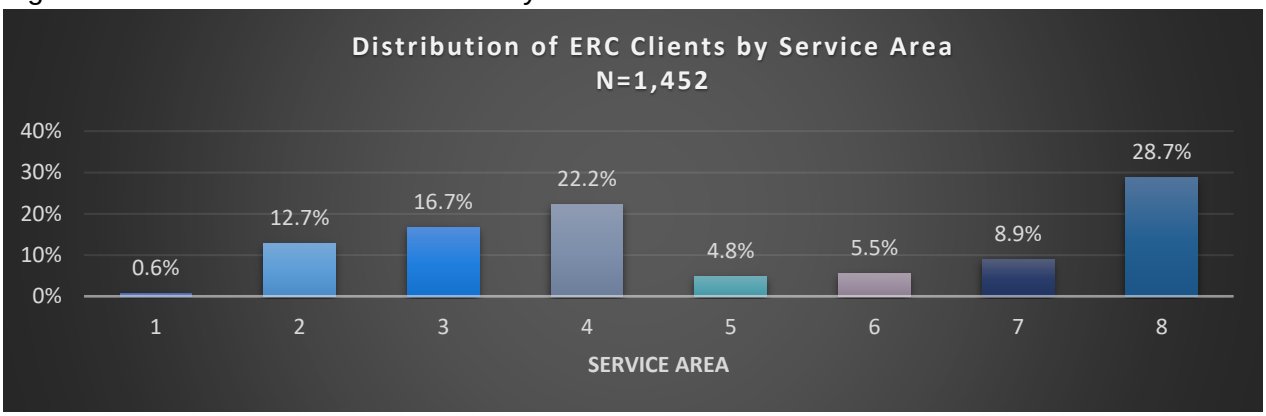
Table 31. ERC Client Financial Support Summary

ERC FINANCIAL SUPPORT RECEIVED	NUMBER OF CLIENTS*
Rent	471
P&I	419
Enhanced Rate	1,439

* Clients represented in this chart may have received more than one type of financial support through ERC.

The Service Area distribution of ERC clients is driven by the location of ARFs and RCFEs that are willing to accept DMH clients. For example, the highest percentage of ERC clients were living in Service Area 8, which can be explained by the fact that Service Area 8 had the highest concentration of licensed residential care facilities serving DMH clients. In contrast, Service Area 1 had the lowest percentage of both clients served and facilities serving DMH clients. The figure below provides further details on this distribution.

Figure 61. Distribution of ERC Clients by Service Area



Throughout FY 2023-24, DMH also continued to move forward with implementation of its Community Care Expansion (CCE) Preservation Program, which is a California Department of Social Services funded program intended to support the rehabilitation and preservation of ARFs and RCFEs through funding for capital projects and operating subsidy payments. DMH received a total of $97.5 million in CCE funds and is using $11.2 million of MHSA funds to serve as the required match for capital projects. To implement the CCE Capital Projects program, DMH partnered with LACDA to issue a solicitation in January 2024 to award funds to support health and safety capital improvements such as improvements to roofs, windows and air conditioning systems. Final awards for CCE preservation and operational funding will be made in FY 2024-25. DMH will also release an application in FY 2024-25 to implement the CCE Operating Subsidy Payment program. This funding is intended to help facilities experiencing operating deficits.

Interim Housing

The Interim Housing Program (IHP) is intended to provide shelter services for adults with SMI and their minor children who are experiencing homelessness and do not have adequate income to pay for temporary housing. Serving as a bridge to permanent housing, IHP provides clients with safe and clean shelter, 24-hour general oversight, three meals per day, linens, clothing, toiletries and case management services.

In FY 2023-24, MHSA funds enabled DMH to contract for 763 IHP beds across 24 sites. This included 700 beds serving 1,750 individuals and 63 family units serving 95 families. The IHP average occupancy rate was 90%. New beds added included 55 beds across two sites in Service Area 6 that target the justice-involved population, which are in addition to 45 beds funded with local Care First Community Investment (CFCI) dollars that were successfully implemented in FY 2022-23 for this population. An additional 96 beds were also added across two sites to support clients being served by the MHSA Innovation-funded Hollywood 2.0 program.

The figure and table below provide detail on the demographics of IHP clients served and the Service Area location where they were served. As shown, the highest number of clients served was in Service Area 4 and the lowest number of clients served was in Service Area 3, which aligns with where DMH IHP has the highest and lowest number of beds. DMH is continually looking to identify new opportunities for interim housing beds and plans to release a Request for Applications (RFA) for interim housing in FY 2024-25 to help fill service gaps using funds awarded to the County through the State-funded Behavioral Health Bridge Housing (BHBH) program.

Figure 62. Location of Clients Served in IHP Beds and Family Units

Age of Clients Served by Interim Housing Program		
Age Group	Number Served	Percentage
TAY (Ages 16-25)	116	6.3%
Adult (Ages 26-59)	1,408	76.3%
Older Adult (Ages 60+)	271	14.7%
Unknown/ Not Reported	50	2.7%
Total	1,845	100%

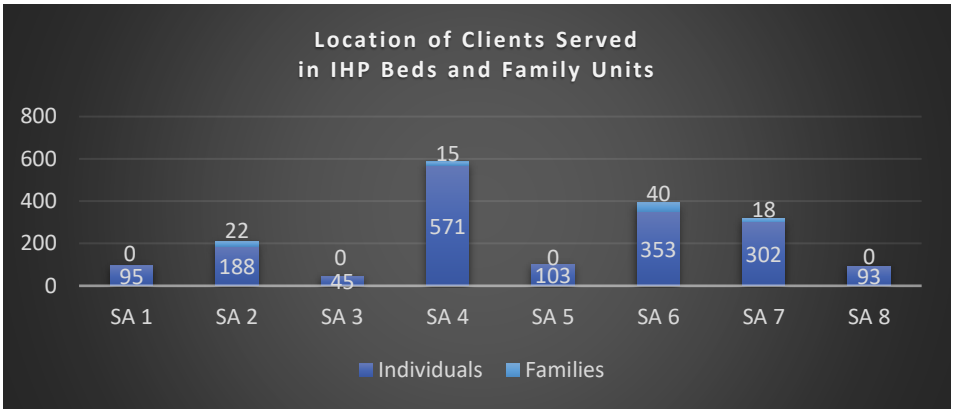


Table 33. Demographics of Clients Served by IHP

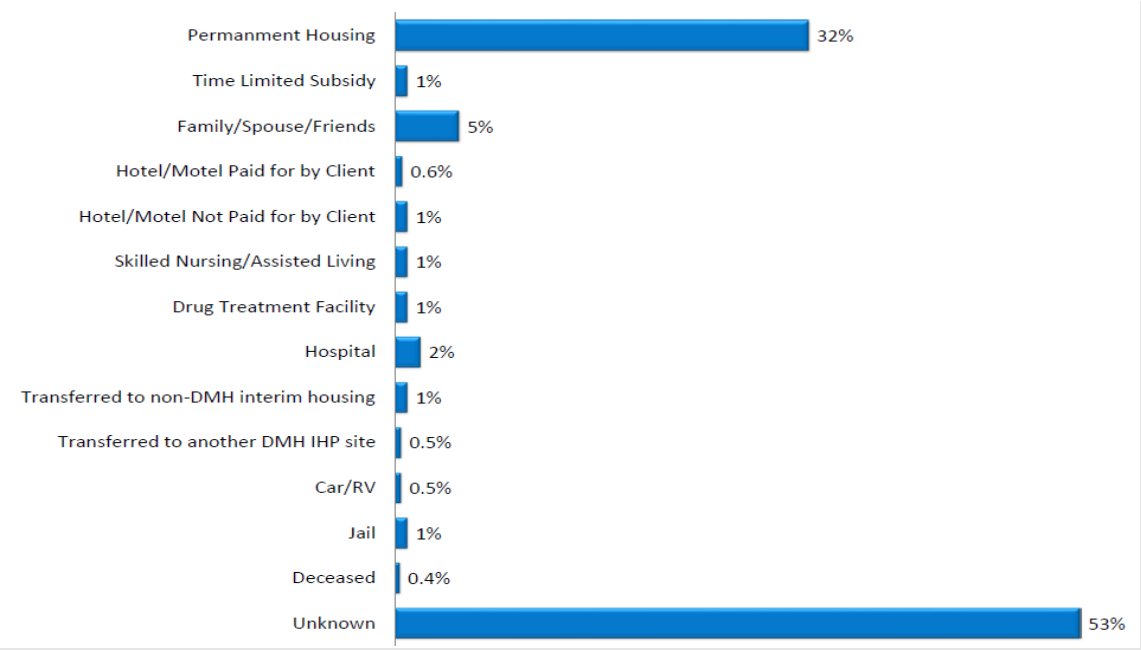
Age of Clients Served by Interim Housing Program		
Age Group	Number Served	Percentage
TAY (Ages 16-25)	116	6.3%
Adult (Ages 26-59)	1,408	76.3%
Older Adult (Ages 60+)	271	14.7%
Unknown/ Not Reported	50	2.7%
Total	1,845	100%

Gender of Clients Served by Interim Housing Program		
Gender	Number Served	Percentage
Additional Gender Category/Other	2	0.1%
Chose Not to Disclose	4	0.2%
Female	644	34.9%
Female-to-Male (FTM)/Transgender Male/Trans Man	2	0.1%
Genderqueer, Neither Exclusively Male nor Female	2	0.1%
Male	1,053	57.1%
Male-to-Female (MTF)/Transgender Female/Trans Woman	18	1%
Unknown/ Not Reported	120	6.5%
Total	1,845	100%

Race and Ethnicity of Clients Served by Interim Housing Program		
Race and Ethnicity	Number Served	Percentage
Asian/ Pacific Islander	46	2.5%
Black/ African American	699	37.9%
Hispanic/Latino	460	24.9%
Multiracial/ Two or More Races	101	5.5%
Native American	14	0.8%
White	263	14.3%
Other	37	2%
Unknown/ Not Reported	225	12.2%
Total	1,845	100%

Additionally, a total of 1,081 IHP clients exited the program in FY 2023-24, of which 32% exited to permanent housing. See figure below for further details on the breakdown of exit outcomes.

Figure 63. IHP Exit Outcomes



During FY 2023-24, IHP Client Satisfaction Surveys were also conducted to ensure that the client experience was aligned with the IHP provider expectations outlined in their funding agreement. A total of 358 clients were surveyed to determine their satisfaction with the program. Over 98% of clients reported that they agreed or somewhat agreed to the questions asked, which seems to reflect an overall satisfaction with their interim housing experience as reflected in the table below.

Table 34. IHP Client Satisfaction Survey Results

Total number of clients surveyed: 358	NUMBER OF CLIENT RATINGS				
AREAS EVALUATED	AGREE	SOMEWHAT AGREE	NEUTRAL	SOMEWHAT DISAGREE	STRONGLY DISAGREE
The living environment, including the sleeping areas and kitchen, is clean and free of bugs and pests.	96%	3%		1%	
I receive 3 meals a day and at least two of these meals are served hot.	100%				
I receive toiletries when I need them.	99%	1%			
I receive clean bedding and towels at least once a week.	98%	1%		1%	
Staff responds to my concerns.	96.6%	2.8%		0.6%	
If I need shelter services again, I would like to return to this shelter.	98.6%	0.8%		0.6%	

For FY 2024-25, DMH IHP plans to continue to monitor vacancy data, expenditures and bed usage patterns and evaluate the overall need for beds in each Service Area and will make adjustments as necessary.

Enhanced Emergency Shelter Program – TAY

The Enhanced Emergency Shelter Program (EESP) uses MHSA and other funds to serve the urgent housing needs of the TAY population, ages 18-25. This includes TAY who are unhoused or at immediate risk of becoming unhoused with no alternative place to stay and no significant resources or income to pay for shelter and are experiencing mental health concerns and willing to accept the treatment offered. The EESP offers a warm, clean and safe place to sleep, hygiene facilities, three balanced meals including a hot dinner and case management services. TAY have generally been provided shelter in the EESP for up to 60 nights while working with the TAY Navigation Team to identify longer-term and more permanent housing resources to help ensure stability as well as linkage to needed mental health and other supportive services. However, with the increase in the unhoused TAY population and the difficulties experienced in securing housing resources, many EESP clients stay longer than 60 nights until a longer-term housing option can be identified.

During FY 2023-24 the EESP capacity was 110 beds, with shelters in Service Areas 2, 4 and 6. The total number of TAY served in the EESP during the fiscal year was 575. The following tables show the total number of EESP shelters per Service Area and the corresponding number and percentage of TAY served during FY 2023-24 as well as their demographics.

Table 35. EESP Sites and Clients

Service Area	# of EESP Shelters	# of TAY	Percentage
2 – San Fernando Valley	1	90	16%
4 – Metro Los Angeles	3	189	33%
6 – South Los Angeles	4	296	52%

Table 36. Demographics of Clients Served by EESP

Race and Ethnicity of Clients Served by Enhanced Emergency Shelter Program		
Race and Ethnicity	**Number Served**	**Percentage**
Asian/Pacific Islander	8	1.4%
Black/African American	163	28.3%
Hispanic/Latino	135	23.5%
Multiracial/ Two or More Races	30	5.2%
Native American	5	0.9%
White	54	9.4%
Other	15	2.6%
Unknown/Not Reported	165	28.7%
Total	575	100%

Gender of Clients Served by Enhanced Emergency Shelter Program		
Gender	**Number Served**	**Percentage**
Additional Gender Category/Other	5	0.9%
Chose Not to Disclose	1	0.2%
Female	133	23.1%
Female-to-Male (FTM)/Transgender Male/Trans Man	7	1.2%
Genderqueer, Neither Exclusively Male nor Female	6	1%
Male	328	57.0%
Male-to-Female (MTF)/Transgender Female/Trans Woman	22	3.8%
Unknown/Not Reported	73	12.7%
Total	575	100%

Below are some success stories received from the EESP team:

- Staff received reports that a EESP client was having behavioral issues with several shelter staff. While working with their TAY Navigation Team clinician, the client improved his communication and social skills so that he could convey his thoughts without letting his emotions dictate his behavior. The client is employed part-time and attained his guard card to become a security guard. Other notable improvements are the relationships he has built with other residents, who also praise him for being a great friend.
- Two TAY are Central American immigrants who met at the shelter. They worked tirelessly to attain work and found full-time employment together. Despite not being from this country, they acclimated to the shelter quickly with the help of the staff supporting them. They utilized resources to address any needs they had and ensured they understood what was expected of them despite any language barrier experienced. They both exited to transitional housing and reported feeling a greater sense of confidence in comparison to when they arrived. They also left the program with the resources necessary to support their future success.
- One of our TAY clients was formerly incarcerated for three years. They were connected to transitional housing and employment through the EESP. TAY Navigation Team staff saw this client recently, and they are still at their transitional housing and doing well.
- An undocumented TAY client was able to go to school while in the EESP and was then accepted into a university. They were also connected to student housing through the program.
- The TAY Navigation Team Housing Specialist accompanied a TAY client to an Immigration “Notice to Appear” hearing located outside the County. The client was alone in the U.S. and a monolingual Spanish-speaker and would not have been able to travel or attend this hearing without the team’s assistance. The client successfully addressed the matter and was able to update their mailing address so that subsequent appointments would take place in Los Angeles County.

FY 2024-25 and 2025-26 in Housing

DMH continues to look for opportunities to grow and enhance its housing services and resources for DMH clients experiencing or at risk of homelessness. Recent activities and future plans include:

- In FY 2024-25, DMH will increase MHSA funding for its ERC and HSSP programs to support program growth. Additionally, in FY 2024-25, the HSSP program will transition to being funded entirely with MHSA dollars on an ongoing basis. An increase in MHSA funding for the HSSP program will again be needed in FY 2025-26 to ensure specialty mental health services can be offered to clients residing in new PSH developments.

- In FY 2024-25, DMH launched its Housing for Empowered Adult Living (HEAL) program, which provides tenant and project-based housing subsidies to DMH clients who currently reside in licensed residential facilities but are ready to transition to more independent living settings. Accepting referrals for both ERC clients and clients residing in facilities that are not supported by ERC, the HEAL program fills an important gap by providing housing

resources for individuals who traditionally do not qualify for these types of subsidies due to not meeting homelessness criteria.

- Although CCE Capital Projects funds have been fully allocated to improvements for 24 licensed residential care facilities, demand has far exceeded available funding. As a result, many additional projects that could have benefited from CCE Capital Projects funding have been unable to receive support. Looking ahead, DMH is planning to allocate an additional $20 million in MHSA dollars to complete other needed work on the 24 facilities that have already been awarded funding and to fund an estimated 8 to 12 new projects, which will help preserve 580-875 more licensed residential care beds.

- DMH is also assessing whether MHSA funds may be available to support the capital development of an interim housing site targeting TAY with serious behavioral health conditions on the campus of Metropolitan State Hospital. The MHSA funds would be used to supplement BHBH funding that was awarded toward this effort.

- With the passage of Proposition 1, which includes bond funding for the development of PSH through Homekey+, DMH is developing a process to implement the program. Also, with the transformation of MHSA to BHSA, which requires 30% of the funds to be allocated for housing interventions, DMH is preparing for this transition by analyzing how the funds can be used and developing a plan to increase housing investments to meet this new requirement by July 1, 2026.

- The DMH Interim Housing Program continues to fund dedicated interim housing beds, including motel beds, for clients of the Women's Community Reentry Program, Men's Community Reentry Program and Homeless Outreach and Mobile Engagement (HOME) Program.

Linkage

Linkage provides programming that works with those in the community to connect them to essential services that include treatment, housing and other mental health service programs throughout the County. Linkage programs include:

- Jail Transition and Linkage Services
- Mental Health Court Linkage
- Service Area Navigation
- Homeless Outreach and Mobile Engagement (HOME)
- Veteran & Military Family Services

Intended Outcomes

- Linkage programming engages in joint planning efforts to ensure that an active locally-based support network comprised of community partners, including community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups:
- Increase access to mental health services and strengthen the network of services available to clients in the mental health system
- Promote awareness of mental health issues and the commitment to recovery, wellness and self-help
- Engage with people and families to quickly identify currently available services, including supports and services tailored to a client's cultural, ethnic, age and gender identity

Key Activities

- Assist the judicial system with individual service needs assessments of defendants, link defendants to treatment programs, and provide support and assistance to defendants and families
- Assist a multi-disciplinary team in considering candidates' eligibility and suitability for pre-trial rapid diversion and linkage to treatment services
- Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations

Jail Transition and Linkage Services

This 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. 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 is to successfully link individuals to community-based services upon discharge to prevent releasing them to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

Mental Health Court Linkage Program

- The Court Liaison Program is a problem-solving collaboration between LACDMH and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery-based program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care.

- The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants with a mental illness including those with co-occurring substance abuse. The goal of CRP and its participating providers is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. Also, this program provides admission to two specialized mental health contract facilities for judicially involved individuals with mental illness who voluntarily accept treatment in lieu of incarceration.

- The Rapid Diversion Program (RDP) is a pre-plea diversion program targeting individuals with a mental health diagnosis or substance use disorder. Individuals in this program participate in programming, receive housing resources, and are case managed for a period recommended by the service provider and approved by the court. Cases are dismissed for individuals who successfully complete the program.

Priority Population

This recovery-based program serves adults with a mental illness and/or co-occurring disorder who are involved with the criminal justice system. Participation is voluntary and available to individuals above 17 years old.

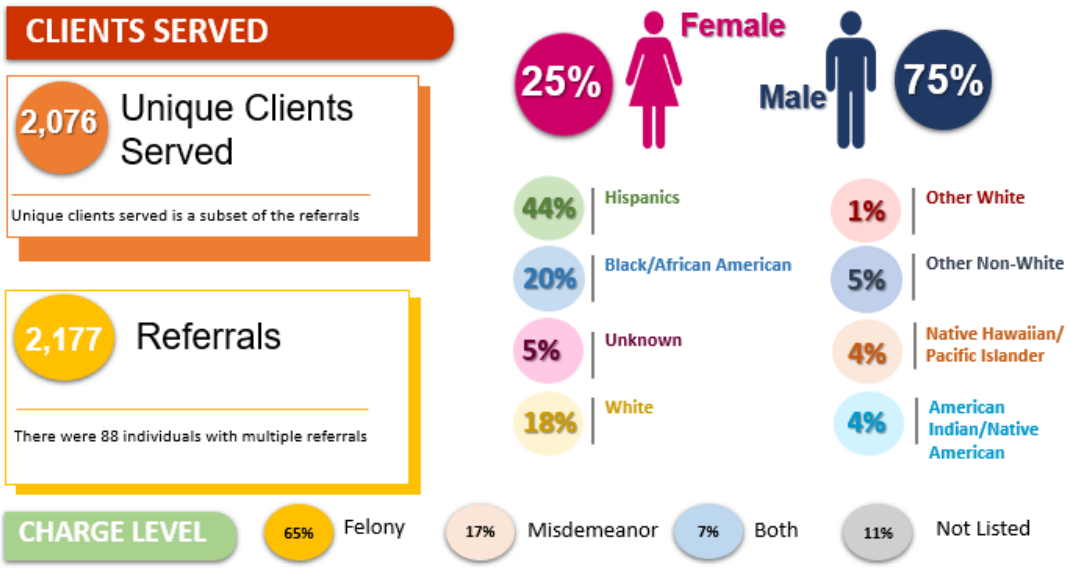
Intended Outcomes

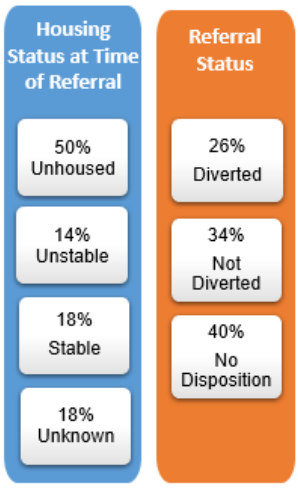
The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The Court Liaison Program further aims to provide ongoing support to families and to educate the court and the community-at-large regarding the specific needs of these individuals.

Key Activities

- Assist the judicial system with individual service needs assessments of defendants, link defendants to treatment programs, and provide support and assistance to defendants and families
- Assist a multi-disciplinary team in considering candidates' eligibility and suitability for pre-trial rapid diversion and linkage to treatment services
- Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations

Figure 64. Clients Served





Successful Diversions

Level of Care	Percentage
Outpatient Services with SUD Tx	26%
Outpatient Services without SUD Tx	11%
Wellness Centers	11%
Full Service Partnerships	11%
Substance Abuse Tx	10%
Dual Diagnosis Residential	9%
SUD Liaison	5%
CRP	4%
DHS/ODR Pilot	2%
VA Arranged by Others in CCC	2%
CODC	2%

Reasons for Not Being Diverted

Reasons	Percentage
Does Not Meet Focal Population	17%
Client Refusal	13%
Level of Care Not Available	11%
Incompetent to Stand Trial	10%
Jail	10%
Consultation Only	8%
Level of Care Not Acceptable to Court	6%
AB 109 Client	5%
Time Served	5%
Prison	3%
Probation	3%
Trial	3%
Other	6%

FY 2025-26

Establishment of a Post-Linkage Action Team- Understanding the link between receiving mental health and substance use disorder treatment and its impact on recidivism, reduction of mental health symptoms, and functional impairments is a complex challenge. Multiple factors influence this relationship, including the variability in treatment engagement, differences in the severity of mental health conditions, co-occurring disorders, and the quality and accessibility of services.

Additionally, offenders often face barriers such as stigma, limited social support, and inadequate resources, which can complicate their treatment journeys. Evaluating the effectiveness of these interventions requires robust longitudinal studies that consider a range of clinical, social, and

environmental factors to determine how and when treatment truly makes a difference in reducing symptoms, improving daily functioning, and lowering the risk of re-offense.

Potential data collection metrics might include:

1. **Treatment Engagement** as evidenced by:
    - Attendance at scheduled appointments (therapy, counseling, medical)
    - Medication adherence rates
    - Participation in substance use disorder treatment
2. **Clinical Outcomes**, such as:
    - Changes in mental health status (e.g., symptom severity scales, depression or anxiety scores)
    - Frequency and intensity of substance use
    - Reduction in hospitalizations or emergency room visits related to mental health crises
3. **Legal and Criminal Justice Metrics**:
    - Rates of recidivism or re-arrest
    - Compliance with probation or parole conditions
    - Number and type of legal incidents or infractions
4. **Quality of Life and Social Functioning**:
    - Housing stability
    - Employment or educational engagement
    - Social support networks and community integration
5. **Service Utilization and Cost**:
    - Types and frequency of mental health and substance use services used
    - Costs associated with treatment, hospitalization, and criminal justice involvement

Modernization of the program's referral procedure and mechanism
The MHCLP began the discovery process with the department's CIOB approximately 2 years ago and recently participated in a 'kick-off' meeting to collaborate on design of the solution. However, the DMH has also commenced design of a universal coordinated entry tool that might perform similar functions, rendering this MHCLP-specific effort unnecessary.

Modernization of the unit's data collection process
The program currently uses Microsoft ACCESS for data collection which is no longer a supported application. Therefore, plans are underway to migrate this information to a supported and more efficient platform. Data analysis tools, such as Microsoft Power BI, will be leveraged to facilitate data integration, real-time analytics, advanced data visualization, and deeper, more sophisticated data analysis.

Transition out of DMH directly operated involvement in the Rapid Diversion Program
While DMH was an integral part of the implementation of the initial pilot for the Rapid Diversion Program, DMH will now continue this effort through two of it's legal entities. At Long Beach Court and Clara Shortridge Foltz Criminal Justice Center (CCB), the RDP program at these sites will be

fully transferred to Special Services for Groups (SSG). This will increase the program's capacity to serve non-RDP referred individuals at each courthouse.

Homeless Outreach and Mobile Engagement

The Homeless Outreach & Mobile Engagement (HOME) program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services substance abuse treatment and shelter).

HOME serves individuals 18 and over who are experiencing chronic unsheltered homelessness and who have profound mental health needs and associated impairments. These vulnerable and disengaged individuals struggle with securing appropriate food, clothing, and shelter due to their mental illness. In addition, they may have critical deficits in hygiene and communication, and are generally highly avoidant of services. They are unable to live safely in the community and require specialized mental health services to secure and sustain housing.

Most referrals are submitted by generalist homeless outreach providers who identify individuals with severe impairment that require specialized and intensive support and engagement.

The severe and persistent nature of the mental illnesses experienced by individuals referred to HOME has prevented programs at lower levels of care in the mental health and homeless outreach systems from effectively serving this population. With HOME's specialized outreach and treatment, many can be successfully served and moved into appropriate placement. However, some of those served by HOME lack capacity to successfully utilize the services offered and will require the extraordinary interventions of involuntary hospitalization and, potentially, Lanterman-Petris-Short (LPS) Conservatorships to avoid death, achieve psychiatric stabilization, and obtain appropriate placement. HOME's use of these interventions is detailed in the figures below.

The HOME Program expanded their service capacity by increasing the number of teams over a two fiscal year period beginning in FY 2022-23 and into FY 2023-24. This expansion is part of an effort to address the homelessness crisis as part of a lawsuit settlement between Los Angeles County and Los Angeles Alliance. Los Angeles County has committed to funding increased services, outreach, and interim housing for the most vulnerable people experiencing homelessness; in particular, the terms of agreement include expanding the number of HOME teams. In fiscal year 2022-2023 the program increased by 67 new positions and in 2023-24 the HOME program increased their capacity by adding 40 new positions. This increased capacity facilitated the following program developments:

- Rightsized existing teams to align the team staffing pattern across service areas;
- Expanded the number of HOME teams from 16 to 18 teams;
- Expanded the administrative infrastructure to support the program expansion;
- Expanded psychiatry services by adding Nurse Practitioners and Psychiatrists in each service area;

- Created a HOME Recovery & Wellness Program to provide ongoing service to the most vulnerable individuals following successful placement;
- Participate in Inside Safe and Pathway Home Encampment Resolution Efforts and the associated Service Connections Events.

Key Activities for FY 2023-24

HOME provides the following to the people we serve:

- Basic Needs Provision
  - Provision of Food, clothing, hygiene products, medical supplies
- Housing
  - Placement in motels, the interim housing system, and/or the permanent housing system. HOME accesses the full scope of housing related services that any other homeless service or mental health service provider can provide.
- Mental Health Assessment
  - Clinical determination of symptoms, diagnosis, functional impairment caused by a mental illness
- Psychiatry
  - Medical Doctors and Nurse Practitioners visit people wherever they are and prescribe medication.
- Nursing care
  - Physical health assessment and intervention including vital monitoring, wound care, hygiene assistance, and arranging more intensive medical care when necessary.
- Medication Management
  - Procurement and delivery of medication to people served wherever they are, on a daily basis when necessary
- Psychiatric Rehab
  - Skill building to overcome functional impairments, assisting people in learning to navigate the tasks necessary to care for themselves.
  - Can include anything from teaching someone to shop for themselves to helping them manage their emotions while waiting in line at the DMV
- Case Management
  - Assistance in navigating systems and obtaining resources such as disability income, identification documents, legal representation, etc.
- Involuntary Hospitalization
  - An intervention reserved as a last resort in cases where all other efforts to achieve psychiatric stability and housing placement have been insufficient
- Outpatient Initiated Conservatorship
  - An extraordinary intervention reserved as a last resort in cases where a brief involuntary hospitalization is insufficient to achieve psychiatric stability. In these instances, HOME providers initiate and complete this process historically reserved only for providers in acute inpatient psychiatric facilities.

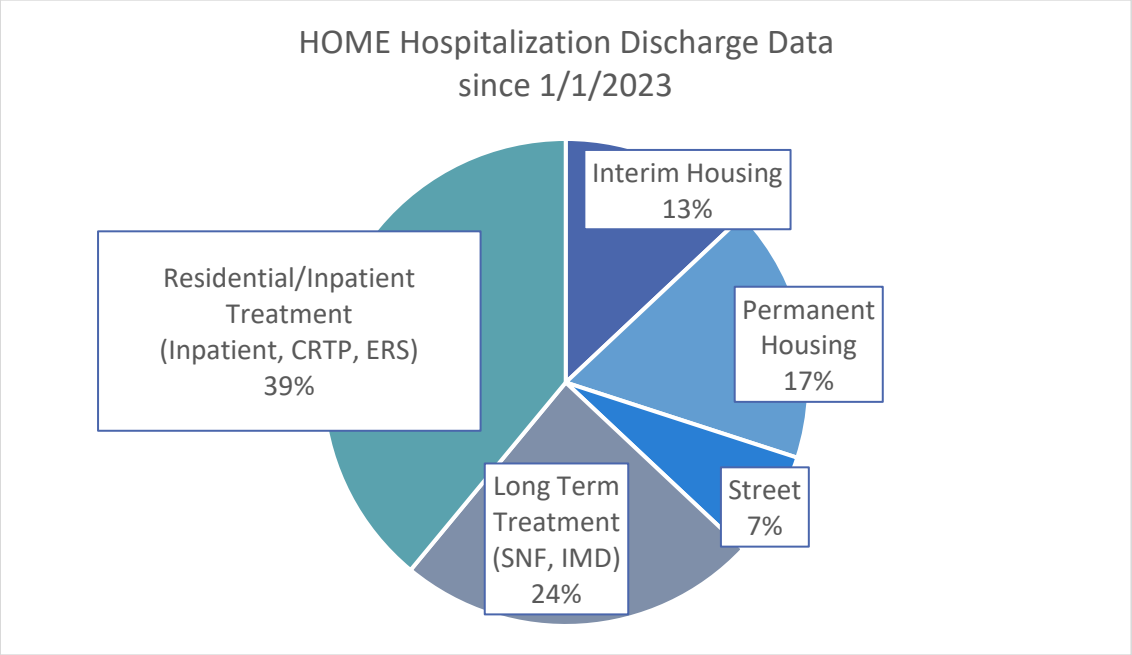
Data for Fiscal Year 2023-24

- How many clients did you work with? 2,200
- How many were treated involuntarily? 246
- How many conservatorships? 96 LPS Referrals for HOME clients, 87 Appointed and 9 Failed
- How many clients moved into permanent housing? 168
- How many clients moved into interim housing? 247

Lessons Learned for Fiscal Year 2023-24

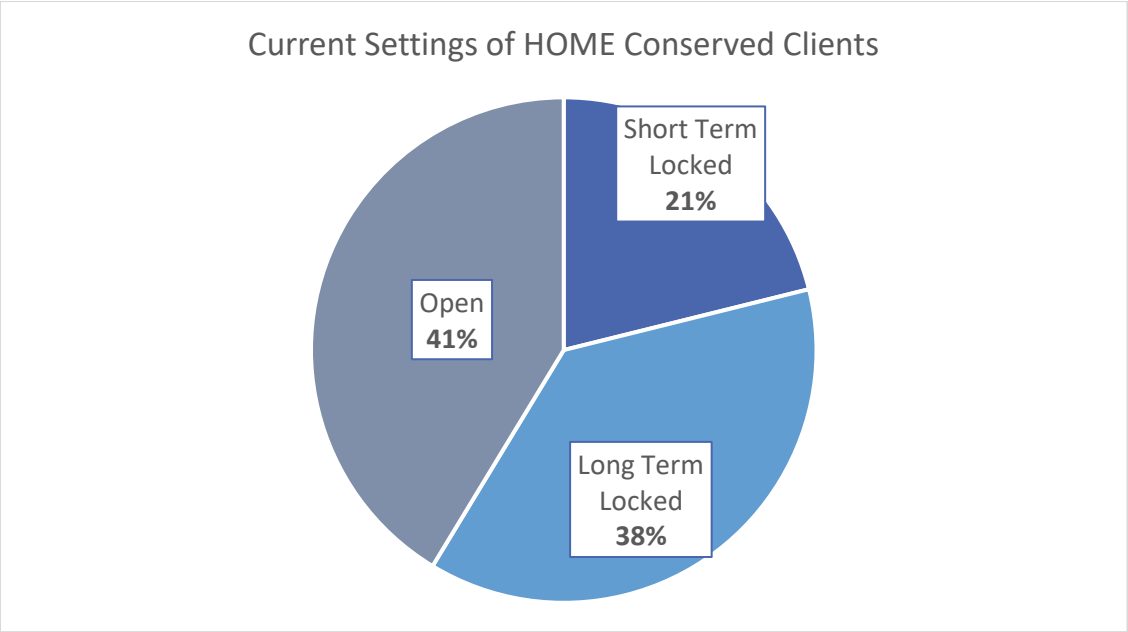
Most HOME hospitalizations result in linkage to housing or ongoing residential treatment. Only a small percentage return to the street.

Figure 65. HOME Hospitalization Discharge Data



Of the 213 currently conserved clients in HOME's care, 88 people are currently treated in unlocked settings.

Figure 66. Current Settings of HOME Conserved Clients



Challenges and obstacles that the program had to overcome for FY 2023-24 and continue to be barriers:

- **The lack of an available full array of housing and treatment bed options with flexibility for the program to utilize.**
    - Limits on the number of available and fully funded acute psychiatric beds, licensed mental health rehabilitation center (MHRC) beds, and skilled nursing facility beds, pose a significant challenge to HOME in the program's efforts to serve the most ill and vulnerable people experiencing homelessness. Difficult triaging decisions must be made and service at the most clinically appropriate level of care is often delayed due to a lack of availability of these resources.
- **The inability to utilize video technology (WebEx) for LPS conservatorship hearings.**
    - Clients are often resistant or refuse to be transported to court for these hearings. In some cases, clients become agitated, aggressive, or abscond during the process of transporting them to and from a hospital or their location on the street. Were the California Superior Court and the relevant legislation to permit the utilization of WebEx for LPS hearings in the same manner is is used for CARE and AOT these challenges would be resolved, and clients would receive safer and more appropriate care.
- **The denial of client referrals by contracted subacute and enriched residential service facilities.**
    - Clients needing and ready for these levels of care are often denied by the contracted entities operating these facilities. Denials are often due to the symptoms and nature of the very illnesses that require the need for placement in these facilities, histories of violence, histories of medication non-compliance, histories of co-occurring substance use, poor hygiene, etc. The creation of directly operated subacute facilities to ensure access and oversight of these vital levels of care would alleviate this challenge.
- **The need to hire and retain staff.**

    - Field based work with the most severely ill and vulnerable people experiencing homelessness is difficult. The fact that many programs at lower levels of care have been unsuccessful in serving the very individuals served by HOME is evidence of and emphasizes this fact. The people serving as staff in in HOME have many other options for employment, including options that serve similar populations in less intensive settings and programs. Hiring and retaining staff willing to serve high acuity clients in a high-pressure environment is a significant challenge. Incentives and retention bonuses to hire and retain staff who want to work in Public Mental Health and specifically with field-based programs serving high acuity clients would help to alleviate this challenge.
- **Inflation and increased costs.**
    - Field based programs serving people experiencing homelessness rely on many resources that have been subject to increasing costs. Chief among these are food, motel-based interim housing, and vehicles. HOME is required to abide by limits on spending on food and motel-based interim housing put into policy years ago without any provision for rising costs. It has been increasingly difficult to abide by these limits and any need to exceed them requires time consuming approval processes. A revision to the relevant policies would alleviate this issue. The cost of vehicles has increased, and inventory has decreased, resulting in a far more competitive market than it once was. Acknowledgement and realization of inflation and the impact it has had on field-based programs being able to bring in vehicles within the designated budget. A lack of vehicles curtails the number of services able to be provided on any given day.
- **The lack of available nursing staff.**
    - The Department's adoption of a new nursing class series to bring in entry level registered nurses who can be supported and supervised by DMH nursing staff will increase the pool of candidates as well as offer opportunities for internal promotions and the training of employees who meet the needs of the programs and populations being served.

Service Area Navigation

Service Area Navigation teams work to destigmatize mental health challenges, promote available mental health services in the community, and connect individuals to essential services that include treatment, housing, and other mental health service programs throughout the County. Linkage programs include:

- Service Area Outreach, Engagement, and Navigation
- Housing Navigation

Priority Population:
The priority population is individuals with severe mental illness in the following age ranges:

Children Ages 0-17; Transition Age Youth (TAY) Ages 16-24; Adults ages 24-59; Older Adults ages 60+

Intended Outcomes:

- Engage in collaborative planning efforts to ensure that an active locally based support network is comprised of community partners, including community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups.
- Minimize stigma associated with mental health challenges, increase awareness of available mental health resources, and provide linkage to services, increase access to mental health services, and strengthen the network of services available to clients in the mental health system.
- Promote awareness of mental health issues and the commitment to recovery, wellness, and self-help.
- Engage with people and families to quickly identify available resources, including supports and services tailored to a client's cultural, ethnic, age, and gender identity.

Key Activities FY 2023-2024:

- Plan community outreach and engagement events throughout the year, particularly for May is Mental Health Month, to minimize stigma associated with mental health challenges, increase awareness of available mental health resources, and provide linkage to services.
- Host monthly Service Area Leadership Team (SALT), Clergy Roundtables, and Health Neighborhood meetings to engage the community and build partnerships with local city, community and county agencies, organizations, and businesses.
- Collaborate with Los Angeles Homeless Services Authority (LAHSA) and Los Angeles County Development Authority (LACDA) and build relationships with landlords and property management companies.
- Provide technical assistance and training with housing applications and referrals for directly operated and contracted programs and assist individuals as needed.

Results & Outcomes:

May is Mental Health Month

The May 2024 Take Action LA initiative featured multiple service area events, community-based grants, major sports and community partnerships, and media outreach and public education, with the aim of decreasing stigma and expanding knowledge around mental health and resources countywide. More than 200 events were held across the county, with more than 40,000 people attending at least one event. Take Action LA programs were offered in 21 different languages, with 9,000 meals served, and 70 grants provided to community-based organizations. Major sports venue events with the LA Dodgers, Sparks, Galaxy, and Clippers reached more than 65,000 people and over 400,000 social media impressions.

Media outreach resulted in 59 million impressions, over 200,000 social media engagements, and 170,000 video views. The Get Help Now and Call Helpline calls to action resulted in 22,509 and 18,754 conversations, respectively.

Service Area Outreach, Engagement, and Navigation

Outreach & Engagement teams (Service Area Leadership Teams, Service Area Community Collaboration, Clergy Engagement, Health Neighborhood, and Peer Resource Center) partnered with community agencies/organization to produce over 160 events throughout the year.

Service Area Navigator Teams assisted individuals and families with accessing mental health and other supportive services. They also network with community-based organizations to strengthen

the array of services available to clients of the mental health system and create portals of entry in a variety of settings.

In FY 2023-24, the Integrated Behavioral Health Information System (IBHIS) data shows that Directly Operated clinics received 83,679 referrals.

Table 37. Service Area Referrals

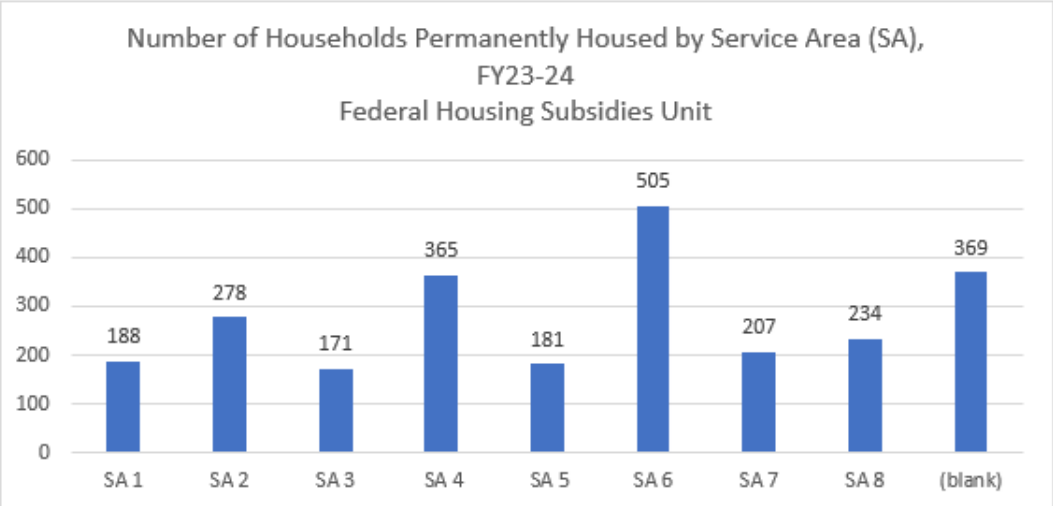
Service Area	Referrals Received
1	8,560
2	14,839
3	6,466
4	12,125
5	4,047
6	11,333
7	8,049
8	18,260
Total	**83,679**

Housing Navigation

Tenant-Based Permanent Supportive Housing (Section 8)

In FY 2023-24, DMH's tenant-based housing managed by the Housing and Job Development Division's (HJDD) Federal Housing Subsidies Unit (FHSU) permanently housed 2,498 clients. The table below shows the number of households permanently housed by service area, the service area reflecting the location of the agency/provider assisting the client.

Table 38. Number of Households Permanently Housed by Service Area



Project-Based Permanent Supportive Housing

In addition to the tenant-based housing resources the DMH-funded project-based permanent supportive housing units housed approximately 2,825 clients in FY 2023-24. The table below shows the estimated number of clients housed by service area.

Table 39. Project-based Permanent Supportive Housing by Service Area

	Service Area	number	percentage
	SA 1 - Antelope Valley	124	4.4%
	SA 2 - San Fernando Valley	447	15.8%
	SA 3 - San Gabriel Valley	43	1.5%
	SA 4 - Metro Los Angeles	1,021	36.1%
	SA 5 - West Los Angeles	122	4.3%
	SA 6 - South Los Angeles	501	17.7%
	SA 7 - East Los Angeles	150	5.3%
	SA 8 - South Bay	256	9.1%
	Unknown/Not Reported	161	5.7%
Total	—	2,825	100.0%

This table displays Service Area information for clients in DMH CI during Fiscal Year 2023-24. Service Area information is sourced directly from HJDD program data.

Lessons Learned

May is Mental Health Month (MMHM)

In FY 2023-24, Service Areas planned for one main big event and smaller community events throughout the month, which helped improve event coordination, organization, and communication.

Service Area Outreach, Engagement, and Navigation

Service Area teams continue to grow and foster the community relationships they have developed over the course of the past couple years, post-covid. The MHSA Admin team encourages the teams to continue planning meaningful and intentional events well in advance to increase community engagement and access and to improve communication and coordination in the planning process.

Plans:

Strategic planning of MMHM events

- Focus on 1 large event per SA to include all grantees and multiple Community Based Organizations (CBOs).
- Continued partnerships with organizations (Sparks, Clippers) for O&E resource tabling.
- Work to avoid scheduling conflicts with other Department events.
- Mobilize Mental Health Promotors to register and engage the community prior to all scheduled events.

Service Area Outreach & Engagement Events

- Increase the number of Service Area events throughout the year to raise awareness and connect individuals with needed services.
- Incorporate more Maternal Mental Health and Men's/Fatherhood Mental Health events throughout the Service Areas.

Veteran and Military Family Services (Formerly known as Veterans Peer Access Network -VPAN)

The Veteran and Military Family Services (VMFS) program is currently a prevention-focused initiative and linkage program designed to support veterans and their families across Los Angeles County. VMFS leans on successes of the peer-to-peer model of services. Majority of our staff are veterans and military family members. The program seeks to lower risk factors such as high suicide rates, homelessness, and underemployment among veterans while increasing protective factors like social connectivity, financial stability, resilience, and socio-emotional skill development.

VMFS will transition to fully implementing a Full-Service Partnership (FSP) Intensive Case Management Services model, which will include linkage, mental health services, housing, medication support, and 24-hour crisis support services. Current DMH VMFS clients will continue to receive support through Early Intervention (EI) efforts, while linkage services will be expanded to include comprehensive mental health care and crisis response. The program's cornerstone, the VMFS Support Line, will remain a vital resource, offering immediate assistance to active-duty military personnel, veterans, reservists, and military family members. The line will continue to operate 7 days a week, 9AM -6PM and will continue to be funded by Early Intervention. Through the means of the VMFS Support line and other Outreach and Engagements efforts, Veterans and their families will benefit from Emotional First Aid, psychoeducation on mental health, referrals to community resources, and direct connections to field-based teams. The range of referrals from low risk to high-risk will be dispositioned and triaged according to level of care and need. Individuals with mild mental health needs will be referred to community veteran service providers, moderate to high needs will be services within the FSP model. This hybrid model will enable the program to continue with ease of access to care for veterans and military family members as many veterans with mental health will not come in for mental health services but will be more inclined to come in for housing or benefits.

VMFS will also continue with our contract with SAMHSA PATH focusing on housing services and mental health linkage for mentally ill unhoused veterans. Our PATH team will continue to work closely with various Housing Authorities in LA county, VA partners and DMH housing division to provide permanent housing solutions for our veterans.

These initiatives will continue to strengthen our efforts to support unhoused veterans and those with limited or no clinical history in the Integrated Behavioral Health Information System (IBHIS). The VMFS program encompasses all aspects of care, as veterans often fit into multiple categories, and its staff are equipped to provide services across all areas. By fully integrating the hybrid FSP model with its current offerings, including EI, linkage, medication support, and crisis services, VMFS will ensure a more comprehensive and individualized approach to care. This integration will enhance social connectivity, improve mental health outcomes, and promote housing stability for veterans and their families. Through ongoing data tracking and analysis, and regular feedback from the veteran community (such as LAVC), VMFS will continuously refine its services to expand its reach, impact, and outcome bettering the lives of veterans and their loved ones.

Planning Outreach and Engagement

Program Description

POE programs:

- Service Area Liaisons
- Underserved Cultural Communities Unit (UsCC)
- Stipend for Community Volunteers, examples include Wellness Outreach Workers (WOW) and the Countywide Client Activity Fund (CCAF)

Intended Outcomes

- Increase mental health awareness to all communities within the County
- Identify and address disparities amongst target populations
- Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contract providers

Key Activities

- Outreach communities throughout the County by conducting conferences and special events
- Communities and education community members using various media and print media, as well as grassroot level community mental health presentations.
- Communicate and educate community members using various media and print media, as well as and grassroot level community mental health presentations
- Conduct surveys to gather results for data analysis to continue planning, outreach and engagement activities
- Enlist the help of community members to collaborate in outreach and engagement activities
- Planning facilitation

Service Area Liaisons

Planning, Outreach and Engagement (POE) is a vital component of the Mental Health Services Act (MHSA), which aims to inform the public about MHSA programs and services, garner community input, and integrate feedback into the O&E planning process.

O&E activities focus on reaching a wide diversity of backgrounds and perspectives represented throughout the county, with a special emphasis on unserved, underserved, inappropriately served and hard-to-reach populations.

O&E creates an infrastructure that supports partnerships with community resources and providers, schools, community-based agencies, Faith-Based organizations, historically disenfranchised communities, and other county departments.

The purpose of POE:

- Provide outreach, education, and engagement as a means of increasing access and linkage to mental health services and supports for individuals, families, and communities towards great wellbeing
- To develop partnerships with community supports (e.g. schools, other service providers, community-based organizations, and other natural community supports) to build networks/capacity to better serve individuals, families, and communities towards great wellbeing
- To reduce stigma
- To build greater capacity for communities and stakeholder groups to provide input into the DMH Community Planning Process to: (1) identify community issues related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the MHSA; (2) analyze the mental health needs in the community; and (3)identify and re-evaluate priorities and strategies to meet those mental health needs (9 CCR § 3200.070).

POE supports:

- Collaborative efforts and activities with Community Partners (i.e. non DMH agencies/entities) for events that focus on education, access and linkage to mental health services for individuals, families and communities and to encourage greater involvement by those needing and/or receiving services in the DMH Community Planning Process.
- Strategies and training that develop and support grass-roots Community Based Organizations (CBOs) to provide services and supports that increase the public mental health service network countywide, especially for historically underserved ethnic and cultural communities.
- Regular convening of Stakeholders (i.e. Community Planning Team and the public) towards the development, implementation and monitoring of MHSA programs and services.

Examples of Events and Activities Supported by POE:

- Strategies to reduce ethnic/racial disparities
- Resource & information faris for awareness days/months/holidays and cultural events
- Sports and Media Partnership Events (examples: Dodger and Galaxy games/events)
- Events that leverage resources with other County Departments (e.g. Parks after Dark)
- Food, clothing, and shelter, but only when the purpose is to engage unserved individuals, and their families (when appropriate) in the mental health system
- Outreach to entities, including but not limited to CBOs; Schools; Tribal communities; Primary care providers; Faith-Based organizations; Outreach to individuals, including but not limited to community leaders, those who are experiencing homelessness and those who are incarcerated in county facilities or those re-entering communities post incarceration

Pictures of POE Supported Events Across Los Angeles County:

Figure 67. SA 1 “Count Her In” Event

Figure 68. SA 2 Refugee Children’s Center Resource Event

Figure 69. SA 3 May is Mental Health Awareness

Figure 70. SA 4 Father’s Wellbeing Celebration

Figure 71. SA 5 Dodgers Pride Night

Figure 72. SA 6 Line Dancing @ Jessie Owens Park

Figure 73. SA 7 Men’s Health Awareness Family Fun Day

Figure 74. SA 8 Family Unity Day

Underserved Cultural Communities

One of the cornerstones of MHSA is to empower underrepresented ethnic populations. In June 2007, LACDMH established the Underrepresented Ethnic Populations (UREP) to develop a stakeholder platform for historically underserved ethnic and cultural communities in LA County. Subcommittees were established to work closely with the various underrepresented/ underserved ethnic and cultural populations to address their specific needs. In 2017, the UREP became the Underserved Cultural Communities (UsCC) after the incorporation of two (2) additional subcommittees implemented by the Cultural Competency Unit (CCU) in collaboration with the Cultural Competency Committee (CCC).

UsCC Subcommittees:

- Black and African Heritage
- American Indian/Alaska Native
- Asian Pacific Islander
- Access for All (formerly known as Deaf, Hard of Hearing, Blind, and Physical Disabilities)
- Eastern European/Middle Eastern
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

Each UsCC subcommittee is allotted one-time funding to focus on CSS-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach.

Intended Outcomes:

- Increase mental health awareness to all communities within the LA County
- Identify and address disparities faced by target populations
- Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contracted providers

The goals of the UsCC Capacity Building Projects include increasing knowledge about mental illness, increasing access to mental health resources, and decreasing stigma related to mental illness in the targeted UsCC community. These projects are not intended for the delivery of mental health services but to increase access to care by unserved, underserved, and inappropriately served populations who are uninsured/uninsurable and across age groups (children, TAY, adult, and older adult) consistent with the language and cultural needs and demographics of those communities. The UsCC capacity building projects are community-based and include culturally effective outreach, engagement, and education and respond to historical and geographic disparities and barriers to services.

An overview of each UsCC subcommittee's projects for FY 2023-24 is provided in the following table.

Table 40. UsCC Subcommittee Projects

Access for All (People with Disabilities) UsCC
African American Family Mental Health and Disability Awareness Black babies and mothers have disproportionately high rates of death upon birth and birthing. This project integrates the topics of mental health and disability into current African American infant and maternal mortality prevention efforts in Los Angeles County. The project identifies and engages 24 community-based organizations serving African American families exposed to chronic stress and racism. Staff and volunteers at twelve organizations are receiving presentations, training 48 participants, and reaching 240 African American community members with relevant information and resources during home visits, outreach activities, coalition meetings, and local events.
American Indian/Alaska Native (AI/AN) UsCC
Suicide in Native Communities Toolkit Los Angeles County is home to the highest concentration of American Indian or Alaska Native people in the United States. Diverse Native communities experience disproportionately high rates of suicide. The aim of this project is to develop a resource guide and accompanying video for American Indian/Alaska Native individuals experiencing the aftermath of a suicide in the family or community. Included in the Toolkit is culturally specific information on cleaning services, coroner/funeral arrangements, low-or no-cost legal services, traditional mental health and spiritual healing providers, and community support resources. Roundtable discussions with 100 participants elicit community input on what to include in the content and how to most effectively present the information. **Missing and Murdered Indigenous Women and Girls** This project focuses on increasing awareness of and reducing the disproportionate rates of violence against and homicide of Native girls and women in Los Angeles County, where violence is a leading cause of premature death. The contracting organization is strategically engaging 10 American Indian or Alaska Native women to develop, produce, and distribute a series of five videos to highlight the crisis of missing and murdered indigenous women and girls and share relevant culturally specific community violence prevention resources. **American Indian/Alaska Native Elder Gathering Project** The purpose of the AI/AN Elder Gathering Project is to reduce mental health access barriers for AI/AN elders by engaging this population in conversations about the role of cultural traditions in mental health and healing. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. This project engages 75 American Indian/Alaska Native older adults through a series of five community gatherings focusing on storytelling, plant medicine, history, songs, food, and cultural traditions. **American Indian/Alaska Native Cooking for Wellness Project** The AI/AN Cooking for Wellness Project will engage 60 AI/AN adults in a series of six cooking classes, conversations about wellness, nutrition, food insecurity, and associated mental health challenges. The AI/AN population is often underserved and marginalized; this project seeks to increase access to mental health services among participants and community members. The project will create community, reduce social isolation, strengthen cultural identity, and facilitate opportunities for healthy cooking and eating.

American Indian/Alaska Native Community Garden Project
The purpose of the AI/AN Community Garden Project is to reduce mental health access barriers through conversation and classes about traditional food and wellness. This project convenes 60 AI/AN adult participants in a series of six gardening classes and will facilitate culturally specific food sustainability learning activities, increasing cultural identity and community for mental health.

American Indian/Alaska Native Youth Graphic Novel Project
This project facilitates creative self-expression and reinforces indigenous cultural identity and mental wellness among 15 transitional age youths (16-24) over the course of five group graphic novel development and production sessions. During the creative art sessions, mental health stigma in the AI/AN community is discussed while participants learn various techniques such as graphic novel, comic book art, writing, drawing, manga, and anime.

Asian Pacific Islander (API UsCC)

Filipino Comic Book
The purpose of this project is to educate, empower, and heal the rising generation of Filipino-American youth through storytelling and illustration. Through collaboration with community agencies, 15-20 Filipino American youths (ages 16-24) will be recruited and engaged in six workshops on comic book development and production. They will design, write, and produce their own comic book illustrating how mental health issues impact their lives. The project increases community and cultural identity as youth participate in workshops on art as a medium for healing, consciousness, creative wellness, and comic book protagonists.

Recovery Talk
This project aims to reduce culturally specific shame and stigma of mental health challenges; and consists of a series of recorded group mental health discussion sessions with a total of 125 API adult community members. Topics will include depression, anxiety, bipolar, schizophrenia, PTSD, substance misuse, and community resources. Languages will include Korean, Mandarin, Cantonese, Tagalog, Vietnamese, and Khmer. Recordings will be distributed on social media, including YouTube and WeChat.

Storytelling Theater for Healing and Social Justice
This project focuses on API immigrant experiences and mental health challenges. An API theater consultant recruits and engages five API community members with lived experience in mental health issues to develop, produce, and stage an empowering play to be performed 12-16 times, at five venues, with an audience of 160 community members and a cast of 12-16 members, addressing stigma, anti-immigrant discrimination, and healing.

Black/African Heritage UsCC

Prevention Works 4 Communities Toolkit
DMH aims to engage diverse cultural groups in services and stakeholder activities. This project focuses on African immigrants in Los Angeles County. It develops a community survey tool, a wellness outreach strategy, a comprehensive wellness toolkit, and an informative PowerPoint presentation on stress reduction, mindfulness, self-help, mental health, and culturally specific wellness resources to be presented to 100 Pan-African (West African, Caribbean, and other Black African) immigrant community members.

ReFRESH (Finding Restoration, Self-Help

This project is designed for Black justice-involved and/or formerly incarcerated individuals to bring training and mentoring opportunities to the community. It seeks to reduce stigma and increase access to care among 15-20 formerly incarcerated Black/African American men with lived experience in mental health, by providing a 14-hour training program to become community facilitators. Community facilitators will reach up to 400 of their peers with messages and resources on trauma, mental health services, job opportunities, financial wellness, and mentoring.

Youth and Young Adult Drug Prevention
In Los Angeles County, Black youth and adults are less likely to use Fentanyl; yet they are more likely to die from an overdose than other groups. This project responds to the opioid crisis by focusing on culturally specific youth outreach and training. It aims to recruit and train 15 youths living in the underserved Antelope Valley/Palmdale area of Los Angeles County, to reach 100 of their peers with overdose prevention, Fentanyl awareness, harm reduction access, substance misuse resources, and mental health information.

Eastern European, Middle Eastern UsCC

Sharing Our Stories: Russian/Farsi Book
This project engages 15-20 Russian and Farsi speaking adults in remembering, writing, editing, and sharing their stories of immigration, trauma, mental health, family, healing, and community. Participants' stories will be compiled into a digital book, which will be widely disseminated during community events and promoted through local Russian and Farsi-speaking media channels.

Parenting Seminars for the Armenian Community
There are hundreds of thousands of Armenians living in the Greater Los Angeles County area. This community has experienced intergenerational trauma from the Armenian Genocide, including high levels of stress related to parenting and caregiving for older relatives. A series of 14 culturally and linguistically specific, in-person and online parent education courses will reach Armenian adults interested in reducing family stress and increasing peace in the home.

Arabic Poetry Night
Reading, writing, sharing, and discussing poetry in a group can be a healing experience for many people who have experienced social isolation, discrimination, oppression, and violence, including Arab Americans. A series of 20 culturally and linguistically specific poetry nights will be facilitated to increase community and reduce stigma and barriers to accessing mental health services among Arabic-speaking adults and older adults in Los Angeles County.

Latino UsCC

Latina Power: Latinas as Community Leaders
This culturally and linguistically specific project develops a comprehensive curriculum and provides a 10-week intensive course on Latina empowerment, reaching 60 Latina adults with group education and discussion on self-love, goal setting, immigration, gender roles, patriarchy, acculturation stress, parenting, boundary-setting, healthy communication, relationships, and cultural norms. The community-based contractor creates a safe space for participants to see themselves as leaders and to take action to improve individual and community health.

Culture and Mind-Body Health Education

This project reaches 200 Latino community members with chronic disease prevention education and wellness education sessions. Topics include the connection between physical health and mental health, culturally specific nutrition, exercise, stress management, and self-care.

Breaking Bread Podcast
This project engages system-involved transitional age youths (ages 16-24) in the development, presentation, and dissemination of ten 45-minute podcast and YouTube episodes on mental health topics of interest. Focus groups and surveys will be conducted to determine priority topics and messages. The community contractor will elevate the voices of participating youths to share their insights with the larger Los Angeles community, to reduce the stigma of mental health challenges and dismantle harmful stereotypes about justice-involved, foster-care youths.

Finding Balance: Sacred Mayan Ceremonies
Los Angeles County is home to tens of thousands of indigenous Latin American community members who speak languages other than Spanish or English and they are often overlooked and marginalized. This project engages 120 Mayan community members in a series of eight cultural ceremonies for peace and healing, and creates a safe space to discuss healing, housing, financial challenges, and mental wellbeing in community.

Personalismo
This project engages 45 Latino community members in a 12-hour training on mental health literacy and strategies for effective participation in promoting the public mental health system. Participants share information learned within their social networks, increasing information on how to effectively access the many resources of the local public mental health system.

LGBTQIA2-S UsCC

Neurodivergent Voices Album
This project recruits 12 neurodivergent LGBTQIA2-S musical artists over the course of 12 sessions, in songwriting and performance, culminating in the development and dissemination of an original musical album celebrating mental wellness and community. Through making music together, participants will strengthen their confidence, self-acceptance, and mental wellbeing. The album will be widely disseminated throughout Los Angeles County, which will increase inclusion of neurodivergent artists.

Liberation Workshop Series
This project creates a safe space for marginalized sex workers to experience community and healing through group art classes. It convenes 10 sex workers, ages 18+, and facilitates a series of five ceramics classes and an exhibit showcasing their artwork, with an audience of 75 community members. The project seeks to build skills, trust, inclusion, and creative self-expression in the diverse LGBTQIA2-S community.

Violence Prevention Lab
LGBTQ+ community members in Los Angeles County experience high rates of violence and discrimination. This project convenes 18 LGBTQIA2-S adult community members over a series of workshops totaling 24 hours, to design, test, and present to decision-makers 6-8 innovative strategies to prevent interpersonal and community violence. These ideas will become violence prevention proposals for consideration by a wide range of decision-makers in Los Angeles County.

LGBTQIA2-S Housing Listening Sessions
This project brings together 100 LGBTQIA2-S adult community members, targeting individuals who are transgender or Two-Spirit, and commercial sex workers in a series of town hall meetings to identify and address specific unmet housing needs. The findings from these sessions will inform housing services planning efforts for LGBTQ+ individuals and communities at DMH and other County agencies.

Proyecto Mariposa (Project Butterfly)
Modeled after a Latin American Tanda, a rotating credit association, this project facilitates a series of 10 discussion and mutual support sessions on self-care, mental health, financial wellbeing, and acculturation stress among 10 Latinx LGBTQIA2-S migrant adults. This project aims to reduce stigma, increase inclusion, and facilitate access to mental health services among this marginalized community.

Transforming Community Care: API LGBTQ+ Mental Health and Wellness Project
This project enables 150 API LGBTQ+ adults to participate in a community mental health leadership academy training and culturally specific wellness workshops, as well as a community event reaching 75 people. Recommendations from these sessions will inform program planning and evaluation efforts for API LGBTQ+ individuals and communities at DMH and other County agencies.

Two-Spirit Storytelling as Medicine
This project increases mental health awareness and support for 20 Two-Spirit Latinx community members through culturally specific gatherings, featuring storytelling and holistic wellness activities. This project seeks to increase inclusion, affirmation, and participation of Two-Spirit Latinx individuals in DMH and Los Angeles County services and stakeholder groups.

Bi-Affirming Mentorship
To increase visibility, acceptance, inclusion, and mental wellbeing of bisexual community members, a community contractor will facilitate an intergenerational project. This project engages 25 bisexual adults in a series of discussion and recording sessions examining, documenting, and sharing personal experiences of biphobia, mental health stigma, and confidence-building. Recordings will be disseminated widely through social media and community promotion.

Prevention and Early Intervention (PEI)

This section outlines the services and activities associated with the various components of PEI. Over the last year, LACDMH has moved toward a more robust and upstream approach to PEI services. While the focus of early intervention continues to be evidence-based practices (EBP), promising practices and community-defined evidence practices, LACDMH is in the process of implementing prevention strategies in settings such as schools and libraries where access platforms are being established. By identifying individuals with specific risk factors, particularly for trauma, and through the promotion of protective factors, such as social connectedness and engagement, a prevention service platform is being developed that:

- Raises awareness of the importance of mental and emotional well-being and health, the impact of trauma and the promotion of resilience strategies on systems and communities;
- Builds organizational and community capacity to promote well-being and resiliency and to recognize and respond to trauma and mental health needs; and
- Builds bridges to mental health care when it is requested.

The prevention strategies involve, at a minimum, a combination of training, resource infusion at the site of the access platform, partnership development and consultation to educators. PEI includes, Prevention, Early Intervention, Stigma and Discrimination and Suicide Prevention

SB 1004 PEI PROGRAM PRIORITY AREAS

All PEI programs are required to comply with WIC Section 5840.7 enacted by Senate Bill 1004 which requires counties to specify how they are incorporating the following six Commission-identified priorities in the MHSA plan:

1. Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
2. Early psychosis and mood disorder detection and intervention; and mood disorder and suicide prevention programming that occurs across the lifespan;
3. Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs;
4. Culturally competent and linguistically appropriate prevention and intervention;
5. Strategies targeting the mental health needs of older adults;
6. Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis

Each of these priorities outlined in WIC Section 5840.7/SB 1004 are integrated into our plan and aligned with our previously outlined strategies which are consistent with our community planning process.

Per WIC Section 5840.7/SB 1004, counties are also required to provide an estimate of the share of PEI funding allocated to each priority. The following table provides these estimates:

Table 41. PEI Priority Percentages by SB 1004 Priority Categories

SB 1004 PRIORITY CATEGORIES	% OF FUNDING ALLOCATED BY PRIORITY
Childhood Trauma Prevention and Early Intervention	94%
Early Psychosis and Mood Disorder Detection and Intervention	55%
Youth outreach and engagement strategies that target secondary school and transition age youth	92%
Culturally competent and linguistically appropriate prevention and intervention	95%
Strategies targeting the mental health needs of Older adults	28%
Early identification programming of mental health symptoms and disorders, including but not limited to, anxiety, depression, and psychosis	95%

PEI – Early Intervention

Early intervention is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment. Early intervention services feature the inclusion of evidence based and community defined evidence based treatment, providing clients with access to proven, research-supported interventions. Training and equipment are essential to support evidence-based practices and community defined evidence based treatment.

FY 2023-24 Early Intervention Programming, Data and Outcomes

Table 42. Early Intervention Summary: age group, average cost per client, unique clients served and total number of clients to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2025-26[2]
Children	$5,518	23,702	22,893
TAY	$5,736	7,736	7,669
Adult	$3,708	4,632	4,850
Older Adult	$4,615	938	1,012

[1]Cost is based on direct mental health services, not inclusive of community outreach services or client supportive services expenditures.
[2]FY 2025-26 total number to be served, reflects an average of the two prior fiscal years.

The Department will continue to evaluate and review the usage of EBPs as needs are identified. The following are examples of EBPs that are implemented in Fiscal Year 2023-24, which will continue in future years.

Table 43. FY 2023-24 EBPs

Early Intervention EBP	Description
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17)	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.
Alternatives for Families **Cognitive Behavioral Therapy (AF-CBT)** Children (ages 4-15) TAY (ages 16-17)	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.

Early Intervention EBP	Description
Brief Strategic Family Therapy (BFST) Children (ages 10-15) TAY (ages 16-18)	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.
Caring for Our Families (CFOF) Children (ages 5-11)	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.
Center for the Assessment and Prevention of Prodromal States (CAPPS) TAY	The focus of CAPPS is to conduct outreach and engagement specifically to those youths 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.
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6)	CPP is a psychotherapy model that integrates psycho-dynamic, 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.
Cognitive Behavioral Intervention for Trauma in School (CBITS) Children (ages 10-15)	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.
Crisis Oriented Recovery Services (CORS) Children TAY Adults Older Adults	CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.

Early Intervention EBP	Description
Depression Treatment Quality Improvement (DTQI) Children TAY Adults Older Adults	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.
Dialectical Behavioral Therapy (DBT) Children (ages 12-15) TAY (ages 16-20)	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.
Families Over Coming Under Stress (FOCUS) Children TAY Adults	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 by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18)	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.
Family Connections (FC) Families and Children (ages 0-15) TAY (ages 16-18)	The goal of FC is to help families meet the basic needs of their children and prevent child maltreatment. Nine practice principles guide FC interventions: community outreach, individualized family assessment, tailored interventions, helping alliance; empowerment approaches, strengths perspective, cultural competence, developmental appropriateness, and outcome-driven service plans. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults	Group CBT focuses on changing an individual's thoughts (cognitive patterns) 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.

Early Intervention EBP	Description
Incredible Years (IY) Young Children (ages 2-5) Children (ages 6-12)	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.
Individual Cognitive Behavioral Therapy (Ind. CBT) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics only	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 psycho-education, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults	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.
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8)	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.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21)	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 the County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.
Mental Health Integration Program (MHIP) **Formerly known as IMPACT** Adults	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.

Early Intervention EBP	Description
Multidimensional Family Therapy (MDFT) Children (ages 12-15) TAY (ages 16-18)	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.
Multisystemic Therapy (MST) Children (ages 12-15) TAY (ages 16-17)	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).
Nurturing Parenting (NP) Young Children (birth-5) Children (5-15) TAY (16-18)	The Nurturing Parenting Programs are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and home-based formats ranging from 5-58 sessions. Programs are designed for parents with young children with birth to 5 years old, school aged children 5-11 years old, and teens 12-18 years old. Parents and their children meet in separate groups that meet concurrently. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age-appropriate expectations and neurological development of children, (2) to develop empathy and self-worth in parents and children, (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline, (4) to empower parents and children to utilize their personal power to make healthy choices, (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy caring relationships.
Providing Alternative Thinking Strategies (PATHS) Children (5-12)	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.
Parent-Child Interaction Therapy (PCIT) Young Children (2-7)	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.

Early Intervention EBP	Description
Portland Identification and Early Referral (PIER) Children (ages 12-15) TAY (ages 16-25)	PIER provides early treatment for youth who pose a clinical-high-risk of developing severe mental illness, such as schizophrenia and psychosis. By detecting and treating patients at the onset of psychosis, the negative impact of psychosis may be mitigated. The PIER program assists youth and families to increase performance in all areas of life by building coping skills, reducing stress, and implementing problem-solving techniques.
Problem Solving Therapy (PST) Older Adults	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.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults	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.
Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only	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.
Reflective Parenting Program (RPP) Young Children (ages 2-5) Children (ages 6-12)	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.
Seeking Safety (SS) Children (13-15) TAY Adults Older Adults	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.

Early Intervention EBP	Description
Stepped Care (SC) Children TAY Adults Older Adults	This service delivery option intends to improve access to services for clients and families who are experiencing early signs and symptoms of mental illness, require engagement into the mental health system, and are not ready to participate in evidence-based early intervention services. Client level of care received is determined by the initial and ongoing assessment.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18)	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.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle Children (ages 3-8)	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. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)	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 LACDMH directly operated and contract agencies.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12)	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).

Table 44. EBP Outcomes since 2009 through June 2024

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,433	43%	- 21% Improvement in disruptive behaviors (as reported by parents and children) - 10% Reduction in the severity of problem behaviors (as reported by parents and children) - 14% Improvement in disruptive behaviors (as reported by teachers) - 6% Reduction in the severity of problem behaviors (as reported by teachers)
ART Skillstreaming	328	54%	- 21% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
AF-CBT	1,745	53%	- 62% Reduction in trauma related symptoms
BFST	203	63%	- 50% Reduction in behavioral problems - 66% Reduction in anxiety symptoms - 60% Reduction in attention problems - 100% Reduction in psychotic behaviors - 50% Reduction in aggressive behaviors
CFOF	733	67%	- 30% Improvement in disruptive behaviors - 20% Reduction in the severity of problem behaviors
CAPPS	213	42%	- 60% Reduction in prodromal symptoms
CPP	7,918	47%	- 17% Improvement in mental health functioning following a traumatic event
CBITS	132	71%	- No Data to Report (n=12)
CORS	4,187	60%	- 19% Improvement in mental health functioning
DBT	329	55%	- 10% Improvement in emotional regulation
DTQI	1,372	65%	- 55% Reduction in symptoms related to depression
FOCUS	803	72%	- 50% Improvement in direct communication
FC	24	44%	- No Data to Report (n=1)
FFT	1,727	66%	- 31% Improvement in mental health functioning
Group CBT	1,149	42%	- 42% Reduction in symptoms related to depression
IY	2,869	64%	- 35% Reduction in disruptive behaviors - 18% Reduction in the severity of problem behaviors
Ind. CBT	Anxiety 4,195 Depression 8,232 Trauma 1,240	Anxiety 47% Depression 45% Trauma 48%	- 63% Reduction in symptoms related to anxiety - 58% Reduction in symptoms related to depression - 60% Reduction in trauma related symptoms
IPT	8,815	50%	- 50% Reduction in symptoms related to depression
LIFE	433	65%	- 50% Reduction in disruptive behaviors - 23% Reduction in the severity of problem behaviors
MAP	71,063	49%	- 43% Reduction in disruptive behaviors - 25% Reduction in the severity of problem behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 48% Reduction in trauma related symptoms
MHIP	Anxiety 3,211 Depression 7,288 Trauma 302	Anxiety 39% Depression 34% Trauma 30%	- 54% Reduction in symptoms related to anxiety - 57% Reduction in symptoms related to depression - 24% Reduction in trauma related symptoms
MPG	16	86%	- No Data to Report (n=1)
MDFT	77	89%	- No Data to Report (n=6)
MST	126	72%	- No Data to Report (n=0)
NPP	3	33%	- No Data to Report (n=0)
PCIT	5,009	40%	- 61% Reduction in disruptive behaviors - 36% Reduction in the severity of problem behaviors
PIER	93	17%	- No Data to Report (n=2)
PST	413	63%	- 45% Reduction in symptoms related to depression
PEARLS	176	49%	- 45% Reduction in symptoms related to depression
PE-PTSD	99	57%	- No Data to Report (n=15)

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
PATHS	747	33%	- 33% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
RPP	256	71%	- 15% Reduction in disruptive behaviors - 6% Reduction in the severity of problem behaviors
SS	21,508	40%	- 51% Reduction in trauma related symptoms (Adults) - 44% Reduction in trauma related symptoms (Children)
SC	12,410	100%	- 24% Improvement in mental health functioning
SF	237	89%	- No Data to Report (n=15)
TF-CBT	27,691	54%	- 51% Reduction in trauma related symptoms
Triple P	6,652	60%	- 50% Reduction in disruptive behaviors - 27% Reduction in the severity of problem behaviors
UCLA TTM	197	50%	- No Data to Report (n=11)

PEI – Prevention

The following prevention activities and services are geared toward addressing the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support. These risk factors are addressed through awareness, education, training, outreach and/or navigation activities.

Prevention services may feature the inclusion of evidence based and community defined evidence-based treatment, providing clients with access to proven, research-supported interventions, as the need arises. Training and equipment are essential to support evidence-based practices and community defined evidence-based treatment. Prevention services are inclusive of assessment, linkage, and crisis intervention services at medical hubs for children who are involved with the Department of Children and Family Services (DCFS).

Prevention services are also administered by the California Mental Health Services Authority (CalMHSA). CalMHSA is a Joint Powers of Authority (JPA) providing administrative and fiscal services in support of the Department of Mental Health.

LACDMH has expanded its PEI Community Outreach Services (COS) in order to achieve the following:

- Increase the number of individuals receiving prevention and early intervention services;
- Outreach to underserved communities through culturally appropriate mental health promotion and education services; and
- Provide mental health education and reduce stigma on mental health issues in our communities.

COS affords an avenue for the LACDMH PEI network to provide services such as education and information to individuals who are not formal clients of the mental health system and providers who are outside the county mental health system. Often individuals, as well as their parents, family, caregivers, and other support system, who need or would benefit from prevention and early intervention mental health services do not seek traditional clinic-based services due to a multitude of factors. Community outreach is a key component in initiating and providing effective mental health supportive services to these individuals. Most programs are not evidence-based practices, but nonetheless have significant data and research indicating the effectiveness of their services.

Programming listed below will continue unless otherwise indicated.

FY 2023-24 Prevention Programming, Data and Outcomes

LACDMH partners with several county and city agencies, such as the Los Angeles County Departments of Parks and Recreation, Children's and Family Services, Public Health, Sheriff's Department, and Public Library; and the Los Angeles Unified School District (LAUSD) to deliver mental health prevention and promotion programming to populations served by those agencies.

The Brief Universal Prevention Program Survey (BUPPS) is a tool created by the Los Angeles County Department of Mental Health (LACDMH). Several prevention programs throughout Los Angeles County utilize the BUPPS to assess an individual's protective factors as a result of the program and/or services accessed. By measuring these areas, the BUPPS helps LACDMH understands the impact prevention programs have on various protective factors.

BUPPS protective factor questions include:

- I feel hopeful about the future.
- I feel like part of a community.
- I know at least one thing I can do to deal with uncomfortable feelings.
- I know at least one thing I can do to deal with difficult thoughts.
- I know at least one thing I can do to deal with challenging behaviors.
- I know about resources that might be helpful for me or someone I care about.

To note, the BUPPS protective factor subscale has a score range from 0 to 30 (total) or 0 to 5 (per item). The difference in scoring (out of 5 vs. out of 30) depends on how the survey results are aggregated and reported.

Scores out of 30: When scores are reported out of 30, it means that each question in the survey was rated and the total score across multiple questions (all 6 questions) is summed to provide an overall score. This method provides a cumulative view of the participant's protective factors across all areas assessed by the survey.

Scores out of 5: When scores are reported out of 5, it's typically an average score across per question. Each individual question is rated on a scale of 0 to 5, and then an average is taken to simplify the overall results into a single representative number. This approach makes it easier for some programs to interpret a general level of protective factors, showing how participants are performing across all areas in a more concise way.

In general, low scores indicate fewer protective factors and a greater need for support. In contrast, higher scores suggest that participants have stronger protective factors, meaning they feel more hopeful, connected, and equipped to manage difficult emotions, thoughts, and behaviors, as well as access helpful resources.

- Abundant Birth Project

  The California Abundant Birth Project provides monthly unconditional income supplements to pregnant individuals over the age of 18 years old who are experiencing financial instability, represent a marginalized population and are most likely to experience the worst birth outcomes: identifying as Black, diagnosed with sickle cell anemia, previous preterm birth, pre-existing hypertension or pre-existing diabetes starting in the 1st or 2nd trimester up until 18 months. Through this partnership with the Los Angeles County Department of Public Health, DMH is funding the Abundance Coaching component, where Abundance Birth stipend recipients are offered Abundance Coaching (in-person and virtual sessions). The coaching is culturally concordant, strengths-based support, providing referrals and service connections through partnership and learning opportunities to help participants gain access to the tools they need for birth and parenting.

  This project's goals are to close the gaps for birth outcomes and infant mortality rates. Disaggregating progress within the target populations by those who are experiencing homelessness and/or are former foster youth. Acknowledging that individuals are in the best position to know how best to mitigate stress in their own lives, providing a stipend without condition (including dictated services) honors the approach of honoring self-agency. Additionally, participants will meet with Abundant Birth Coaches, who will offer participant-centered wraparound supports also designed to alleviate stress, economic hardship, and support healthy and joyous births. Coaches provide a warm

hand-off to services (or wrap around supports), also designed to alleviate stress/hardship and assist with birth.

In total, 133 people were served by the project, however no prevention outcomes were collected during service implementation. A setback experienced by the program was that there were delays in finalizing contracts, which resulted in delays with the program launch. Demographics are listed in the table below.

Table 45. FY 2023-24 Abundant Birth Project Demographics

Count (n =133)			
▪ Primary Language		▪ Ethnicity	
English	133	Hispanic or Latino as follows:	
▪ Current Gender Identity*		Other Hispanic	5
Woman	133	Non-Hispanic or Non-Latino as follows:	
▪ Disability		African	113
Declined to answer	133	European	1
▪ Age		Other Non-Hispanic	1
16-25	19	More than one ethnicity	13
26-59	114	▪ Race	
▪ Veteran Status		Asian	1
Declined to answer/Missing/Unknown	133	Black or African-American	113
▪ Sex Assigned at Birth		White	1
Female	133	More than one race	13
▪ Sexual Orientation*		Other	5
Declined to answer/Missing/Unknown	133	* Participants can select more than one response option	

- Antelope Valley Community Family Resource Centers (AV-CFRC)

  The Antelope Valley Community Family Resource Center's vision is to continue to develop relationships with key community partners and stakeholders. In addition, the AV-CFRC is designed to support individuals and families through the delivery of Community Outreach Services to identify, mitigate and address mental health needs among community members and to support access to any needed resources. To support this vision, Children's Bureau of Southern California (CB) has been working with partners in the Palmdale, Lancaster, and Lake Los Angeles area to form the AV-CFRC.

  In partnership with subcontracted support from Antelope Valley Partners for Health (AVPH) and Foundation Christian Ministries (FCM), the AV-CFRC has successfully delivered prevention services to members of the AV communities, including but not limited to those who are at identified risk, underserved and those who may be at risk but not understand mental health issues, yet might need this support. The goal for this program is to reach those who already have identified mental health needs, those who may be at-risk of developing mental health issues, and to increase community accessibility to mental health services. An additional goal of this program is to continue to collaborate with our community partners both mental health and non-mental health organizations to promote de-stigmatization and access to care, as needed.

  Services were delivered in various ways: in-person, phone, and virtually. The first goal was to promote protective factors that could lead to improved mental, emotional and relational functioning. An additional goal was to reduce prolonged suffering (risk

factors) of our community members that could be the result of an undetected, untreated mental illness.

A total of 19,877 individuals were served during the reporting period. The number of surveys collected for the Community Outreach Services (COS) under the Antelope Valley Community Family Resource Center (AV-CFRC) came to a total of 895 surveys. The gap between service delivery and survey administration, is largely due to only a percentage of the individuals served electing to respond to the surveys. In addition, it was the first full fiscal year of program implementation, which caused some onboarding delays in the consistent implementation and collection of outcome measures.

Single Survey Events

There was a significant positive response to the single event services provided (Table 3). This was evidenced by verbal testimonials and via the one-time event surveys (the Single Event Survey – AV-CFRC, N = 158), as they demonstrated that over 61% of those who completed one-time event surveys reported increased feelings of social connectedness/sense of belonging and hopefulness as well as access to resources (protective factors) as a result of the program. Additionally, 79% of individuals stated they would do things differently as a result of something they learned at the event. Over 88% reported learning something new/useful that could strengthen their family's wellbeing. Additionally, over 88% of respondents reported that they would return for future events/activities and recommend others. Finally, 87% of respondents reported that based on their experience they would recommend the event to a friend or family member.

Pre/Post Surveys Events

There were 304 unique individuals who completed the BUPPS during pre, interval, and post assessments (see Table 45). To aid in survey collection efforts, the AV-CFRC team added an element of having a designated staff member ask the individuals the BUPPS questions at the time of the service, which yielded a higher result than either the link or the QR code. The data reflected that there was a positive change across the protective factors, including positive coping, increased emotional resources, increased emotional self-regulation, clear expectations for behavior & resiliency as demonstrated by the improvements in items: #3 "I know at least one thing I can do with uncomfortable feelings," #4 "I know at least one thing I can do to deal with difficult thoughts," and #5 "I know at least one thing I can do to deal with challenging behaviors." There was also an increase in the protective factors of Access to Care, Concrete Supports, and resources. As noted in item #6 "I know about resources that might be helpful for me or someone I care about". Another benefit of program participation was that, by consumers knowing how to access services it can also support the reduction of risk factors, such as substance use and/or mental health difficulties. Demographics are shown in Table 49.

Table 46. Results of Single Event Survey

Survey Question	Evaluation Focus	% Positive
1. Connected with others	Social Connectedness	61%
2. Discovered something new	Knowledge/Skill Development	56%
3. Learned something useful	Hopefulness & Resources	67%
4. Learned about community resources	Concrete Supports	88%
5. Will act differently with family	Hopefulness & Resources	79%

Survey Question	Evaluation Focus	% Positive
6. Learned tips/tools for well-being	Coping Skills & Supports	88%
7. Likely to attend future events	Program Support	88%
8. Likely to recommend event	Program Support	87%

Table 47. BUPPS: Protective Factor Subscale Results (out of a total score of 5)

BUPPS Protective Factor Question: Protective Factors	Pre	Interval	Post	Single
1. I feel hopeful about the future. Hopeful & Resiliency	3.36	3.46	3.95	3.34
2. I feel part of a community. Support, Social connectedness / Sense of belonging	3.3	3.51	3.95	3.14
3. I know at least one thing I can do to deal with uncomfortable feelings. Emotional Resources & Coping & Resiliency	3.18	3.55	4.1	3.04
4. I know at least one thing I can do to deal with difficult thoughts: Emotional self-regulation / good coping skills	3.1	3.62	4.11	2.95
5. I know at least one thing I can do to deal with challenging behaviors. Positive Coping, Emotional Resources, Emotional Self-Regulation, Clear expectations for behavior & Resiliency	3.02	3.68	3.97	2.99
6. I know about resources that might be helpful for me or someone I care about. Concrete Support, Resources	2.87	3.78	3.84	3.24

Table 48. BUPPS: WHO Wellbeing Subscale Results (out of a total score of 5)

BUPPS: WHO Wellbeing Subscale	Pre	Interval	Post	Single
7. I have felt cheerful and in good spirits. Emotional Resources & Coping & Resiliency	3.03	3.59	3.79	2.81
8. I have felt calm and relaxed. : Emotional Resources & Coping	2.91	3.57	3.85	2.61
9. I have felt active and energetic. Emotional Resources	2.83	3.56	3.86	2.51
10. I woke up feeling fresh and rested. Emotional & Physical Resources	2.88	3.62	3.82	2.54
11. My daily life has been filled with things that interest me. Clear expectations & Hopefulness	3.11	3.74	3.89	2.99

Table 49. FY 2023-24 Demographics

Count (n = 895)			
Primary Language		Ethnicity	
Arabic	1	Hispanic or Latino	
English	583	Caribbean	1
Spanish	291	Central American	134
Other responses	2	Mexican/Mexican-American	345
Declined to answer/Missing/Unknown	18	South American	18
Current Gender Identity*		Other Hispanic	47
Man	210	Non-Hispanic or Non-Latino follows:	

Count (n = 895)			
Woman	576	African	38
Transgender man/Transmasculine	1	Asian	2
Nonbinary	1	Chinese	2
Declined to Answer/Missing/Unknown	107	Eastern European	1
Sex Assigned at Birth		European	9
Male	241	Filipino	3
Female	628	Korean	2
Prefer not to answer	26	More than one	16
Sexual Orientation*		Other Non-Hispanic or Non-Latino	9
Gay or Lesbian	3	Declined to Answer/Missing/Unknown	268
Heterosexual or Straight	601	Race	
Bisexual	8	American Indian or Alaska Native	5
Declined to Answer/Missing/Unknown	283	Asian	6
Disability		Black or African-American	252
No	811	Native Hawaiian	1
Yes	47	White	364
Physical/mobility domain	25	More than one race	15
Chronic health condition	11	Other	99
Difficulty seeing	1	Declined to Answer/Missing/Unknown	153
Difficulty hearing	5	Age	
Another type of communication disability	2	15 and under	3
Another type of disability	20	16-25	168
Declined to answer	87	26-59	506
Declined to Answer/Missing/Unknown	37	60+	99
Veteran Status		Declined to Answer/Missing/Unknown	119
Yes	197	* Participants can select more than one response option	
No	697		
Declined to Answer/Missing/Unknown	1		

- Anti-Racism Diversity and Inclusion (ARDI) Training

  This training series targets Los Angeles County Department of Mental Health Expanded Management Leadership to create a concentrated effort to dismantle anti-Black racism, white supremacy along with other forms of intersectional oppression, through ,training, education and leadership accountability with intention to transform the entire department.

  The goal is to cultivate a safe and enriching workplace environment that will positively impact services to the community. To create a welcoming, affirming, anti-racist, anti-oppressive, multicultural spaces for our staff and our consumers. These actions will offer deep healing and provide leadership with skills to positively impact staff for the overall health and wellbeing of our communities. Anticipated changes include:

  - Reconceptualize organizational leadership by shifting from a hierarchal system to a more horizontal, collaborative Department
  - Develop protocols for transparent reports, including when these reports will be generated and how they will be disseminated
  - Identify and implement best practices in anti-racist and trauma-informed supervision and service provision

- Asian American Pacific Islander (AAPE) Community Empowerment Project

  The Asian American Pacific Islander (AAPI) Community Empowerment project was created out of a need to address the longstanding challenges faced by the AAPI community in dealing with mental health issues. Some of the challenges included

culturally specific beliefs and values, as well as a lack of understanding of mental health disorders. In many AAPI communities, there are no explicit words to describe certain mental health symptoms or disorders, thus cultural and linguistically appropriate pathways to obtain information and receive services are needed. In response to the needs conveyed by community members and considering their suggestions, the AAPI Equity Alliance Mental Health Committee developed a multi-year strategy to address both the immediate and ongoing needs of their community. These initiatives include increasing education on mental illness, developing strategies to address stigma, and creating pathways to better access and utilize mental health services.

Some strategies this program utilized included:

- Raising awareness of the risks and protective factors associated with various mental health disorders, and the importance of increasing protective factors
- Raising awareness of signs and symptoms of the different mental health disorders, definition of mental health and mental health disorder
- Increasing awareness of coping skills, treatment approaches and resources
- Increasing awareness of effects of stress and trauma on mental health
- Increasing awareness of barriers to help-seeking and how to reach out to a family/friend/loved one who may be struggling with mental health challenges
- Providing linkages to culturally and linguistically appropriate mental health services

A total of 14,351 individuals were served during this reporting period through outreach events. In addition, 4,295 individuals were reached via educational workshops, 998 surveys were collected post educational workshops, 275 individuals were referred to mental health services, and 171 individuals were enrolled in ongoing mental health services. Furthermore, the collaborative increased workforce capacity by recruiting 3 new staff members and providing extra training to 6 providers, which overall improved access to mental health services. Despite these efforts, no prevention outcomes were reported during the 2023-2024 Fiscal Year (FY). Demographics are listed in the table below.

Table 50. FY 2023-2024 Demographics of AAPI Community Empowerment Project

Count (n = 998)			
▪ Primary Language		▪ Ethnicity	
Cambodian	224	Hispanic or Latino as follows:	
Cantonese	44	Central American	2
English	78	Mexican/Mexican American/Chicano	14
Korean	292	Non-Hispanic or Non-Latino as follows:	
Russian	1	Asian Indian/South Asian	8
Mandarin	166	Cambodian	230
Other Chinese	6	Chinese	214
Spanish	3	European	2
Tagalog	19	Filipino	41
Vietnamese	1	Japanese	20
Other	29	Korean	298
Declined to answer/Missing/Unknown	135	Middle Eastern	1

Count (n = 998)			
▪ Current Gender Identity*		Other Non-Hispanic	22
Man	229	More than one ethnicity	15
Woman	630	Declined to answer/Missing/Unknown	131
Transgender Man	1	▪ Race	
Transgender Woman	1	Asian	834
Genderqueer/Non-Binary	3	Black or African-American	1
Undecided/Unknown at this time	1	Native Hawaiian or Pacific Islander	1
Declined to answer/Missing/Unknown	133	White	9
▪ Disability		More than one race	2
No	532	Other	2
Yes	71	Declined to answer/Missing/Unknown	149
Mental domain	12	▪ Sexual Orientation*	
Physical/mobility domain	9	Gay or Lesbian	5
Chronic health condition	16	Heterosexual or Straight	718
Difficulty seeing	4	Bisexual or Pansexual	6
Difficulty hearing	4	Undecided/Unknown at this time	6
Another type of communication disability	2	Something else e.g. queer, asexual	1
Another type of disability	1	Declined to answer/Missing/Unknown	262
Declined to answer disability type	23	▪ Veteran Status	
Declined to answer	395	Yes	9
▪ Age		No	818
15 and under	2	Declined to answer/Missing/Unknown	171
16-25	21	▪ Sex Assigned at Birth	
26-59	343	Male	224
60+	485	Female	620
Declined to answer/Missing/Unknown	147	Prefer not to answer	154
*Participants can select more than one response option			

- Center for Strategic Partnership

  Defined by a joint collaboration to support philanthropic engagement and strategic consultation on various complex countywide Board directed initiatives and priorities.

  The Center for Strategic Partnerships helps the County and philanthropy partner more effectively transform systems, promote equity, and improve the lives of children and families. This is accomplished by supporting cross-sector initiatives and fostering a culture of collaboration.

  This program does not submit traditional outcome measures; instead, it collaborates closely with the County's Chief Executive Office (CEO) to align with and support the broader mission and strategic priorities set forth by the County. Through this partnership, the program ensures that its initiatives are integrated with countywide objectives, and it effectively contributes to the overall impact on the community.

- Community Ambassador Network (CAN) (Formerly Innovation 2 Project)

  The Community Ambassador Network (CAN) program is a community capacity building initiative, designed to enhance community resiliency and promote community healing from a trauma-informed perspective. This objective is accomplished through supporting nine lead agencies and their community partnerships to foster the collective capacity to identify, educate and support members of the community who are at risk of, or experiencing trauma.

Collectively, the strategies associated with INN 2 serve as a method for building capacity through innovative outreach and education, providing needed resources and supports while addressing important issues such as healthy parenting skills, social connectedness, coping skills, homelessness, or trauma-informed professional development for educators.

Since the outreach and engagement activities are driven by community need and interest, INN 2 activities vary in frequency, duration and delivery method. Community outreach and events can be described as a single event, while outcomes are generally collected for community members who participate in multiple classes or group activities.

Staff faced challenges in collecting surveys consistently across all participants due to virtual programming and the diversity of event formats (e.g., single-event, community gatherings and monthly food drives). As a result, not all participants were tracked across all survey periods.

A total of 986 participants completed the BUPPS. The program demonstrated modest improvements in participants' well-being and protective factors, while highlighting the intricacies of working with a varying participant base dealing with complex issues. Further efforts will focus on consistency in participant engagement and refining the survey process to capture more accurate data across diverse groups. Outcomes are summarized in table 51 while demographics are reported in table 52.

Table 51. FY 2023-2024 Outcomes – CANS

Name of Outcome Measure	Total Number of Reported Cases with both a Pre and Post Score	Average Pre Score	Average Post Score
BUPPS Protective	986	23	23
BUPPS Well-being	986	17	18
Parenting	986	17	16

Table 52. FY 2023-2024 Demographics – Innovation 2 (INN 2)

Count (n = 2,152)			
▪ Primary Language		▪ Ethnicity	
Arabic	2	Hispanic or Latino as follows:	
Cambodian	954	Caribbean	2
English	499	Central American	46
Spanish	371	Mexican/Mexican American/Chicano	579
Tagalog	6	Puerto Rican	4
Vietnamese	2	South American	12
Other	8	Other Hispanic/Latino	39
Declined to answer/ask or Missing or Unknown	314	Non-Hispanic or Non-Latino as follows:	
▪ Sex Assigned at Birth		African	138
Male	349	Asian Indian/ South Asian	12
Female	1,743	Cambodian	1,139
Declined to answer/Missing/Unknown	64	Chinese	4
▪ Current Gender Identity*		Eastern European	3
Man	346	Filipino	17
Woman	1,746	Korean	1
Undecided/ unknown at this time	3	Middle Eastern	5
Declined to answer/Missing/Unknown	61	Vietnamese	1
▪ Sexual Orientation*		Other	42
Heterosexual or Straight	1,857	More than one ethnicity	9

Count (n = 2,152)			
Gay or Lesbian	5	Declined to answer/Missing/Unknown	103
Bisexual or Pansexual	6	▪ Disability	
Something else e.g. queer, asexual	1	No	1,667
Declined to answer/Missing/Unknown	287	Yes	399
▪ Age		Mental domain	139
15 and under	11	Physical/mobility domain	55
Between 16 and 25	75	Chronic health condition	38
26-59	1,081	Difficulty seeing	25
60+	901	Difficulty hearing	14
Declined to answer/Missing/Unknown	88	Another communication disability	3
▪ Race		Another type of disability	17
American Indian or Alaska Native	3	Decline to disclose type of disability	1,865
Asian	1,164	Declined to answer/Missing/Unknown	90
Black or African-American	177	▪ Veteran Status	
Native Hawaiian/ Pacific Islander	13	Yes	5
White	399	No	2,067
More than one race	17	Declined to answer/ask or Missing or Unknown	84
Other	217	* Participants can select more than one response option	
Declined to answer/Missing/Unknown	166		

Community Schools Initiative (CSI)

The Los Angeles County Office of Education (LACOE) Community Schools Initiative (CSI) focuses on both academic and out-of-school factors that impact the lives of high school students. The Community School (CS) Model is an evidence-based school improvement framework that recognizes the roles of family and community, and the importance of collaborating with educators to address external factors influencing student achievement, such as family circumstances, traumatic events (including adverse childhood experiences), poverty, and health concerns, while incorporating cultural differences, and student engagement. The CS Model aims to address longstanding inequities throughout Los Angeles County by serving the most underserved students and families. The services provided include concrete supports, school resources, staff support, mental health services, and on-site well-being centers to provide health services and referrals/linkages to community resources.

A total of 19,038 individuals were served during this reporting period. Service data is collected through LACOE's Community Schools Case Management System which was established in the 2021-22 school year and continues to be refined. Data collection challenges included data entry accuracy, reliability, inconsistencies in data definitions and time constraints. In addition to coordinating the events, partnerships, programs, and resources provided at school sites, CSI staff must also record these efforts in the Case Management System. Due to the time-consuming nature of data entry, not all events and services may be recorded. The LACOE Community Schools (CS) Survey is an annual survey conducted in the Spring semester. It is a voluntary survey distributed to students, parents/caregivers, and school staff at all CSI school sites. At school sites, there are often multiple surveys being conducted simultaneously, which can lead to survey fatigue and can result in lower completion rates. The biggest challenge is that surveys are distributed once annually versus as a pre and post to services.

CSI targets high school students from 15 school districts. Currently each of the 15 districts has one identified high school site. LACOE CSI served a total of 19,038 students and

families in this reporting period collecting a total of 8,817 single event surveys (Community Schools Survey).

On average, students demonstrated the presence of the protective factors of resilience, self-efficacy, and social support, as evidenced by the following survey results:

- 67% of 7,265 students surveyed selected “a lot” or “quite a bit” when asked: I solve problems without harming myself or others (avoiding using drugs and/or being violent).
- 73% of 7,265 students surveyed “agree” or “strongly agree” with the following statement: I feel that I can do well in this school.
- 68% of 7,265 students surveyed “agree” or “strongly agree” with the following statement: I know an adult at school that I can talk with if I need help.

Parents on average demonstrated the presence of the protective factor of family engagement, as evidenced by the following survey results:

- 68% of 530 parents surveyed selected “agree” or “strongly agree” with the following statement: This school includes me in important decisions about my children’s education

Table 53. FY 2023-2024 Demographics of Participants – Community Schools Program

Count (n = 8,817)			
▪ Primary Language		▪ Ethnicity	
Arabic	6	Hispanic or Latino as follows:	
Armenian	18	Other (Hispanic/Latino)	5,027
Cambodian	1	Non-Hispanic or Non-Latino as follows:	
Cantonese	19	Filipino	170
English	5,957	More than one	103
Farsi	2	Other	76
Korean	16	Declined to answer/Missing/Unknown	3,441
Mandarin	38	▪ Race	
Other Chinese	4	American Indian/ Alaska Native	91
Spanish	741	Asian	362
Russian	9	Black or African-American	591
Tagalog	20	Native Hawaiian/ Pacific Islander	40
Vietnamese	5	White	1,255
Other	140	Other	4,596
Declined to answer/Missing/Unknown	1,841	More than one	266
▪ Sex Assigned at Birth		Declined to answer/Missing/Unknown	1,616
Male	3,440	▪ Current Gender Identity*	
Female	3,870	Male	3,440
X	89	Female	3,870
Another category e.g. intersex	18	Transgender man/Transmasculine	4
Prefer not to answer	1,400	Non-Binary	89
▪ Age		Another category e.g. two-spirit	14
15 and under	3,436	Declined to answer/Missing/Unknown	1,400
16-25	4,131	* Participants can select more than one response option	
26-59	788		
60+	68		
Declined to answer/Missing/Unknown	394		

- First 5 LA – Home Visitation: Deepening Connections and Enhancing Services

  The Home Visitation: Deepening Connections and Enhancing Services prevention program overseen by First 5 Los Angeles (F5LA) and home visiting services are delivered through the Healthy Families America (HFA) and Parents as Teachers (PAT) models. These models are national evidence-based, voluntary, home-based intervention programs for families identified as needing more focused support. The programs include home visits delivered weekly, every two weeks, or monthly, depending on the program model and family's needs. Clients receive client-centered, strength-based information and support during visits with a focus on positive parenting behaviors and child development; information on key developmental topics such as attachment, discipline, health, safety, sleep, transition/routines, and family well-being. This prevention program enhances the pathway for referrals between home visiting and the Department of Children and Family Services' (DCFS) Prevention and Aftercare (P&A) Network. Additionally, licensed clinical therapists were incorporated to the home visiting programs to provide mental health support to identified program participants. These efforts are focused in Service Areas 1 and 2.

  Home visiting programs represent a proven two-generation approach that gathers family information to tailor services to the whole family, including assessments, direct education, and connections to needed services, including linkages to mental and behavioral health services. Home visiting programs frequently engage and serve families with complex histories who are at high risk for depression and other mental health challenges and have been demonstrated to build social and emotional competence in young children and their parents, with improved social and emotional outcomes.

  The target population for this prevention program includes participants of Healthy Families America (HFA) and Parents as Teachers (PAT) programs in SPA 1 and 2. The HFA and PAT Programs are both voluntary, home-based interventions for clients identified as needing more focused, intensive support. HFA and PAT will target serving parents/caregivers who are:
    - Pregnant and postpartum with children up to age 2
    - Identified as at risk of mental health concerns and/or anxiety
    - At risk for involvement with DCFS
    - Referred to services at a P&A Network agency
    - Experiencing extreme stressors (e.g., substance abuse, domestic violence, mental health issues)

  A total of 480 individuals were served during the reporting period. Several challenges impacted data collection, which included a lack of clinician data, programs encountering difficulties in hiring licensed clinicians, a lack of prevention and aftercare referrals, and programs required additional time to connect with prevention and aftercare providers for referral exchanges. In addition, low screening scores for the Parent's Assessment of Protective Factors (PAPF) due to home visitors adjusting to new reporting requirements and intervals also affected program outcomes. High number of "prefer not to answer"/missing responses for the current gender identity and sexual orientation questions occurred due to home visitors feeling unsure or uncomfortable asking these questions in Spanish and ensuring they were asked respectfully. In addition, demographics were only available for the newly open cases and not those that were transferred to this program at implementation.. Lastly, there

were challenges with survey administration which impacted the number of surveys collected.

In SPA 1, families showed improvement across all protective factors measured by the Parents' Assessment of Protective Factors (PAPF). For reference, a score of **4.0** typically reflects that a parent perceives themselves as demonstrating a moderately strong level of protective factors. There were notable increases in parental resilience. Additionally, children's social-emotional competence, social connections, and access to concrete support improved slightly. In contrast, SPA 2 had mixed results. While social connections saw a small increase, parental resilience, access to concrete support, and children's social-emotional competence all declined slightly over time. This suggests that families in this area may need additional resources and support or perhaps families felt more comfortable over time and were more forthcoming with their answers to survey questions; in which case results may appear artificially deflated. Further investigation into matter needs to take place. Combined demographics are shown in Table 54.

Table 54. FY 2023-2024 Demographics of First 5 LA

Count (n = 480)			
▪ Primary Language		▪ Ethnicity	
English	219	Hispanic or Latino as follows:	
Spanish	242	Central American	127
Tagalog	2	Mexican/Mexican American/Chicano	219
Other	1	Other Hispanic/Latino	20
Declined to answer/Missing/Unknown	16	Non-Hispanic or Non-Latino as follows:	
▪ Current Gender Identity*		Filipino	5
Man	3	Other Non-Hispanic	28
Woman	370	More than one ethnicity	16
Transgender Man	1	Declined to answer/Missing/Unknown	65
Another Category	2	▪ Race	
Declined to answer/Missing/Unknown	104	American Indian or Alaska Native	2
▪ Disability		Asian	6
No	441	Black or African-American	23
Yes	14	White	22
Physical/mobility domain	2	More than one race	21
Chronic health condition	3	Other	395
Difficulty seeing	3	Declined to answer/Missing/Unknown	11
Difficulty hearing	1	▪ Sexual Orientation*	
Another type of disability	5	Heterosexual or Straight	343
Decline to answer disability type	14	Bisexual or Pansexual	3
Declined to answer/Missing/Unknown	25	Something else e.g. queer, asexual	15
▪ Age		Declined to answer/Missing/Unknown	119
16-25	129	▪ Veteran Status	
26-59	350	Yes	1
60+	1	No	479
▪ Sex Assigned at Birth		* Participants can select more than one response option	
Female	480		

- Friends of the Children LA (FOTC-LA)

  The FOTC-LA ("Friends") program aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at high risk of entering foster care, and who are facing challenges like intergenerational poverty and

multiple adverse childhood experiences. The program currently focuses on children residing in the Antelope Valley, where professional “friends” support a child and their family for more than 12 years. The focus is on developing parental resilience, social connections, knowledge of parenting and child development, concrete supports, and social and emotional competence of children. The number of surveys collected is the number of caregivers. Some caregivers have more than one child enrolled in the program. The program only collects demographics for the children.

A total of 53 children and their families were served during the reporting period. The Protective Factors Survey (PFS) was utilized for the collection of program outcomes. The survey results showed that when it comes to family function and resilience, respondents rated themselves quite high, with an average score of 4.51 out of a 5 point scale. This means that, on average, participants felt they "frequently" or "always" experienced strong nurturing and attachment within their families which is a strong protective factor.

Social Supports and Concrete Supports were measured using PFS and PFS-2 items. These PFS scores reflect how often caregivers feel they have people the caregivers can rely on during difficult times. For example, caregivers responded to statements like, "I have others who will listen when I need to talk about my problems." An average score on the survey prior to programming of 3.81 (out of 5) suggests that most caregivers "sometimes" or "often" felt supported by their social networks, but there is room for improvement to ensure that they consistently feel connected to others during times of need.

Caregivers surveyed after participating in the program averaged a score of 4.28 out of 5 for Social Supports. This higher score indicates that caregivers "frequently" or "always" feel supported in meaningful ways by their social network. This result shows an increase in protective factors for the caregivers that participated in this program. Demographics are only available for 5 of the children in this program, as 5 completed a “pre” or baseline survey at the end of this reporting period, and are depicted in table 55.

Table 55. FY 2023-2024 Demographics of Children Participants – FOTC-LA

Count (n = 5)			
▪ Primary Language		▪ Ethnicity	
English	5	African	5
▪ Gender Identity*		▪ Race	
Woman	5	Black or African-American	5
▪ Disability		▪ Age	
No	5	<16	5
* Participants can select more than one response option			

- Incubation Academy

The Incubation Academy program is a capacity-building project in collaboration with Community Partners. The project provides mentorship, training, technical support, and financial resources for 28 small and mid-sized grassroot organizations that are providing prevention-related mental health activities within their communities. The organizations vary in their programming and target population as the goal is to prepare such organizations to compete for future contracting with LACDMH.

Populations served include foster youth and adults, adoptive/foster parents, previously abused women in transition, unhoused individuals, staff working with unhoused individuals, students and youth, immigrants and asylum seekers, parents, justice-involved individuals, economically disadvantaged communities unlikely to attain mental health services. Overall, the range of prevention services provided support to various targeted communities across the County by uplifting communities and creating a better quality of life.

Each of the 28 Community Based Organizations (CBO's) participating in the Incubation Academy program are required to regularly collect outcomes data. The majority utilize BUPPS and given the range of services provided and target populations reached, some organizations have experienced more challenges than others. In general, the challenges shared are as follows: refusal to complete due to a reluctance to share what is perceived to be personal data; incomplete surveys, which may be due to working with a population that is over surveyed or prevention activities that are less structured (such as outdoor events, without specific start and end times); limited staff to ensure that surveys are collected and that they are complete; young children having difficulty completing and understanding BUPPS (even on the children's survey); and minimal survey completion, which skews overall averages.

Outcomes

The program served a total of 7,137 individuals, and while challenges were encountered in accurately collecting BUPPS data and providing outcomes data, the team has been working diligently to improve their data processes. With a diverse range of subcontractors, services, target populations, and geographies across the County, summarizing outcomes has its complexities. However, CBOs have consistently reported significant benefits to the populations they serve, and the program is committed to achieving more robust outcomes in the upcoming 2024-2025 FY. Unfortunately, no prevention outcomes were reported during the 2023-2024 FY. Demographics are listed in the table below (Table 56).

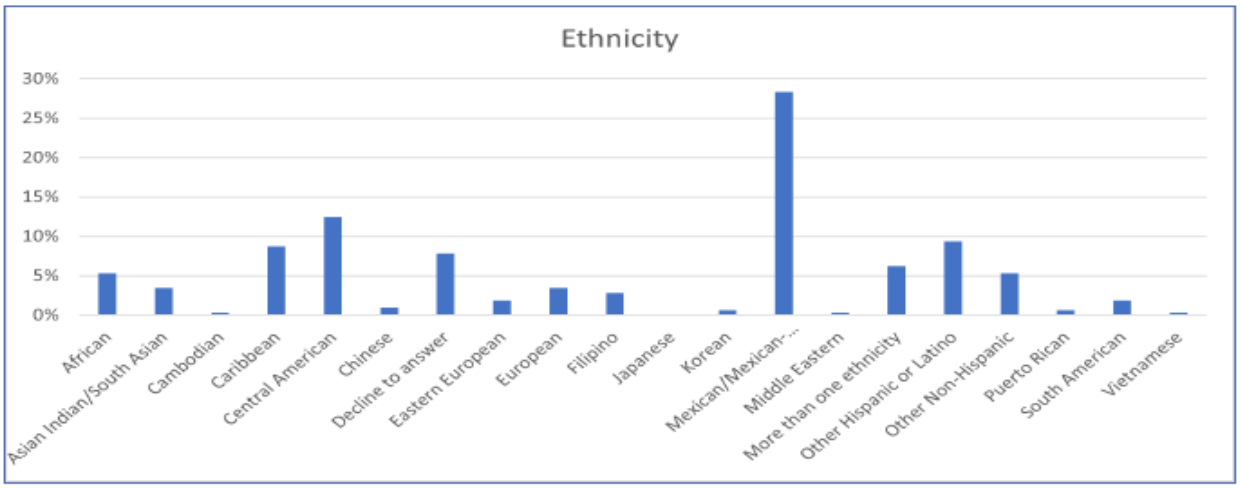
Table 56. FY 2023-2024 Demographics – Incubation Academy

Count (n = 5,049) Not all respondents answered all questions			
▪ Primary Language		▪ Ethnicity	
Arabic	7	Hispanic or Latino as follows:	
Cambodian	4	Caribbean	22
Armenian	27	Central American	165
Cantonese	1	Mexican/Mexican American/Chicano	1,525
English	3,312	Puerto Rican	17
Farsi	7	South American	53
Russian	12	Other Hispanic/Latino	302
Korean	3	Non-Hispanic or Non-Latino as follows:	
Spanish	1,040	African	771
Tagalog	3	Asian Indian/South Asian	36
American Sign Language	2	Cambodian	24
Vietnamese	2	Chinese	13
Other	88	Eastern European	16
Declined to answer/Missing/Unknown	544	European	162
▪ Current Gender Identity*		Filipino	43
Man	1,684	Japanese	7

Count (n = 5,049) Not all respondents answered all questions			
Woman	2,405	Korean	8
Transgender Man	2	Middle Eastern	10
Transgender Woman	5	Vietnamese	3
Genderqueer/Non-Binary	58	Other Non-Hispanic	255
Another Category	3	More than one ethnicity	523
Undecided/Unknown at this time	45	Declined to answer/Missing/Unknown	927
Declined to answer/Missing/Unknown	75	▪ Race	
▪ Disability		American Indian or Alaska Native	133
No	2,255	Asian	228
Yes	571	Black or African-American	1,415
Mental domain	258	Native Hawaiian or Pacific Islander	101
Physical/mobility domain	170	White	646
Chronic health condition	160	More than one race	476
Difficulty seeing	116	Other	1,124
Difficulty hearing	58	Declined to answer/Missing/Unknown	881
Another type of communication disability	9	▪ Sexual Orientation*	
Another type of disability	117	Gay or Lesbian	127
Decline to answer disability type	1,030	Heterosexual or Straight	2,677
Declined to answer/Missing/Unknown	850	Bisexual or Pansexual	91
▪ Age		Undecided/Unknown at this time	28
<16	1,146	Something else e.g. queer, asexual	18
16-25	1,816	Declined to answer/Missing/Unknown	1,494
26-59	1,592	▪ Sex Assigned at Birth	
60+	273	Male	1,601
Declined to answer/Missing/Unknown	197	Female	2,358
▪ Veteran Status		X	4
Yes	94	Another Category	1
No	3,404	Prefer not to answer	673
Declined to answer/Missing/Unknown	206	** Participants can select more than one response option*	

- <u>iPrevail</u>
  iPrevail works with the Los Angeles County Department of Mental Health (“LACDMH”) which allow Los Angeles County residents access to virtual mental health care platforms, including the capacity to implement technology-based mental health solutions accessed through multi-factor devices (for example, computer, smartphone, etc.) to identify and engage individuals, provide automated screening and assessments and improve access to mental health and supportive services focused on prevention, early intervention, family support, social connectedness peer support, and decreased use of psychiatric hospitals and emergency services.

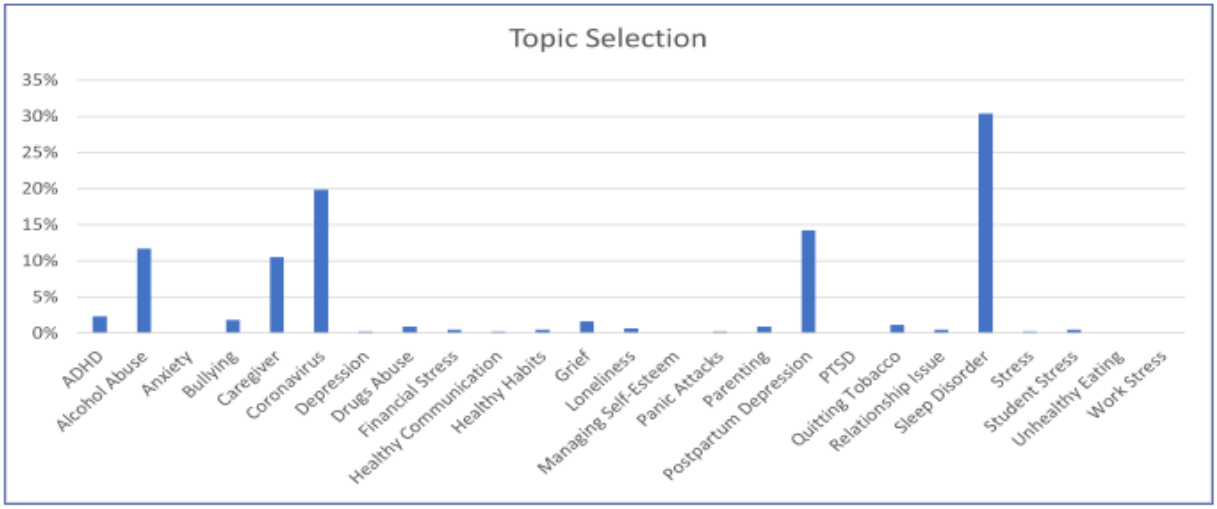
Figure 75. iPrevail Data

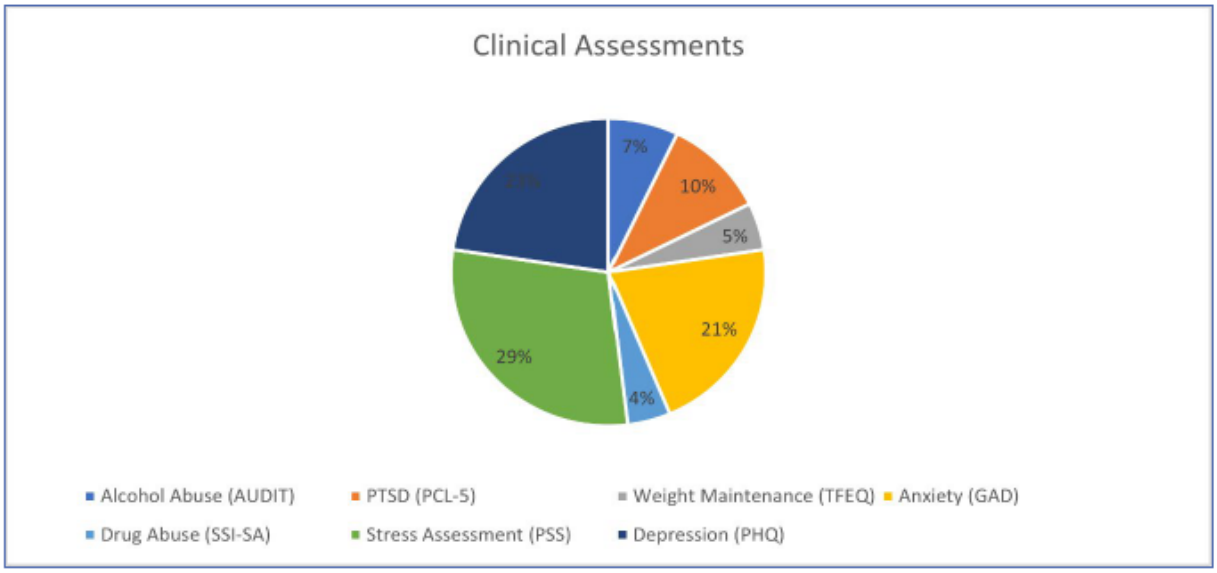


Users Created

915 New Users	100,348 Total Users (Lifetime)
1,960 Active Users	

PREVAIL HEALTH MONTHLY REPORT 9/1/24 – 9/30/24





- <u>Los Angeles County Department of Arts & Culture: Creative Wellbeing Program</u>

  The LA County Department of Arts and Culture's (Arts and Culture) Creative Wellbeing Program is a non-traditional, arts and culture–based approach for promoting mental health in young people, youth-serving adults, and caregivers. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing that allows young people to function well in the face of challenging circumstances.

  The two primary project activities are arts-based professional development sessions for youth-serving adults and healing-centered arts instruction for systems-impacted young people. These activities are in the form of live and virtual professional development sessions that are interactive, arts-based workshops that promote

creativity and connection. They provide educators and other youth-serving adults with tools to practice self-care, engage young people, and support their wellness and resiliency. The second activity is in-person arts instruction for youth, and varies across school sites, residential care centers, and age levels. However, all programming is centered on utilizing the arts as a vehicle to implement healing-informed strategies that promote resiliency and positive social-emotional development.

Services are offered to youth who are served by, and adult staff who are part of:

- School districts and schools with high numbers of systems-impacted students and foster youth
- Foster youth-serving sites (i.e., Short Term Residential Therapeutic Programs (STRTP), Temporary Shelter Care Facilities (TSCF), Foster Family Agencies, (FFA) that support resource families and foster youth)
- County Agencies and initiatives focused on supporting systems-impacted young people (i.e. Department of Mental Health (DMH), Department of Health Services (DHS), Department of Children and Family Services (DCFS), Department of Youth Development, Department of Public Health, Probation Department, Los Angeles Suicide Prevention Network, Wellbeing4LA Learning Center, etc.)

Arts-based prevention, advocacy, and treatment have increasingly served to promote healing and wellbeing for individuals who have experienced trauma. Research shows creative arts interventions are effective at enhancing psychological wellbeing by decreasing negative emotional states and enhancing positive ones. For young people, the arts can be an outlet for addressing trauma and building resiliency against painful experiences. Studies also show that the arts can promote academic achievement, reduce justice system involvement, and enhance positive socio-emotional factors like self-confidence, self-control, conflict resolution, and collaboration. The Creative Wellbeing approach works to encourage and increase protective factors and healthy behaviors that can help shield against the development of mental health challenges. It focuses on four areas of mental health promotion:

- Increasing awareness of protective factors and risk factors
- Reducing stigma and shame in acknowledging discomfort or unpleasant feelings/situations
- Understanding typical adolescent behavior
- Nurturing confidence in offering and receiving support through networks of care

The program served a total of 4,325 individuals during the reporting period. Newly developed adult and youth surveys were completed in the fall of 2023. A live training on the purpose and procedures of the data collection was held for program partners and participants. A distribution guide was also created to support program partners to implement the survey. Beginning in December, teachers and teaching artists began to administer the survey as part of arts instruction for youth and professional development sessions with adults. Because time was needed to develop the survey, the survey was not administered to all participants during the fall services which led to a limited response rate. As data collection continued through the spring, Arts and Culture identified barriers and sought solutions. For example, a significant number of participants are Spanish speakers, so the program created Spanish translations of the survey instruments. Additionally, a portion of the participants are in the primary grades, so programs are exploring how to create a survey version that is age appropriate. To further increase the response rate, program administrators have added an incentive

approach that will be offered throughout 2024-2025. Additional live training for all program partners and making recorded trainings available regarding survey administration will help to ensure all teachers and teaching artists are aware of the data collection procedures. This will also ensure all program partners are supported in planning for and administering the survey to future program participants.

Program participants were administered a self-developed youth and adult retrospective pre-post survey to measure the following outcomes: Mental Health Stigma Reduction; Increased Awareness and Knowledge of Protective Factors; Increased Protective Factor - Social Support; Increased Protective Factor - Social-Emotional Competence of Children and Social Support.

The number of surveys differs from the number of individuals served for multiple reasons. Direct services through Creative Wellbeing were provided to 662 youth, and 3,663 adults. An additional 10,683 youth and 23,394 adults were served through Creative Wellbeing art activities, workshops, and presentations embedded into partners' special events. Periodically, the survey was not provided to Creative Wellbeing participants due to time constraints or lack of awareness by the workshop leaders. Additionally, since services are not contingent on survey completion, individuals may lack the willingness to participate or experience logistical challenges, such as limited access to the survey or time constraints, resulting in lower response rates. Lastly, the youth survey was designed for participants ages 8 and older. Since some participants were as young as 5 years old, the survey was not accessible for this group and therefore not completed. Program administrators are currently working on an alternative method for collecting input from those younger than 8 years old.

Among the youth and adults served, protective factors increased from the "pre" surveys to the "post" surveys. Adults improved their abilities to provide social support for their students and increased their awareness and knowledge of protective factors. Young people increased their social support and social-emotional competence.

Adults increased their capacity around all outcome areas after participating in a Creative Wellbeing activity. While they reported a higher level of knowledge than skills in pre-surveys, post-surveys show a particular increase in arts-based skills. Notably, their ability to use healing-centered arts strategies to create opportunities for young people to experience connection and support increased from 64% before Creative Wellbeing to 91% after. Additionally, a higher percentage of adults felt capable of supporting their students' or clients' mental health and wellbeing, rising from 89% before to 97% after their participation and of providing a healing-centered response to young people who are struggling (80% at the pre-survey, 91% at post). Lastly, the majority of adults (89%) expressed confidence in nurturing young people's strengths to build resilience after engaging with Creative Wellbeing, compared to 82% before. These results point to the idea that participating in Creative Wellbeing is reducing mental health stigma and increasing awareness around various protective factors.

Young people that participated in these programs improved their capacity in nearly all outcome areas after participating in a Creative Wellbeing activity. The most notable increase was in the protective factor area of social-emotional competence. Before engaging with Creative Wellbeing, only 49% felt comfortable talking about their feelings, but this increased to 67% afterward. Similarly, 58% indicated they could manage their emotions before the activity, and this number rose to 74% afterward. In

the social support domain, more young people felt connected to their classmates (58% at the pre-survey, 74% at post) and able to help others when they needed help (72% at the pre-survey, 88% at post). However, young people demonstrated slight decreases from the pre-survey to the post-survey in reaching out to their parent, caregiver, teacher or other supportive adult for help when having a bad day (64% at the pre-survey, 63% at post) along with agreeing that everyone needs help or support sometimes (91% at the pre-survey, 88% at post). Overall, Creative Wellbeing is positively impacting the reduction of mental health stigma and the increase of protective factors for young people. Demographic information is presented in Table 57.

Table 57. FY 2023-2024 Demographics Los Angeles County Department of Arts and Culture

Count (n = 312)			
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino as follows:	
Armenian	3	Caribbean	3
Cantonese	3	Central American	16
English	218	Mexican/Mexican American/Chicano	88
Farsi	1	Puerto Rican	3
Mandarin	1	South American	5
Korean	1	Other Hispanic/Latino	6
Other Chinese	3	Non-Hispanic or Non-Latino as follows:	
Russian	2	African	16
Spanish	48	Asian Indian/ South Asian	6
Vietnamese	2	Chinese	17
Other	11	European	32
Declined to answer/Missing/Unknown	16	Filipino	7
▪ Sex Assigned at Birth		Japanese	2
Male	55	Korean	3
Female	231	Middle Eastern	7
Decline to answer	26	Vietnamese	6
▪ Current Gender Identity*		Other	14
Man	54	More than one ethnicity	27
Woman	223	Declined to answer/Missing/Unknown	54
Transgender man/Transmasculine	1	▪ Race	
Transgender female/Transfeminine	1	American Indian or Alaska Native	4
Nonbinary	7	Asian	38
Another Category	2	Black or African-American	37
Undecided	2	Native Hawaiian/ Pacific Islander	2
Declined to answer/Missing/Unknown	22	White	76
▪ Sexual Orientation*		More than one race	35
Heterosexual or Straight	215	Other	61
Gay or Lesbian	6	Prefer not to answer	59
Bisexual or Pansexual	15	▪ Veteran Status	
Something else	10	Yes	3
Undecided	12	No	284
Prefer not to answer	54	Declined to answer/Missing/Unknown	25
▪ Disability		▪ Age	
No	249	15 and under	26
Yes	32	16-25	43
Mental domain	23	26-59	192
Physical/mobility domain	9	60+	23
Chronic health condition	10	Decline to answer	28

Count (n = 312)		
Difficulty seeing	4	* Participants can select more than one response option
Difficulty hearing	2	
Another type of disability	1	
Declined to answer/Missing/Unknown	31	

- Los Angeles County Library

The Los Angeles County Library offers two programs through the use of prevention programming funding. The first program, the Los Angeles County Library School Readiness Program Smarty Pants Storytimes is offered at 85 LA County libraries. The primary audience is children, and the secondary audience is parents/caregivers. Libraries offer five series of six weekly sessions of Smarty Pants Storytime in person, annually with up to two weeks off between series and time off during winter and summer school breaks. Smarty Pants Storytime outline includes books, songs, rhymes and supports school readiness.

The Positive Parenting Program (Triple P) is offered at 50 Los Angeles County libraries. Positive Parenting Program accredited Librarians work with parents and caregivers using Triple P materials to help them address common parenting challenges for babies, children, and teenagers. Librarians will offer Triple P Parent Cafes, Triple P Seminars (Workshops), and provide on the spot Triple P consultations when appropriate. All programs and services happen in person. Libraries offer 10 Triple P Parent Cafes annually and 4 Triple P Seminars.

Both programs utilized the BUPPS (as described earlier in this report) for the collection of prevention outcomes. See table 58 for outcome data and table 59 for demographic information.

Table 58. FY 2023-2024 BUPPS Protective Factor Subscale Results (out of a total score of 30)

Program	Average BUPPS Score	Maximum Possible Score	Interpretation
School Readiness Program	23	30	High protective factors present
Positive Parenting Program	25	30	High protective factors present

Table 59. FY 2023-2024 Demographics Los Angeles County Library

Count (n = 446)			
▪ Primary Language		▪ Ethnicity	435
Arabic	1	Hispanic or Latino as follows:	
Cambodian	2	Caribbean	8
Cantonese	3	Central American	26
English	347	Mexican/Mexican American/Chicano	162
Farsi	1	Puerto Rican	2
Mandarin	14	South American	4
Korean	3	Other Hispanic/Latino	22
Other Chinese	2	Non-Hispanic or Non-Latino as follows:	
Spanish	46	African	11

Count (n = 446)			
Tagalog	2	Asian Indian/ South Asian	16
Vietnamese	4	Cambodian	2
Other	6	Chinese	35
Declined to answer/Missing/Unknown	15	Eastern European	4
▪ Sex Assigned at Birth		European	36
Male	54	Filipino	10
Female	366	Japanese	3
Decline to answer	26	Korean	3
▪ Current Gender Identity*		Middle Eastern	3
Man	53	Vietnamese	9
Woman	369	Other	17
Transgender man/Transmasculine	1	More than one ethnicity	31
Declined to answer/Missing/Unknown	23	Declined to answer/Missing/Unknown	42
▪ Sexual Orientation*		▪ Race	
Heterosexual or Straight	364	American Indian or Alaska Native	9
Gay or Lesbian	3	Asian	82
Bisexual or Pansexual	9	Black or African-American	27
Prefer not to answer	66	Native Hawaiian/ Pacific Islander	1
Not sure what this question means	4	White	168
▪ Disability		More than one race	38
No	381	Other	18
Yes	21	Prefer not to answer	103
Mental domain	11	▪ Veteran Status	
Physical/mobility domain	5	Yes	8
Chronic health condition	2	No	406
Difficulty seeing	5	Declined to answer/Missing/Unknown	32
Difficulty hearing	7	▪ Age	
Another type of disability	3	16-25	15
Declined to answer/Missing/Unknown	44	26-59	380
* Participants can select more than one response option		60+	26
		Decline to answer	25

- Los Angeles Department of Parks and Recreation

  Los Angeles County Department of Parks and Recreation conducts a variety of mental health programs and risk prevention activities that improve protective factors for communities, individuals, and families. In fiscal year 2023 to 2024 the Los Angeles County Department of Parks and Recreation served a total of 145,950 individuals with a total number of 1,159 outcomes surveys collected from participants who attended various events/programming. Through funding by the Department of Mental Health, the Los Angeles County Department of Parks and Recreation put fourth four programs including Parks After Dark, Spot Teen Center, Safe Passages and Parks at Sunset.

  Parks After Dark: The program was implemented across 34 parks, engaging the community through a range of dynamic and enriching activities. This program fosters community resilience, safety, and well-being. The comprehensive range of activities offered catered to the physical, cultural, and emotional needs of the communities.

  Social Places and Opportunities for Teens (Our SPOT) Teen Center: Our SPOT programs, activities and curriculum provide socially relevant educational services to support underserved communities in moving beyond the cultural norms of violence, underachievement, and youth disengagement in Los Angeles. The "Our SPOT" program focuses on teenagers at risk of mental health challenges, due to various socio-economic, environmental, and developmental factors. These teens are particularly vulnerable to

issues like anxiety, depression, and behavioral disorders. "Our SPOT" mitigates these risks by offering early intervention, teaching coping strategies, building a sense of community, and connecting teens with mental health resources. These efforts help prevent the escalation of mental health issues and promote positive behaviors. The program has shown effectiveness through evaluations indicating improved mental health outcomes, increased engagement in positive activities, and stronger community connections among participants.

Safe Passages: The Safe Passages Initiative employs a peer-centric strategy, leveraging the expertise of trained gang interventionists and ambassadors to foster peace in our parks and communities affected by gang violence. By deploying these professionals, Safe Passages helps ensure the safety of individuals commuting to and from parks, as well as during park activities and special events. Additionally, Safe Passages offers crisis intervention services at parks when immediate support is required.

Parks at Sunset: Parks at Sunset is a proactive initiative designed to provide accessible self-care programming, and community activities and events at 56 Park locations during the summer. This program invites community members to participate in therapeutic benefits of outdoor activities amid friends, family, or solo, all while soaking in the sunset. Each event features diverse visual arts, mindfulness exercises, and self-care activities. Utilizing the arts as a healing medium, Parks at Sunset fosters opportunities for the development of self-care practices and routines for individuals and families.

A total number of 145,950 individuals were served during the reporting period. During this reporting period, the program encountered challenges in data collection, particularly with a lower number of survey responses compared to the total number of participants. This discrepancy may be attributed to several factors: many attendees were primarily focused on participating in activities and workshops rather than completing surveys, some found the surveys too long or unengaging, others were not motivated by the incentives offered, and in some cases, participants may not have been aware of the survey’s importance or availability. These challenges impacted the program’s ability to collect comprehensive data.

The BUPPS Protective Factors Survey was utilized for the collection of program outcomes. The Parks after Dark program reported an average score of 4.8 out of 5, the Spot Teen Program reported 3.95 out of 5, the Safe Passages program reported 3.21 out of 5 and the Parks at Sunset program reported 3.92 out of 5. These scores indicate that individuals were able to identify a high level of protective factors as a result of program participation.

Safe Passages: During FY 2023-2024, the average BUPPS protective factors subscale score for "Safe Passages" participants decreased indicating a drop in perceived protective factors. This decline may be due to changes in program delivery, external stressors, or variations in the participant group. Further investigation is needed to understand the reasons behind this decrease and to identify potential adjustments that could strengthen the program's impact on participants' protective factors.

Parks at Sunset: All protective factors showed an increase during FY 2023-2024.
The most significant increases were in the areas of "I feel hopeful about the future" and "I know about resources that might be helpful for me or someone I care about," suggesting that participants felt more hopeful and informed as a result of the program.*Parks After*

Dark: There was a slight decline across the board in protective factors and well-being subscales, with the largest drop being in “feeling active and energetic.” Risk factors remained stable. While the declines in protective factors were small, they may indicate areas to watch and support to prevent further decreases in well-being. This data shows the need for continued attention to maintaining and improving well-being among the population.

Spot Teen Program: The results show slight differences during FY 2023-2024, with most of the subscale scores decreasing slightly. However, the difference is minimal, indicating that the program's impact has remained relatively stable. Demographic data for all Los Angeles County Department of Parks and Recreation programs is listed in table 60.

Table 60. FY 2023-2024 Demographics Los Angeles County Parks & Recreation

Count (n = 1,159)			
▪ Primary Language		▪ Ethnicity	
Arabic	4	Hispanic or Latino as follows:	
Armenian	19	Caribbean	52
Cambodian	10	Central American	100
Cantonese	17	Mexican/Mexican American/Chicano	483
English	516	Puerto Rican	7
Farsi	2	South American	18
Hmong	1	Other Hispanic/Latino	77
Mandarin	12	Non-Hispanic or Non-Latino as follows:	
Other Chinese	3	African	68
Russian	4	Asian Indian/ South Asian	21
Spanish	243	Chinese	25
Tagalog	2	Eastern European	2
Vietnamese	2	European	9
Other	11	Filipino	4
Declined to answer/Missing/Unknown	313	Japanese	1
▪ Sex Assigned at Birth		Korean	1
Male	375	Vietnamese	1
Female	677	Other	56
X	10	More than one ethnicity	18
Another Category	1	Declined to answer/Missing/Unknown	216
Decline to answer	96	▪ Race	
▪ Current Gender Identity*		American Indian or Alaska Native	43
Man	366	Asian	72
Woman	671	Black or African-American	110
Transgender man/Transmasculine	2	Native Hawaiian/ Pacific Islander	7
Transgender woman/Transfeminine	2	White	239
Non-Binary	4	More than one race	62
Another Category (e.g. Two-spirit)	5	Other	281
Undecided/ unknown at this time	2	Prefer not to answer	345
Declined to answer/ask or Missing	107	▪ Disability	
▪ Sexual Orientation*		No	711
Heterosexual or Straight	645	Yes	68
Gay or Lesbian	31	Mental domain	25
Bisexual or Pansexual	28	Physical/mobility domain	25
Something else e.g. queer, asexual	11	Chronic health condition	10
Undecided/ unknown at this time	7	Difficulty seeing	6
Declined to answer/Missing/Unknown	437	Difficulty hearing	6
▪ Age		Another communication disability	4
15 and under	144	Another type of disability	8

Count (n = 1,159)			
Between 16 and 25	221	Decline to disclose type of disability	11
26-59	542	Declined to answer/Missing/Unknown	380
60+	13	▪ Veteran Status	
Declined to answer/Missing/Unknown	239	Yes	29
* Participants can select more than one response option		No	858
		Declined to answer/Missing/Unknown	272

- Los Angeles Unified School District (LAUSD)

  The LAUSD School Mental Health (SMH) program conducts a variety of mental health promotion and risk prevention activities with students and their parents. Referrals for services are received from administrators, teachers, support staff, students, and their families. SMH services promote parent involvement in the educational process, provide consultation to teachers, provide direct mental health services in crisis and emergency situations, participate in multi-disciplinary school teams, and identify and assist with appropriate referrals to community agencies.

  SMH Psychiatric Social Workers (PSWs) work as mental health providers, consultants, and trainers with students, families, and school communities to build both academic and social-emotional competence and skills, thereby supporting resilience and interpersonal connection. SMH PSW's deliver this essential work through school-based social work programs, wellness centers and clinics, and crisis counseling and intervention services.

  The SMH program supports resiliency and positive student connections with peers, family, school, and community. In addition, it promotes healthy relationships, self-reflection, and problem-solving skills to optimize school success. This program works with all members of the educational team (e.g., principals, teachers, and related service providers) and school community (e.g., parents or other caregivers, community groups) to improve student mental health and wellbeing, student engagement, family engagement, and school climate by implementing targeted prevention and interventions, services, and mental health consultation. Furthermore, it is a national leader in the development and implementation of two key strategies that create safe and supportive school environments: utilizing a trauma informed approach and implementing evidence-based clinical practices.

  Over the course of the year, LAUSD put forth a total of 60 mental health workshops, trainings, and interventions to students and their families. Some of these programs included Bounce Back, CBITS, Erika's Lighthouse, FOCUS Resilience Curriculum, Second Step, Seeking Safety and various additional parent education workshops and classroom interventions. These programs served over one million students and parents. However, only demographic data was collected (see Table 61), and no prevention outcome data was reported for these specific programs.

  Table 61. FY 2023-2024 Demographics - LAUSD

Count (n = 1,388,856)			
▪ Primary Language		▪ Ethnicity	
Arabic	51	Hispanic or Latino as follows:	
Armenian	176	Caribbean	36
Cambodian	10	Central American	1,449
Cantonese	29	Mexican/Mexican American/Chicano	1,768
English	20,883	Puerto Rican	22
Farsi	80	South American	427

Count (n = 1,388,856)			
Korean	76	Other Hispanic/Latino	23,298
Mandarin	40	Non-Hispanic or Non-Latino as follows:	
Russian	143	African	28
Spanish	20,023	Asian Indian/ South Asian	106
Tagalog	11	Cambodian	73
Vietnamese	47	Chinese	113
American Sign Language	14	European	3
Other	891	Eastern European	60
Declined to answer/Missing/Unknown	1,346,382	Filipino	595
▪ Sex Assigned at Birth		Japanese	54
Male	19,643	Korean	133
Female	22,522	Middle Eastern	135
Declined to answer/Missing/Unknown	1,346,691	Vietnamese	78
▪ Disability		Other	7,020
No	34,723	More than one ethnicity	787
Yes	7,751	Declined to answer/Missing/Unknown	1,352,671
Mental domain	5,066	▪ Race	
Physical/mobility domain	36	American Indian or Alaska Native	42
Difficulty seeing	18	Asian	1,019
Difficulty hearing	91	Black or African-American	4,298
Another communication disability	652	Native Hawaiian/ Pacific Islander	54
Another type of disability	1,888	White	2,568
Decline to answer	1,346,382	More than one race	1,095
▪ Age		Other	32,499
15 and under	31,563	Declined to answer/Missing/Unknown	1,347,281
Between 16 and 25	10,648		
Declined to answer/missing	1,346,645		

- Media Campaign: Take Action LA

  Each year in May, the Los Angeles County Department of Mental Health (LACDMH) reaches across the county — throughout service areas and neighborhoods, into community centers, parks and major sporting events — to educate and raise awareness. Our goal: reduce stigma, expand helpseeking behaviors and increase understanding of available mental health resources.

Take Action LA

Overview and Summary Outcomes of Major Initiatives

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

AUGUST 2024

Contents

Introduction

Each year in May, the Los Angeles County Department of Mental Health (LACDMH) reaches across the county – throughout service areas and neighborhoods, into community centers, parks and major sporting events – to educate and raise awareness. Our goal: reduce stigma, expand help-seeking behaviors and increase understanding of available mental health resources.

This year, the department once again collaborated with county service leaders and the California Mental Health Services Authority (CalMHSA) on its major Mental Health Awareness Month activities. Our priority was to connect with the county's diverse communities through inclusive events and with messages of equity – including accommodations for individuals with disabilities and those who communicate in languages other than English.

This report offers highlights and outcomes of the four major initiatives related to Take Action LA:

- Community-Based Grants
- Service Area Events
- Major Sports and Community Partnerships
- Media Outreach and Public Education

LACDMH is honored to work with many partners, community members and leaders to amplify the messages of well-being, stigma reduction and equity during Mental Health Awareness Month – and every day of the year.

INITIATIVE:

Take Action LA Community Grants

"It meant so much to our participants to have days where they could discuss mental health in non-clinical settings, be treated well with dignity and respect, including beautiful venues and fresh food. People were so grateful for the various modalities offered, connecting to community, etc. It is very apparent community care and healing is the only way forward." – Take Action LA Community Grantee

GOAL:

Invest resources in community-based organizations to host mental health awareness events aimed at decreasing stigma and discrimination related to seeking mental health services among diverse audiences across Los Angeles County.

INVESTMENT:

$5,998,981

Take Action LA grants offered organizations the chance to engage their community through tailored events that encompassed activities such as sharing resources; dance and cultural celebrations; nutrition and movement activities; stress management and wellness education.

Community members making their mark on the interactive mural at VelNonArt's "Your Best Self" art event.

Enhancing mental wellness using neuro-focused brain health & exercise at the Invertigo Dance Theatre "Dancing Through Parkinson's" wellness weekend.

OUTCOMES:

- **70** grants awarded
- **193** events
- More than **27,000** community members served
- Programs/services offered in **21** languages

This information summarizes aspects of the partnerships that focused on the Take Action LA campaign. There were additional partnerships and events throughout FY 23/24 that are not summarized here.

INITIATIVE:

Focused Outreach for Each LACDMH Service Area

Throughout the month of May, nine events were held – one in each of LACDMH's eight service areas and one countywide event at the Santa Monica Pier. Each of the service area events was uniquely designed for the community's underserved and under-resourced groups.

GOAL:

Increase awareness of resources and mental health programs, and minimize the stigma associated with mental health challenges by tailoring events to neighborhoods and neighbors' specific needs.

INVESTMENT:

- **$1 million** DMH prevention funds
- **$850,000** cash and in-kind donations
- **$57,000** DMH outreach funds
- **$120,000** DMH media prevention funds

Hygiene station made available at a service area event during Mental Health Awareness Month

OUTCOMES:

In addition to **$479,000** in donated giveaways*, more than 20 modalities of wellness activities demonstrated, 19 people approved for expungement (314 now in the queue to receive service/ support), and 20 performances by local artists, countywide outcomes included:

- **13,070** registered event attendees
- **636** participating organizations
- **62** county & city programs
- **1,037** haircuts provided
- **48** showers provided
- **2,900** hygiene kits distributed
- **9,000** meals served
- **67** HIV screenings performed
- **96** children screened and fit for free eyeglasses
- **68** mammograms
- **208** Covid/flu vaccinations
- **2,500** mental health books distributed
- **$3.2M** in donated therapy from Better Help

**Tickets to theme parks, concerts and sporting events; skateboards/gear; swim caps, bathing suits, sun products and summer games; hair products; pet care/ toys; maternal health products; food boxes; gift cards; household items, signed memorabilia; and more.*

INITIATIVE:

Social Impact Through Major Sports and Community Partnerships

Collaboration with the Clippers, Kings, Dodgers, Sparks, Galaxy and Univision reached a broad swath of audiences with important messages of mental wellness and stigma reduction.

GOAL:

Raise awareness of local mental health resources and LACDMH programs through highest-visibility venues and events.

LED Display at Mental Health Awareness Night Sparks Game & Resource Fair

Mental Health Awareness Night at Dodger Stadium

OUTCOMES:

Los Angeles Dodgers Mental Health Awareness Night

LACDMH was the presenting partner at the Dodgers' Mental Health Awareness Night on May 4. Dr. Lisa Wong was honored by throwing the first pitch, and LACDMH staff Trung Du and Ryan Nam were recognized for their outstanding work with LACDMH's Teatime Program.

- **2** activation tables
- **44,474** attendees (reported by the league)
- **2,338** Mental Health Awareness Night themed ticket packs sold

Univision Mental Health Awareness Month Facebook Live

On April 30, LACDMH was featured in a collaborative discussion with Univision's Maria Nava, a host on K-LOVE 107.5, via the Univision Facebook page. This livestream event highlighted important mental health topics and reached a broad audience.

- **173,300** impressions
- **113,400** audience members reached
- **35,700** total views

INITIATIVE: *Social Impact Through Major Sports and Community Partnerships (cont.)*

Los Angeles Clippers Mental Health Awareness Night

LACDMH was featured as the presenting partner of the Clippers Mental Health Awareness game on April 10. The event successfully raised the LACDMH profile and made valuable resources available to the community.

- **150** tickets & food vouchers for staff and stakeholders
- **10,000** LACDMH co-branded stress balls distributed
- **2** table activations (Concourse and Plaza)
- Nearly **19,000** attendees (average per game)

LA Sparks Mental Health Awareness Night Game

LA Galaxy Global View on Mental Health: Cultural Perspectives on Mental Health as an Athlete

This event provided youth with important insights into mental health from a global and cultural perspective. Moderated by Cobi Jones and featuring LA Galaxy players and LACDMH Psychiatric Social Worker Monica Reyes, the event fostered an open dialogue and promoted understanding and support for mental health issues.

- **120** attendees (Galaxy academy boys, Carson High School boys' and girls' soccer teams)
- **1** LACDMH activation table
- **54,449** impressions on Galaxy social media
- **11,940** trackable impressions
- Audience reach as high as **651,541,856** based on website promotions
- Recap media: https://mlssoccer.box.com/s/64bharq7fvu96c7dpnj2945drpabhwh4

Los Angeles Sparks Mental Health Awareness Night

This event on May 21 included a resource fair with 10 LACDMH table activations. Through high attendance and extensive social media engagement, the Los Angeles Sparks were able to promote mental health education and support.

- **3,627** attendees (near maximum capacity)
- **Courtside LED**
- **Social Impressions:**
  - Video views: **167,947**
  - Engagements: **169,865**
  - Impressions: **411,065**
- **Social Branded Content:**
  - Impressions: **60,419**
  - Engagement: **880**

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INITIATIVE:

Countywide Media Outreach

The campaign demonstrated above-benchmark success in key performance indicators across multiple channels, including digital, traditional media, and earned media coverage.

GOAL:

Apply an equity approach to reach ethnic, racial, cultural and geographic audiences throughout Los Angeles County with Take Action LA messaging.

INVESTMENT:

$3,000,000

Media outreach included digital and social media, broadcast, radio, print, out-of-home, and community/grassroots opportunities.

Take Action ad (Spanish)

OUTCOMES:

The campaign generated impressive engagement though a multi-channel programmatic approach across CTV, display ads, audio platforms and a combined CTV/video direct strategy. The campaign received impressive engagement throughout the month of May.

- More than **59M impressions**
- More than **71,000 clicks**
- **50,000** conversions in May (800% increase over the previous month)
- **7M** impressions from digital display ads
- **Performance media conversions:**
  - Get Help Now call to action: **22,509** conversions
  - Call Helpline call to action: **18,754** conversions
  - Explore Events: **6,977** conversions
- **On Facebook:**
  - Over **2.1M** impressions and **209,000** engagements
  - **10%** engagement rate – twice the standard for strong campaigns
  - **170,000** video views
- **On Instagram:**
  - Over **1.2M** impressions
  - **24,000** engagements
  - **15.9%** engagement rate of Spanish campaign

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- Medical-Legal Community Partnership

  Medical Legal Community Partnership-Los Angeles (MLCP-LA) is a collaboration between the Los Angeles County (LAC) Department of Health Services (DHS), LAC Department of Mental Health (DMH), and four Legal Partners (Neighborhood Legal Services of Los Angeles is the lead and three subcontractor nonprofit law firms). MLCP-LA integrates attorneys and legal advocates within LAC DHS hospitals and clinics to deliver legal assistance to patients and support clinical teams, through training and individualized technical assistance. Through legal interventions, MLCP-LA's Legal Partners intend to help alleviate legal needs which cause great distress, jeopardize health, and increase the risk for homelessness. MLCP-LA's legal partners actively offer and promote LAC DMH's mental health supports to all clients.

  MLCP-LA Legal Partners help patients address legal barriers which will increase protective factors and decrease risk factors. For protective factors, MLCP-LA's interventions aim to engage the client in their own legal advocacy where possible. For example, an individual may be provided an opportunity to obtain certain documents or take an affirmative step (like sending a school district a letter on behalf of their child requiring an accommodation), with the support of the legal team. MLCP-LA believes these opportunities reinforce and improve problem-solving skills, self-efficacy, conflict resolution, and even parental sense of competence (for education issues). MLCP-LA's interventions also directly look to eliminate insurance barriers or denials that limit access to medically necessary care. MLCP-LA also directly facilitates patient and clinical team communication where a patient could benefit from additional education regarding their care.

  MLCP-LA's work improves circumstances that decrease risk factors. MLCP-LA's work around domestic violence and civil harassment restraining orders helps to provide survivors of violence opportunities to remain safe from violence, allowing them to focus on stability and seeking the mental health care needed to alleviate the trauma. In addition, MLCP-LA works to ensure all individuals have access to housing without harassment/discrimination, are able to receive communication in their preferred language, are able to receive support during evictions, advocacy to improve housing conditions, and assistance with accessing benefits that supplement income. Through the elimination of these barriers and stressors, individuals can focus on maintaining stability and accessing mental health support as needed.

  Of the 2,747 individuals served, 1,306 clients were connected to mental health services, and 59% of clients served were either offered a connection to mental health services via MLCP-LA or were already receiving the services they needed. In addition, a variety of positive outcomes were achieved through program participation, including:

  Increased Protective Factors:

  Increased Stability and Security: The positive outcomes related to housing, benefits, and safety likely contribute to increased stability and security, which are crucial protective factors for mental health. When an individual's homelife is stabilized, they may be more prepared to accept mental health support and to address their mental health impairments.

  Empowerment and Control: Assisting individuals in understanding their rights and advocating for themselves can lead to a sense of empowerment and control.

Throughout all of the types of MLCP-LA's interventions, advocates focus on involving individuals in their own legal advocacy.

Access to Resources: Connecting individuals to essential resources like healthcare, benefits, and community services can improve their overall well-being and resilience.

Improved Living Conditions: MLCP-LA helps individuals maintain stable housing, receive security deposits, remove rental barriers , and avoid eviction. MLCP-LA also helps advise and directly support individuals who face intimate partner violence seek protection through restraining orders. These improvements to housing and safety can also positively impact mental health. MLCP-LA achieved 600 positive housing related outcomes for its clients.

Increased Access to Resources: Through every interaction, MLCP-LA advocates connect individuals to essential resources to address and mitigate the social drivers of health. These social drivers of health are linked to mental health disparities.

Reduced Risk Factors:

Reduced Financial Stress: MLCP-LA's resolution of financial issues like unpaid wages and debt or increase in income or public benefits can alleviate significant financial stress, a known risk factor for mental health problems.

Reduced Legal Stressors: Addressing legal issues can reduce significant sources of stress and anxiety, which are risk factors for mental health problems. At its core, every MLCP-LA interaction aims to improve an individual's legal problems. Overall, MLCP-LA achieved 3,976 positive legal outcomes during the fiscal year including better understanding and processing of legal barriers, improved housing stability, secured public benefits or unpaid wages, removal of traffic tickets or fines, and increased access to healthcare.

Combined demographic information is listed in tab Table 62.

Table 62. FY 2023-2024 Demographics – Medical-Legal Community Partnership

Count (n = 3,582)			
▪ Primary Language		▪ Ethnicity	
Arabic	1	Hispanic or Latino	
Armenian	2	Caribbean	11
English	1,654	Central American	583
Farsi	7	Mexican/Mexican-American	1,596
Mandarin	9	Puerto Rican	10
Russian	1	South American	84
Spanish	1,878	Other Hispanic	215
Tagalog	4	Non-Hispanic or Non-Latino follows:	
Vietnamese	4	African	244
Other	22	Asian	16
▪ Current Gender Identity*		Cambodian	5
Man	1,537	Chinese	12
Woman	2,020	Eastern European	13
Transgender woman/Transfeminine	7	European	106
Nonbinary	1	Filipino	26
Another Category	17	Japanese	7
▪ Sexual Orientation*		Korean	1
Gay or Lesbian	63	Middle Eastern	38
Heterosexual or Straight	2,939	Vietnamese	14
Bisexual	24	More than one	78

Count (n = 3,582)			
Something else e.g. queer, asexual	30	Other Non-Hispanic or Non-Latino	271
Declined to Answer/Missing/Unknown	526	Declined to Answer/Missing/Unknown	252
▪ Disability		▪ Race	
No	394	American Indian or Alaska Native	40
Yes	3,174	Asian	84
Mental Disability	841	Black or African-American	331
Physical/mobility domain	1,248	Native Hawaiian	3
Chronic health condition	558	White	268
Difficulty seeing	150	More than one race	63
Difficulty hearing	50	Other	2,707
Another type of communication disability	11	Declined to Answer/Missing/Unknown	
Another type of disability	455	▪ Age	
Declined to answer	114	15 and under	43
Declined to answer/Missing/Unknown	14	16-25	176
▪ Veteran Status		26-59	2,367
Yes	41	60+	996
No	3,470	Declined to Answer/Missing/Unknown	86
Declined to Answer/Missing/Unknown	71	* Participants can select more than one response option	

- <u>My Health LA Behavioral Health Expansion Program</u>

  On October 1, 2014, DHS formally launched the My Health LA (MHLA) Program with the goal of increasing access to primary health care services for low income, uninsured residents of Los Angeles County. On November 20, 2018, the Board of Supervisors approved numerous changes to the MHLA agreement with Community Partner Clinics (CPs). A workgroup was formed to understand gaps in behavioral healthcare access and how to address those gaps. The group identified as a priority the need to better support CPs who provide mental health care services to MHLA participants in a primary care setting. It was determined that DMH would fund and support mental health prevention services and/or activities (MHPS) to reduce/manage risk factors associated with the onset of serious mental illness, as well as to cultivate and support protective factors of MHLA participants at CPs through a Prevention Program.

  This program ended as of January 2024.

  In this third and final year of this piloted program of integrating MHPS into CPs, a primary objective was to address any implementation challenges that surfaced in year one, and where feasible, make the necessary program modifications to further the original mission and objectives established in year one. As in year one of this piloted program, the ongoing COVID-19 pandemic continued to impact each of the participating CPs' workforce. These community-based health care clinics remained on the front line in their respective communities for handling COVID-19 education and information dissemination, treatment, testing, and vaccinations. The CP staff had again been pulled in multiple directions to help their community manage the pandemic while continuing with their implementation efforts of this MHPS Program. Program implementation challenges included staffing logistics (discontinuation of MHPS contracts and staffing shortages) and revisions to business workflows (claiming and billing processes).

Data collection shifted from the use of the PHQ9 and GAD-7 outcome measures to the BUPPS. The BUPPS was selected for the MHPS program as a tool designed specifically to report prevention outcome data LACDMH-wide, as well as to target program needs directly and track changes more effectively. This data was collected, aggregated, analyzed, and reported for the entire fiscal year. The number of unique MHLA patients receiving at least one MHPS for the period of July 1, 2020 through and including January 31, 2024 was 59,727.

Table 63. FY 2023-2024 Outcomes – MHPS

Name of Outcome Measure	Total Number of Reported Cases (at least one pair of pre & post BUPPS scores)	Average BUPPS Pre-scores	Average BUPPS Post-scores	Average BUPPS Percentage Score Change	Average Number of MHPS Sessions
BUPPS Protective Factors subscale	1,066	19.58	22.3	13.89%	4.68
WHO Wellbeing subscale	1,071	14.71	17.82	21.08%	

*Please note the greater increase reported from pre to post MHPS in the WHO Wellbeing subscale vs. the BUPPS Protective Factors subscale scores, which reflects greater gains reported in feeling states (WHO) vs. protective factors (BUPPS).

An increase in scores was noted among those participants who were assessed at both the beginning and end of the program (for both the BUPPS and WHO Wellbeing subscale) This indicates that there was an overall increase in protective factors and wellbeing through the course of programming (Table 19). Demographics are summarized in table 64.

Table 64. FY 2023-2024 Demographics – MHLA

Count (n = 59,727)			
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino as follows:	
Armenian	159	Other Hispanic/Latino	56,023
English	3,941	Non-Hispanic or Non-Latino as follows:	
Korean	135	African	82
Other Chinese	46	Asian Indian/ South Asian	24
Russian	28	Cambodian	12
Spanish	54,754	Chinese	27
Tagalog	51	Filipino	566
Vietnamese	5	Japanese	4
American Sign Language	1	Korean	103
Other	475	Vietnamese	5
Declined to answer/Missing/Unknown	129	Other	1,354
▪ Sex Assigned at Birth		More than one ethnicity	112
Male	21,154	Declined to answer/Missing/Unknown	1,415
Female	38,549	▪ Race	
X	13	Asian	741
Prefer not to answer	11	Black or African-American	82
▪ Age		Other	57,377
16-25	2	More than one race	112
26-59	51,723	Declined to answer/Missing/Unknown	1,415
60+	8,002		

This programming ended as of January 2024.

- Prevention & Aftercare (P&A)

  Prevention and Aftercare (P&A) is a DCFS-monitored program of ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and resources to mitigate the adverse effects of Adverse Childhood Experiences (ACEs) and social determinants of health. Program services are delivered in-person and virtually and can vary in frequency from one time to a year to ongoing.

  Prevention and Aftercare program services are to be offered and rendered to all families Countywide, who meet one or more of the following criteria:

  - Children and families at-risk of child maltreatment and/or DCFS involvement
    - self-referred or referred by community stakeholders such as LACDMH Specialized Foster Care (SFC) offices, schools, hospitals, and law-enforcement agencies.
  - Children and families with unfounded, closed child abuse DCFS referrals.
  - Children and families with evaluated out DCFS child abuse and/or neglect referrals.
  - DCFS referred clients who are receiving Family Reunification services.
  - DCFS referred children and families who have exited the public child welfare system and need services to prevent subsequent child maltreatment and/or DCFS involvement.

  Negative outcomes identified by MHSA, and which participants of P&A may be risk of these outcomes as a result from untreated, undertreated or inappropriately treated mental illnesses are: 1) suicide, 2) incarceration, 3) school failure or dropout, 4) unemployment, 5) prolonged suffering, 6) homelessness, and 7) removal of children from their homes.

  The program has experienced the same challenges as previous years in regard to the data downloads from the site, but changes have been adapted. In addition, the P&A contractors continue to share that the survey is hard for families to understand and respond to accordingly due to language barriers.

  An estimated 37,697 adults attended P&A single events. With only one person per family completing a survey (Event Survey), there were 3,068 surveys administered. As a result of attending a single event, the following protective factors were noted:

  - 85.0% Connected with others
  - 87.2% Learned about community programs and resources that are useful to themselves and/or their family
  - 88.1% Learned tips/tools that can strengthen themselves and/or their family's wellbeing

  Other outcomes included:

  - 79.8% Discovered something new about themselves or their family
  - 85.3% Learned something different to do with family

  The following findings are based on 527 Protective Factors Surveys (PFS) administered at baseline and after completion of multi-session P&A case navigation services. There was a general increase in protective factors from baseline to end of services. The most notable increases were in:

- Parent/caregiver resilience: score increased from 2.5 to 3.1
- Social connections: score increased from 2.4 to 3.0
- Knowledge of parenting and child development: score decreased from 2.8 to 2.7
- Social and emotional competence of adults: 3.6 to 3.9
- Social and emotional competence of children: 2.8 to 3.0

Demographic data is summarized in table 65.

Table 65. FY 2023-2024 Demographics – Prevention & Aftercare (P&A)

Count (n = 548)			
▪ Primary Language		▪ Ethnicity	
English	337	Hispanic or Latino as follows:	
Korean	5	Caribbean	1
Russian	1	Central American	52
Other	2	Mexican/Mexican American/Chicano	290
Spanish	189	Puerto Rican	2
Declined to answer/Missing/Unknown	14	South American	10
▪ Sex Assigned at Birth		Non-Hispanic or Non-Latino as follows:	
Male	96	African	48
Female	447	Eastern European	1
Prefer not to answer	5	European	7
▪ Current Gender Identity*		Filipino	2
Man	96	Korean	8
Woman	447	Middle Eastern	2
Declined to answer/Missing/Unknown	5	Other	51
▪ Sexual Orientation*		More than one ethnicity	18
Gay or Lesbian	3	Declined to answer/Missing/Unknown	56
Heterosexual or Straight	485	▪ Race	
Bisexual	8	American Indian or Alaska Native	32

- Prevent Homelessness Promote Health (PH^2)

  Prevent Homelessness Promote Health (PH^2) is a collaboration between Los Angeles County Department of Health Services (DHS): Housing for Health (HFH) and Department of Mental Health (DMH). It is a Countywide program that conducts field-based outreach services to previously homeless individuals and families who are experiencing untreated serious and persistent medical and mental illness with the goal of helping these individuals avoid returning to homelessness due to lease violations.

  The DMH Prevent Homelessness Promote Health - PH^2 program employs an interdisciplinary, multicultural, and bilingual staff, utilizing a collaborative approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH), and community housing agencies. This program provides services within the 8 Service Areas of Los Angeles County. All initial outreach is provided in the community where the individual lives, to promote access to care. The PH^2 team conducts triage, coordination of services, and brief clinical interventions, as well as incorporating Motivation Interviewing (MI), Harm Reduction, Trauma Informed therapy, Solution Oriented therapy, Cognitive Behavior Therapy, and Seeking Safety. Services are delivered primarily in person or can be delivered by phone or virtually.

The effectiveness of the program can be demonstrated by examining the PH^2 Activity Log. The purpose of this log is to capture what type of services were offered and/or provided that prevented the return to homelessness. The PH^2 Activity Log is completed for each corresponding billable note in IBHIS (direct or indirect). The categories include resources offered, linkages obtained, peak eviction risk, eviction prevented, eviction date (if applicable) and closure reason.

Housing insecurity is addressed when an individual's protective factors are increased and/or their risk factors are decreased. The PH^2 Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH^2. Meanwhile, linkage to resources (such as mental health services, medical care, In Home Supportive Services, food and other basic needs), indicate progressive housing stabilization. Therefore, the number of referrals with linkages and the number of evictions prevented serve as good proxies for reduced homelessness and increased protective factors.

Several issues affected the collection of outcomes data. The first being the utilization of a relatively new software program exploring salient data points to collect for data collection. In addition, excessive "Clinically Not Indicated to Ask" and "Unknown" responses on data collection tools affected survey outcomes.

The cumulative number of new individuals served during this reporting period is 282. Individuals were referred with the following identified problems, among others: Aggressive/Violent Behavior, Destruction of Property, Failure to Pay Rent, Fire Safety/Health Hazard, Hoarding, Infestation of Unit, Legal Issues, Relationship Conflicts, and Substance Abuse. Once enrolled, clients received a variety of linkages among the greatest include, mental health services, psychoeducation, and substance abuse treatment. The PH^2 team met with individuals weekly, depending on acuity and need. The program saw participants from two weeks to 18 months, with an average of six months. Program outcomes are summarized in tables 66 and 67, while demographic data is documented in table 68.

Table 66. FY 2023-2024 PH^2 Linkages to Each Resource

Resource	#
Mental Health Services	1,597
Psychoeducation	341
Department of Health Services	80
Shelf Stable Food	191
Emergency Services	127
Housing and Supportive Services	111
Transportation	39
Medical Care	173
IHSS	147
Food Bank	142
Substance Abuse Treatment	302
Temporary Housing	44
Psychoeducation (not client)	341

Table 67. FY 2023-2024 PH[2] Risk Factors

Risk Factor	#
Aggressive/Violent Behavior	108
Destruction of Property	81
Failure to Pay	75
Fire Safety/Health Hazard	65
Hoarding	67
Infestation	58
Needs MHS Connection	41
Other	71
Relationship Conflicts	97
Substance Abuse	115
Unit Abandonment	5

Table 68. FY 2023-2024 Demographics – PH[2]

Count (n = 282)			
▪ Primary Language		▪ Ethnicity	
English	222	Hispanic or Latino as follows:	
Russian	1	Caribbean	4
Spanish	17	Central American	4
Declined to answer/Missing/Unknown	42	Mexican/Mexican American/Chicano	20
▪ Sex Assigned at Birth		South American	1
Male	175	Other Hispanic/Latino	23
Female	107	Non-Hispanic or Non-Latino as follows:	
▪ Current Gender Identity*		African	97
Man	163	Chinese	1
Woman	103	Middle Eastern	1
Transgender man/Transmasculine	4	Other	78
Prefer not to answer	16	Declined to answer/Missing/Unknown	53
▪ Sexual Orientation*		▪ Race	
Heterosexual or Straight	160	American Indian or Alaska Native	4
Gay or Lesbian	14	Asian	1
Bisexual	1	Black or African-American	97
Something else e.g. queer, asexual	3	White	61
Undecided	1	Other	112
Prefer not to answer	103	Declined to answer/Missing/Unknown	7
▪ Disability		▪ Veteran Status	
No	61	Yes	12
Yes	171	No	228
Mental domain	149	Declined to answer/Missing/Unknown	42
Physical/mobility domain	69	▪ Age	
Chronic health condition	42	16-25	4
Difficulty seeing	6	26-59	158
Difficulty hearing	1	60+	120
Another type of disability	1	** Participants can select more than one response option*	
Decline to answer disability type	111		
Declined to answer/Missing/Unknown	50		

- Promotores

  The Promotores program is a Prevention program implemented by the Los Angeles County's Department of Mental Health. The program puts forth trainings and education for program participants in an effort to increase protective factors and decrease risk factors leading to mental health issues.

  The Promotores program utilized The California Institute of Behavioral Health Services' (CIBHS) Stigma Discrimination Reduction (SDR) Program Participant Questionnaire to collect program outcomes and assess the impact of trainings on its participants. By completing the measure, participants were able to provide feedback on 1) Attitudes and behavior towards persons with mental health conditions, 2) Knowledge about stigma towards persons with mental health conditions 3) Awareness of ways to support persons who may need mental health resources, as well as training quality and demographics. For the purpose of assessing prevention programming outcomes, the first two categories of outcomes were utilized. For the categories of participant's changes in behavior and changes in knowledge and beliefs, participants responses reflected positive results, indicating an increase of protective factors and decrease of risk factors as a result of program participation.

  Changes in Behavior: Seven items assessed how the trainings influenced participants' willingness to engage in behaviors that support individuals with mental health concerns. The results highlight a significant increase in protective factors and a decrease in risk factors. A total of 150,967 responses reported greater willingness to "seek support from a mental health professional if I thought I needed it," which indicates a boost in protective behaviors related to self-care and early intervention. The trainings also reduced the likelihood of discriminatory behavior toward individuals with mental health conditions, effectively decreasing a key risk factor associated with stigma. Additionally, the program increased the likelihood of participants engaging in supportive actions, enhancing protective factors like advocacy and inclusion. Together, these outcomes suggest that the Promotores trainings not only diminished stigma-related risks but also strengthened participants' capacity to provide and seek support in mental health contexts.

  Table 69. Promotores Changes in Behaviors Survey Results

As a direct result of this program I am MORE willing to:	Strongly Agree	Agree	Agree % Total
1...live next door to someone with a serious mental illness.	34.20%	36.80%	**71.00%**
2…socialize with someone who had a mental health condition.	35.50%	40.50%	**76.00%**
3…start working closely on a job with someone who had a mental health condition.	34.40%	39.10%	**73.50%**
4…take action to prevent discrimination against people with mental health conditions.	43.90%	40.30%	**84.20%**
5…actively and compassionately listen to someone in distress.	47.80%	40.40%	**88.20%**
6…seek support from a mental health professional if I thought I needed it.	52.70%	37.50%	**90.20%**
7…talk to a friend or a family member if I thought I was experiencing emotional distress.	51.20%	38.90%	**90.10%**

  Changes in Knowledge and Beliefs: Seven items assessed the impact of the Promotores training on participants' knowledge about mental illness and their beliefs about individuals with mental health conditions. The results suggest that the trainings successfully increased protective factors by enhancing participants' understanding of mental health and fostering more supportive and inclusive beliefs. By attending the trainings, participants were able to challenge negative stereotypes, a key risk factor associated with stigma and

replace them with more positive attitudes towards people with mental health conditions. This shift in attitudes represents a decrease in risk factors related to discrimination and misunderstanding. The trainings also boosted participants' knowledge of mental health topics, further equipping them to engage in supportive behaviors and attitudes. A majority of participants agreed that the trainings had a positive influence on their beliefs about individuals with mental health conditions, reinforcing the overall increase in protective factors while reducing the impact of stigma-based risk factors.

Table 70. Promotores Changes in Knowledge and Beliefs Survey Results

As a direct result of this program I am MORE likely to believe	Strongly Agree	Agree	Agree % Total
8…people with mental health conditions are different compared to everyone else in the general population.	17.48%	24.24%	**41.72%**
9…people with mental health conditions are to blame for their problems.	11.51%	13.36%	**24.87%**
10…people with mental health conditions can eventually recover.	36.57%	41.24%	**77.81%**
11…people with mental health conditions can contribute to society.	35.54%	40.25%	**75.79%**
12…people with mental health conditions should be felt sorry for or pitied.	13.64%	17.48%	**31.11%**
13…people with mental health conditions are dangerous to others.	13.07%	16.78%	**29.85%**
14…anyone can have a mental health condition.	45.83%	36.97%	**82.80%**

Table 71. FY 2023-2024 Demographics – Promotores

Count (n = 16,211)			
▪ Primary Language		▪ Ethnicity	
American Sign Language	5	Hispanic or Latino	
Arabic	8	Caribbean	903
Armenian	44	Central American	1,809
Cantonese	43	Mexican/Mexican-American	6,945
Cambodian	102	Puerto Rican	43
English	2,301	South American	252
Farsi	5	Other Hispanic	324
Japanese	2	Non-Hispanic or Non-Latino follows:	
Korean	1,709	African	149
Mandarin	199	Asian Indian/South Asian	18
Other Chinese	8	Cambodian	105
Russian	2	Chinese	242
Spanish	9,091	Eastern European	7
Tagalog	15	European	47
Vietnamese	9	Filipino	21
Other	66	Japanese	25
Decline to answer	2,602	Korean	1,775
▪ Current Gender Identity*		Middle Eastern	9
Man	1,542	Vietnamese	12
Woman	12,250	More than one	127
Transgender woman/Transfeminine	47	Other Non-Hispanic or Non-Latino	185
Transgender man/Transmasculine	98	Declined to Answer/Missing/Unknown	3,213
Nonbinary	28	▪ Race	
Not sure what this question means	11	American Indian or Alaska Native	124
Undecided/Unknown at this time	9	Asian	2,220
Another Category	7	Black or African-American	324
Declined to answer/Missing/Unknown	2,258	Native Hawaiian	13
▪ Sexual Orientation*	16260	White	5,525

Count (n = 16,211)			
Gay or Lesbian	207	More than one race	249
Heterosexual or Straight	10,142	Other	1,917
Bisexual	182	Declined to Answer/Missing/Unknown	5,839
Not sure what this question means	291	▪ Age	
Undecided/Unknown at this time	21	15 and under	43
Something else e.g. queer, asexual	33	16-25	540
Declined to Answer/Missing/Unknown	5,384	26-59	10,900
▪ Disability		60+	2,113
No	12,274	Declined to Answer/Missing/Unknown	2,615
Yes	875	▪ Sex Assigned at Birth	
Mental Disability	372	Male	1,650
Physical/mobility domain	251	Female	12,074
Chronic health condition	148	X	15
Difficulty seeing	112	Another Category	7
Difficulty hearing	51	Prefer not to answer	2465
Another type of communication disability	21	▪ Veteran Status	
Another type of disability	92	Yes	180
Declined to answer	160	No	13,105
Declined to Answer/Missing/Unknown	3,062	Declined to Answer/Missing/Unknown	2,926
* Participants can select more than one response option			

- SEED School of Los Angeles (SEED LA)
  SEED LA is the County's first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college pathways in the transportation and infrastructure industry. The school provides on-site support, wellness services and socio-emotional counseling for students.

- Transition Age Youth (TAY) Drop-In Centers
  Drop-In Centers are designed to be an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) Transition-Age Youth (TAY), ages 16-25, who may be homeless or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. The complex trauma may manifest in TAY's inability to maintain relationships, keep jobs, or stay in school, often putting them at risk of unemployment, school dropouts, incarceration, and homelessness. Without early intervention or prevention services, TAY are at risk of experiencing mental disorders that may impair their daily activities and functioning. TAY accessing Drop-In Centers have an opportunity to build trusting relationships with staff, and when ready and willing, connect to needed services and supports to best meet stability/recovery.

- Trauma and Resilience Informed Early Enrichment (TRiEE)
  TRiEE was a trauma-informed mental health prevention initiative, a unique adaptation of the Community Schools model for early education centers (EECs). TRiEE promoted professional development and wellbeing for school staff, facilitated parent involvement, connected families to community resources, and enhanced students' self-regulation skills. TRiEE was dedicated to building school capacity to increase protective factors and reduce risk factors for children, youth, and families. Services were implemented at 39 Early Education Center (EEC) sites throughout Los Angeles

County, serving children 0-6 y/o and their families. Services were provided to the whole school community including staff, students, and families by Psychiatric Social Workers (PSW) on campus, in person or by phone. The program served a total of 3,672 children, youth, and families. This program concluded at the end of the 2023-2024 FY and will not continue in the next FY.

Outcomes

A total number of 3,672 individuals were served during the reporting period. There were some barriers faced by the program during the outcome collection process, one being that the TRiEE surveys had to be moved to a different platform, which led to some challenges in staff accessing the survey, due to new District firewalls. In addition to this, the TRiEE survey depended on site administrators for distribution however, several of the sites had new administrators unaware of the requirement or administrators that were out on leave.

Young children exposed to trauma are at increased risk for various adverse outcomes. Providing adults in children's lives with knowledge of trauma informed practices can increase protective factors by fostering resilience and social and emotional wellbeing. The following provides highlights of findings from 140 parent evaluations and 452 staff evaluations:

- 94-96% of staff reported that because of the training they felt more prepared to help children use positive behaviors, manage their emotions, and use executive functioning skills
- 96% of staff reported that because of the training they felt prepared to build positive relationships with children and their families.
- 90% of parents reported that their child's school has provided them with resources to support their child's emotional wellbeing at home.
- 94% of staff reported they "strongly agree" or "agree" services provided through TRiEE program have helped to bring resources and partnerships to the school.
- 94% of staff reported that the services provided through the TRiEE program help staff to feel less stress.

Table 72. FY 2023-2024 Demographics – TRiEE

Count (n = 3,672)			
▪ Primary Language		▪ Ethnicity	
Arabic	18	Hispanic or Latino as follows:	
Armenian	43	Other Hispanic	2,764
Cantonese	2	Non-Hispanic or Non-Latino as follows:	
English	1,979	African	499
Farsi	27	Filipino	37
Korean	1	Other	372
Mandarin	5	▪ Race	
Other Chinese		American Indian/ Alaska Native	12
Russian	14	Asian	156
Spanish	1,508	Black or African-American	511
Tagalog	8	Native Hawaiian/ Pacific Islander	10
Vietnamese	11	White	2,983
Other	56	▪ Sex Assigned at Birth	
		Male	1,702
		Female	1,970

- Community Partner - United Mental Health Promoters

  The Los Angeles County Department of Mental Health United Mental Health Promoters (UMHP) project is a community outreach and empowerment effort, which serves to both strengthen communities and create career paths for those community members functioning under the umbrella of UMHP (e.g., Community Health Workers, Peer Advocates, Parent Partners, Community Ambassadors, etc.).

  The UMHP program's long-term impact is intended to strengthen the health, mental health, and wellbeing of the most vulnerable individuals and families in Los Angeles County. To achieve progress toward this long-term outcome, the project utilizes a composite of outreach, engagement, and psychosocial support activities within disadvantaged hyperlocal areas. Programmatic efforts include direct and indirect services, household assistance, education and training regarding prevention/mitigation efforts, and linkages to resources.

  The UMHP Project staffing focused on the inclusion of individuals with lived experience who are ambassadors to our most underserved and disproportionally impacted communities. The UMHP staff are crucial to build the bridge between the communities they serve, and the opportunities provided by Anti-Racism, Diversity, and Inclusion (ARDI) Initiative. To achieve the ARDI Initiative goals, the UMHP Project engages with residents, organizations, and community stakeholders to develop activities and evaluation efforts aligned with the needs and values of each area served and support place-based community partnerships.

  Each Community Based Organization (CBO) emphasizes cultural competence, often leveraging staff with lived experiences or shared backgrounds with participants. These efforts aim to enhance trust and provide tailored support to vulnerable populations. Programs generally offer multiple sessions or a mix of single events and ongoing support. Outreach, community building, self-help groups, and psychoeducation workshops are common strategies. Several programs are in the early stages of data collection, with limited baseline surveys completed and no post-survey data yet available. Programs utilizing tools like the BUPPS survey are measuring outcomes such as protective factors and mental wellbeing. However, some programs are still refining data collection methods.

  Challenges experienced during program implementation included hiring difficulties, participant engagement in surveys, cultural and linguistic barriers, and difficulty collecting data due to program development phases. Some programs faced reluctance from participants to fill out surveys, due to distrust in county forms or feeling exploited. Various UMHP programs that did manage to collect data, demonstrated positive outcomes, some of which are highlighted below:

  The Wall de las Memorias is a program focusing on serving low-income LGBTQ+ adults and BIPOC individuals. The program provided trauma-informed care, HIV testing, immigration workshops, and various other supportive services tailored to the LGBTQ+ community. It focused on reducing risk factors and enhancing protective factors through culturally competent, multi-language services. This program successfully collected both baseline and post-survey data using the BUPPS. The program demonstrated positive outcomes, as the average scores increased from the pre to the post measure on both the BUPPS and the WHO Wellbeing measure. These

scores indicate improvement in overall mental health and wellbeing in addition to successfully increasing protective factors due to the programming.

The Parents, Educators/Teachers, and Students in Action (PESA) program served youth impacted by the juvenile justice system, who are often facing housing insecurity. The program provided weekly and monthly sessions with educational workshops, case management, and psychoeducation, to improve life skills and resilience. The program collected pre and post program BUPPS data to track protective factors related to hopefulness, community, coping skills, and resource knowledge. Scores for all measured protective factors increased. Participants also reported feeling calmer, more energetic, and more engaged in life after the program. These scores indicate improvement in protective factors through program participation.

The Emotional Health Association dba SHARE! program targeted older adults age 65+ at high risk of loneliness, anxiety, and depression. In addition, these individuals have been impacted by COVID-19 and untreated mental health issues. The program provided outreach services, community-building activities, and support groups. The goal was to reduce isolation and mental health risks by providing social connections and access to resources. Baseline survey data was collected using the BUPPS survey, specifically measuring protective factors, WHO Wellbeing, and parenting-related outcomes. Baseline scores reported for BUPPS Protective Factors averaged 8 out of a total score of 30 (indicating low initial protective factors), WHO Wellbeing averaged 9.67 out of a total score of 25 (indicating poor initial wellbeing), and Parenting subscale outcomes averaged 17.83 out of a total score of 20. No post-survey data was available during the reporting period.

Available demographic data is listed in table x.

Table 73. FY 2023-2024 Demographics – United Mental Health Promoters

Count (n = *)			
▪ Primary Language		▪ Ethnicity	
Armenian	1	Hispanic or Latino	
English	37	Central American	2
Mandarin	1	Mexican/Mexican-American	38
Spanish	30	Non-Hispanic or Non-Latino follows:	
Other	1	African	11
Declined to answer/Missing/Unknown	1	Chinese	1
▪ Current Gender Identity*		European	2
Man	57	Filipino	1
Woman	28	Other	3
▪ Sexual Orientation*		More than one	4
Gay or Lesbian	21	Declined to Answer/Missing/Unknown	6
Heterosexual or Straight	99	▪ Race	
Bisexual	6	American Indian or Alaska Native	1
Undecided	2	Asian	1
Not sure what this question means	3	Black or African-American	14
▪ Disability		White	36
No	45	More than one race	4
Yes	22	Other	8
Mental Disability	7	Declined to Answer/Missing/Unknown	1
Physical/mobility domain	10	▪ Age	
Chronic health condition	6	15 and under	1
Declined to answer	17	16-25	11
Declined to Answer/Missing/Unknown	4	26-59	33

Count (n = *)			
▪ Veteran Status		60+	24
Yes	9	Declined to Answer/Missing/Unknown	2
No	53	** Participants can select more than one response option*	
Declined to Answer/Missing/Unknown	1		

* Please note, the demographic data presented does not completely align with the expected population distribution. Variations may be due to erroneous reporting, misclassification, or other data collection limitations.

- Veteran and Military Family Services (VMFS) formerly known as Veterans Peer Access Network (VPAN)

  Veteran and Military Family Services (VMFS) is a prevention program which serves Veterans and Military family members in Los Angeles County. The goals are to: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment.

  Under VMFS, The Department of Mental Health, The Los Angeles County Department of Military and Veteran Affairs and SoCal Grantmakers, as well as other Community-based Organizations (CBOs), provide peer support and linkage to services, reducing mental health services utilization. The goal of prevention services provided through VMFS CBOs is to implement a set of strategies that will augment existing programs. In addition, new preventative and trauma-informed community supports are provided to Veterans and Veteran family members in order to promote protective factors and diminish risk factors for developing a potentially serious mental illness.

  Peer services are provided from 8:00am-6:00pm, five days per week, Monday through Friday. Community events may be held on weekends. The program is delivered based on the client's needs in-person, by phone, or virtually. In FY 2023-24; 3,555 veterans and military family members were served through VMFS CBOs.

  The VMFS Support Line is dedicated to assisting active-duty military personnel, veterans, reservists, and guard members. The peers who staff the VMFS Support Line understand the unique sacrifices and emotional needs that come with military life. The VMFS Support Line offers Emotional First Aid related to stressors, referrals to community services, real-time psychoeducation on mental health services, and direct access to field-based teams for additional support and follow-up.

  In FY 2023-24, the Veteran Support Line received a total of 9,642 calls. Due to the nature of the support line, a referral is generated, and demographics collected only when the caller is requesting services and/or benefits.

  In addition, under the VMFS Veteran System Navigators program, the Department of Military and Veterans Affairs (DMVA) provides benefits establishment, reducing potential negative outcomes like homelessness, food insecurity, and associated stress. Prevention programing serves to increase protective factors which include resilience, socio-emotional skill building in Veterans and Veteran family members, and social connectedness through specialty programming. The DMVA County Veterans Service Office has secured more than $ 27 million dollars in benefits for veterans, their dependents, and survivors. Veterans Systems Navigators lead the way in ensuring veterans in the community apply for and secure benefits they have earned, relieving financial stress during transition periods, preventing homelessness by assisting with housing resources, and enrolling veterans into

Department of Veterans Affairs Healthcare/Mental Health to include Veterans Centers so veterans can receive the care they need and deserve.

VMFS faced several challenges in regards to outcomes data collection efforts. The various VMFS programs had different data collection procedures, with variable questions and response options, such that in many cases entire categories were missing. It is also possible that some participants were represented in multiple datasets. DMVA served a total of 1,386 clients in FY 2023-24.

Table 74. FY 2023-2024 VMFS Linkages to Each Resource

Benefits Navigation	1,331	Mental Health Linkage	154
Housing & Shelter	983	Legal Assistance	407
Employment Assistance	717	Clothing & Household Goods	199
Income Support Assistance	1,289	Transportation Assistance	134
Family Support Assistance	1,745		

Table 75. FY 2023-2024 Demographics – VMFS

Count (n = 20,867)			
▪ Sex Assigned at Birth		▪ Ethnicity	
Male	6,400	Hispanic or Latino as follows:	
Female	3,600	Central American	46
Prefer not to answer	10,867	Other Hispanic	2,123
▪ Current Gender Identity*		Non-Hispanic or Non-Latino as follows:	
Man	6,400	Asian	221
Woman	3,600	Other Non-Hispanic	92
Transgender man/Transmasculine	2	Declined to Answer/Missing/Unknown	18,385
Non-Binary	34	▪ Current Gender Identity	
Prefer not to answer	10,831	Male / Man	6,400
▪ Veteran		Female / Woman	3,600
No	1,307	Transgender Woman	2
Yes	6,798	Non-Binary	34
Declined to Answer/Missing/Unknown	12,762	Prefer not to answer	10,831
▪ Race		▪ Age	
American Indian or Alaska Native	143	16-25	1,002
Asian	221	26-59	6,833
Black or African-American	2,559	60+	1,889
Native Hawaiian or other Pacific Islander	64	Declined to Answer/Missing/Unknown	11,143
White	3,312		
Other	1,164	* Participants can select more than one response option	
More than one	1		
Declined to Answer/Missing/Unknown	13,403		

In Fiscal Year 2025-26, VMFS will transition to fully implementing a Full-Service Partnership (FSP) Intensive Case Management Services model, which will include linkage, mental health services, housing, medication support, and 24-hour crisis support services. Current DMH VMFS clients will continue to receive support through Early Intervention (EI) efforts, while linkage services will be expanded to include comprehensive mental health care and crisis response. The program's cornerstone, the VMFS Support Line, will remain a vital resource, offering immediate assistance to active-duty military personnel, veterans, reservists, and military family members. The line will continue to operate 7 days a week, 9AM -6PM and will continue to be funded by Early Intervention. Through the means of the VMFS Support line and other Outreach and Engagements efforts, Veterans and their families will benefit from Emotional First Aid, psychoeducation

on mental health, referrals to community resources, and direct connections to field-based teams. The range of referrals from low risk to high-risk will be dispositioned and triaged according to level of care and need. Individuals with mild mental health needs will be referred to community veteran service providers, moderate to high needs will be services within the FSP model. This hybrid model will enable the program to continue with ease of access to care for veterans and military family members as many veterans with mental health will not come in for mental health services but will be more inclined to come in for housing or benefits.

- Spring Evolution Inc., DBA Wolf Connection

  In Fiscal Year 2023-2024, Wolf Connection was piloted through CalMHSA. Wolf Connection offers unique education and empowerment programs that transform lives via experiential relationships and interactions with rescued wolves and the natural environment. The Wolf Lessons for Human Lives online education and empowerment platform delivers Wolf Connection's signature Empowerment program via an interactive virtual experience. This highly engaging and interactive platform takes the student through a journey across the Wolf Heart Ranch Sanctuary, completing twelve easy-to-follow, intuitively progressive modules. While each module covers a unique "wolf lesson", the primary objectives of the virtual experience are to connect youth with the inherent worth, resilience and sense of belonging to a "pack" or community. As they traverse the Wolf Heart Ranch territory, students intuitively move through the seasons of the year – Spring (light green), Summer (dark green), Fall (brown), Winter (white) and learn the lessons contained in each of the twelve modules. Each lesson is presented by a different wolf guide who embodies that particular lesson in real life. Some of the interactive components include Howl to Action activities, Reflect & Respond writing prompts, and Wolf Paws meditation moments. The platform additionally offers a differentiated approach to meet the needs of students' different learning styles. This includes options to have text read aloud, watch videos, access a Spanish version, as well as different assignment options for them to demonstrate their understanding of the content.

  Alternative healing modalities and spaces that provide safety, connection programming. Specifically, we aimed to serve bilingual youth aged 11-18 years old providing culturally responsive support to meet their unique needs. Our virtual program, Wolf Lessons for Human Lives, was designed to replicate the key principles of our on-site programming, nourishing a sense of self and fostering a sense of belonging to a pack. Inspired by the natural behavior of wolves, our program promotes personal connections and encourages the development of one's authentic self. Wolf Lessons for Human Lives addresses the critical relational, mental health, and self-regulation components of California's Standards for Mental, Emotional and Social Health, providing a comprehensive approach to supporting the well-being of young people.

  A total of 1,197 individuals were served during this reporting period. During this reporting period, the organization encountered challenges in collecting data from some schools due to restrictions on sharing personal identifying information. This limited the program's ability to collect demographics and pre/post-survey data.

  The program received 459 pre/post surveys. The number of surveys collected differs from the number of individuals served, due to limitations with data collection. While pre- and post- surveys were collected during FY 23-24, they did not assess whether protective factors or risk factors specifically increased or decreased as a result of the prevention program, thus no outcomes data is available at this time.

Table 76. FY 2023-2024 Demographics – Wolf Lessons for Human Lives

Count (n =459)			
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino as follows:	
English	350	Central American	42
Spanish	67	Mexican/Mexican American/Chicano	179
Vietnamese	1	Other Hispanic/Latino	95
American Sign Language	5	Non-Hispanic or Non-Latino as follows:	
Declined to answer/Missing/Unknown	33	Chinese	2
▪ Sex Assigned at Birth		Eastern European	7
Male	171	European	7
Female	213	More than one	54
Prefer not to answer	75	Other	62
▪ Disability		Declined to answer/Missing/Unknown	11
No	258	▪ Race	
Yes	107	American Indian or Alaska Native	20
Mental domain	2	Asian	8
Physical/mobility domain	10	Black or African-American	149
Difficulty seeing	48	Native Hawaiian	3
Difficulty hearing	11	White	60
Decline to answer disability type	18	Other	93
Declined to answer/Missing/Unknown	94	More than one	113
* Participants can select more than one response option		Declined to answer/Missing/Unknown	13

- Youth-Community Ambassador Network (CAN-Youth)

  The Los Angeles Trust for Children's Health (The L.A. Trust) was contracted by California Mental Health Services Authority (CalMHSA) to support the Los Angeles County Department of Mental Health (LACDMH) by developing the Youth Community Ambassador Program. The aim was to co-create a Youth Peer Ambassador Program in partnership with students and LAUSD school mental health staff focused on prevention and navigation to care. The L.A. Trust provided oversight of the activities, training, staffing, and student stipend distribution, for the Community Ambassador Network-Youth (CAN Youth) program within the Los Angeles Unified School District (LAUSD). High school students within selected LAUSD school sites were recruited and vetted to serve on the Student Advisory Boards as trained Youth Community Ambassadors and serve as mental health access agents, navigators, and mobilizers within their school communities. Youth Community Ambassadors leveraged their peer relationships to support mental health, driving a collective self-help model to promote healing, recovery, and youth empowerment.

  The CAN Youth Program focused on a peer-to-peer outreach approach both through social media and direct campaigning on ten LAUSD school campuses. The approach focused on overall student wellness with an emphasis on providing mental health awareness and education; reducing stigma; promoting open communication amongst peers; providing information about community, school-based resources, and Wellness Centers services that support mental health.

  To evaluate the effectiveness of the prevention program, several outcome metrics were utilized. Pre- and post-program surveys, combined with the State Stigma Reduction Survey, with the support of UCLA evaluators, were administered to assess changes in students' attitudes, behaviors, and perceptions related to mental health, peer relationships, and school engagement. Program attendance records were tracked to monitor changes in student engagement and participation over the course of the program.

Additionally, qualitative feedback was collected through focus groups, interviews, and open-ended survey questions to gather in-depth insights into students' experiences and perceptions of the program. This program ended at the end of the 2023-2024 fiscal year.

A total number of 40,221 individuals were served during this reporting period. The L.A. Trust continued the Youth Community Ambassador Network (Y-CAN) across ten school sites and some challenges were encountered during data collection. This year's participation goal was 100 students; however, the program ended with a total of 83 students. The student turnover rate is attributed to schedule changes, increased student extracurricular activities and schoolwork load. Additionally, during the 2023-2024 program year, The L.A. Trust worked with UCLA to evaluate the Community Ambassador Network (CAN) in order to standardize the peer-to-peer supports that many other school districts are wanting to implement. The program trained student ambassadors through Summer Academy and the goal was to collect pre and post survey of 83 student participants. The training academies occurred during student summer holiday (e.g., August 2023) and encompassed a new orientation model. Due to this, students who were not present during the orientation academy were given pre-tests as they joined the program throughout the start of the academic year. Additionally, to further evaluate the program, UCLA developed a focus group that occurred over each semester. These focus groups detailed the positive impact of the program on both students and adult allies.

The CAN Youth Program focuses on a peer-to-peer outreach approach both through social media and direct campaigning on ten LAUSD school campuses. The students focus on overall student wellness with an emphasis on providing mental health awareness and education; reducing stigma; promoting open communication amongst peers; providing information about community, school-based resources, and Wellness Centers services that support mental health.

In FY 2023-24, 40,221 youth were served through CAN Youth. A survey was developed by the UCLA evaluators, however, the requirements for approval from LAUSD and parental consent delayed data collection such that surveys were only completed by 83 respondents. Some additional barriers in data collection included staff turnover and students dropping out of the program due to scheduling conflicts. Outcome data related to prevention was not shared with DMH and is therefore not available at this time.

Table 77. FY 2023-2024 Demographics – CAN Youth

Count (n = 83)			
▪ Primary Language		▪ Ethnicity	
English	57	Hispanic or Latino as follows:	
Spanish	12	Central American	9
Declined to answer/Missing/Unknown	14	Mexican/Mexican-American/Chicano	65
▪ Age		South American	2
15 and under	11	Non-Hispanic or Non-Latino as follows:	
16-25	71	African	6
Declined to answer/Missing/Unknown	1	Asian	1
▪ Sex Assigned at Birth		Declined to answer/Missing/Unknown	
Male	20	▪ Race	87
Female	62	American Indian/ Alaska Native	2
Prefer not to answer	1	Black or African-American	3
▪ Sexual Orientation		White	14
Heterosexual or Straight	48	Other	40
Gay/Lesbian	2	More than one race	7
Bisexual	4	Declined to answer/Missing/Unknown	21

Count (n = 83)			
Something else e.g. queer, asexual	6	▪ Disability	87
Undecided/Unknown	9	No	64
Declined to answer/Missing/Unknown	14	Yes	3
▪ Current Gender Identity*	84	A mental disability	3
Man	20	Decline	20
Woman	62	* Participants can select more than one response option	
Transgender man/Transmasculine	1		
Declined to answer/Missing/Unknown	1		

- Youth Development Network Program

  The Los Angeles County Department of Youth Development launched the Youth Development Network/Region through a subcontracted network of community-based organizations (CBOs), within each respective geographic region. These youth-serving networks provide a full continuum of youth development services who provide, or can provide, coordinated, comprehensive, innovative, and culturally responsive resources and services. To right-size service provision, funding will support a range of diverse CBOs depending on need, population, and expertise, providing a coordinated network of care.

  Based on strengths, goals and needs identified in youth's pre-assessment, young people were referred to participating provider services that specialize in programming within the following three program categories: Youth Mentorship and Academic Support, Youth Intervention and Wellness Programs, Youth Development and Employment Opportunity Programs. The activities offered across these programs may include but are not limited to individual one-on-one case management; small group trainings; workshop series; reoccurring classes and/or youth-centered events. Programs range in service delivery type and include both in-person and virtual engagement.

  The prevention priority populations of youth served across LA County were between the ages of 12 – 25 years old and included:

  - Trauma-exposed individuals,
  - Individuals at risk of experiencing onset of serious psychiatric illness,
  - Individuals experiencing extreme stressors, and
  - Underserved cultural populations
  - Black, Latino, and Indigenous youth of all gender identities.
  - Youth experiencing barriers to accessing local youth development services
  - Youth who are involved with, or at risk of being involved with, the youth justice system, experiencing school attachment challenges, school attendance challenges, or at risk of dropping out of school.

  The Program served a total of 264 individuals during this reporting period. Some barriers to the collection of data included difficulties experienced by providers in learning the data collection platform (e.g. single contact vs intake). In addition, the late start of program launch, led to questions about when/how data is expected to be submitted. Many providers were already actively serving their youth caseload prior to our program launch and had completed pre-existing intake and other related documentation from their internal process, which led to a lack of the BUPPS survey completion. Lastly, some of the providers that support youth in school classroom environments had limited time to successfully complete and collect data. The Department of Youth Development (DYD) planned to track basic longitudinal data through its intake and exit assessments. At the end of the 2023-2024 FY, that data collected was minimal, and its quality is still under review due to how recently Youth Development Network (YDN) contracts have been executed (<1 month). Once

there is at least one full quarter of data and quality assurance activities, more robust outcomes are expected.

DYD's targeted outcomes for each of the Youth Development Network regions is to see an average increase in overall protective factor scores at exit as compared to average scores at intake across all 5 protective factors.

1. Resilience/coping skills: "I feel hopeful about the future."
2. Social competences/conflict resolution: "I know at least one thing I can do to deal with difficult thoughts."
3. Social supports/connectedness: "I feel like part of a community."
4. Concrete supports/access to care: "I know about resources that might be helpful for me or someone I care about."
5. Confidence/sense of belonging: "I know if I keep working at something, I will get better at it."

From the start of implementation, across all protective factors, youths' scores increased from intake to exit, indicating improved protective factors as a result of the program.

Table 78. FY 2023-2024 Demographics – Youth Development Program

Count (n = 264)			
▪ Primary Language		▪ Ethnicity	
Armenian	1	Hispanic or Latino as follows:	
English	101	Central American	3
Spanish	16	Mexican/Mexican American/Chicano	49
Vietnamese	1	Other Hispanic	4
Other	4	Non-Hispanic or Non-Latino as follows:	
Declined to answer/Missing/Unknown	141	African	44
▪ Current Gender Identity*		Japanese	1
Man	72	Vietnamese	1
Woman	49	More than one ethnicity	13
Transgender man/Transmasculine	1	Declined to answer/Missing/Unknown	149
Not sure what question means	142	▪ Race	
▪ Sexual Orientation*		American Indian or Alaska Native	1
Heterosexual or Straight	115	Asian	2
Gay or Lesbian	2	Black or African-American	54
Bisexual or Pansexual	4	White	4
Something else e.g. queer, asexual	1	More than one race	9
Undecided/ unknown at this time	2	Other	31
Declined to answer/Missing/Unknown	140	Declined to answer/Missing/Unknown	163
▪ Age		▪ Disability	
15 and under	98	No	97
Between 16 and 25	143	Yes	10
26-59	12	Mental domain	4
Declined to answer/Missing/Unknown	11	Physical/mobility domain	1
▪ Veteran Status		Another type of disability	5
Yes	1	Decline to disclose type of disability	10
No	122	Declined to answer/Missing/Unknown	157
Declined to answer/Missing/Unknown	141	▪ Sex Assigned at Birth	
** Participants can select more than one response option*		Male	75
		Female	49
		Prefer not to answer	140

FY 2025-26 ■ PREVENTION PROGRAMS

The following prevention programming will continue for Fiscal Year 2025-26:

Program	Target Population
Child & Family Teaming Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family. Partner with DCFS to fund CBOs to provide this service.	Children and Transition Age Youth
Community Family Resource Centers Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities, health education on metal health and /or SUDs and wellness classes on meditation, fitness, healthy cooking, etc. Target individuals experiencing homelessness and justice involved. Prioritize high need communities, such as the AV.	People with mental health and substance use disorders (SUDs)
Community Resource Specialists Program To help build trauma-informed communities and resilient families through Community Resource Specialists (CRSs) who work in-home with families to ensure that food, medical or housing crises don't destabilize families.	Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities
Consumer Empowerment Network Educate LACDMH consumers on the history of MHSA, the role of LACDMH consumers and consumers from through the state, components and required processes, county, and state stakeholder events and opportunities to make public comments, recommendations, and legislative process.	LACDMH Consumers
Cultural Reflections Newsletter Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.	LACDMH Consumers
Family Preservation/Solicitation	Specialized Foster Care population, children and families
FosterALL WPW ReParenting Program FosterAll's WisdomPath Way Program addresses both the adults and children in foster care and provides positive outcomes to prevent additional trauma, stress and mental illness for both adults and children	Adults and Children Involved with Foster Care System
Hope & Healing: Mental Health Wellness Support to Victim Families & Relatives Bring Faith and Mental Wellness together to normalize the conversation and consciousness of families to seek mental health services and eliminate common stigmas preventing many traumatized persons from getting the help they need.	African American families who have suffered loss due to violence
K-Mental Health Awareness & K-Hotline Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.	All Age Groups - Korean
Laugh Therapy & Gratitude (Spanish) Enlighten the public on therapeutic alternatives that don't necessarily require the use of drugs to improve one's state of mind and the importance of embracing emotions rather than masking them.	All age groups (multigenerational) - Latino
Long Beach Homeless Prevention (City of Long Beach)	Transition Age Youth
New Parent Engagement-Welcome to the Library and the World Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a virtual program every quarter.	New Parents and Caregivers
Neurofeedback This project will support children and youth by providing Neurofeedback Therapy to treat various conditions including anxiety, depression, pain, and trauma. Neurofeedback is a short-term treatment (20 sessions), complementary and alternative medicine (CAM), that uses electronic devices to help people with self-regulation and self-control. The Los Angeles County Department of Mental Health (LACDMH) offers appointed DO's and practitioners to deliver neurofeedback treatment to the client while monitoring progress and providing feedback.	Children and TAY (DO Clinicians will be trained)
Older Latino Adults & Caregivers (Spanish) Create opportunities for elderly Latino immigrants to prosper and grow independent by	Older Adults - Latino

Program	Target Population
teaching them not fear technology but rather, use it as a helpful tool to stay connected to loved ones, learn new things, find entertainment, and use it as a tool for self improvement.	
Open Arms Community Health & Service Center Provide quality health care, mental health support, housing, case management, employment referrals and supportive services such as food, clothing, hygiene kits, transportation anger management, substance use, sex trafficking, and parenting classes.	All Age Groups
PIER Program Expansion- First Episode Psychosis Program DMH has 5 PIER program sites that are almost at capacity. The request is to expand the number of sites and areas of availability of the program. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.	Adolescents and young adults, ages 12-25
School Readiness An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic math skills, and social skills, and other essential school readiness competencies.	2 to 4 Year Olds (Toddlers to Preschoolers)
Search to Involve Pilipino Americans (SIPA) Provide strength based, youth-centered mental health support services to youth and underserved individuals in SPA 4, with a focus on Historic Filipinotown and adjacent areas	Youth
Steven A. Cohen Military Family Clinic at VVSD, Los Angeles The Cohen Clinic offers personalized, evidence-based mental health care along with outreach and timely access to comprehensive case management support and referrals to address early intervention and suicide prevention, unemployment, finances, housing, and legal issues.	Veterans and Their Families
TransPower Project Increase access and remove treatment barriers such as lack of resources, transportation needs and privacy concerns by offering specialized affirmative mental health services at no cost.	Youth Trans* Population
We Rise Parks at Sunset We Rise a prevention program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access resources and information on mental health support including free mental well-being workshops.	24 years old and below - Families
Youth Development Regions This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs. The target population is youth 18-25 and is projected to serve approximately 6,500 youths annually. Services are provided through contracted CBOs and referral and linkage and will include school engagement, conflict resolution training, mentoring/peer support, educational support, employment/career services, arts/creative expression and social/emotional wellbeing resources.	Transition Age Youth 18-25

PEI – Stigma and Discrimination Reduction (SDR)

The purpose of SDR 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.

FY 2023-24 Stigma and Discrimination Reduction Programming, Data and Outcomes

Mental Health First Aid (MHFA)

MHFA is an interactive 8-hour evidence-based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhances the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

Peer, Family and Community Supports Towards Stigma and Discrimination Reduction: NAMI Urban LA and NAMI Greater LA)

Provides Countywide community-based prevention programs and approaches and supports to reduce stigma and discrimination targeting people living with mental illness, their families, friends and communities. Activities/services include supports to families and communities navigating mental health treatment and recovery resources, evidence-based education classes, training, and advocacy. Program targets:

- Individuals with mental illness and their families
- Individuals who serve as Mental Health peers
- Mental Health professional and paraprofessionals
- Underserved Cultural Communities
- Individuals and families impacted by justice involvement

LGBTQIA-2S

This is an invoice-billed unique contract that focuses on the TAY population, as well as their families and community. It provides educational and stigma addressing training to the community, as well as support groups, and is contracted with three agencies in different parts of LA County:

- Penny Lane
- AMAAD Institute
- The Wall Las Memorias

SDR Outcomes

Los Angeles County's Department of Mental Health conducts Stigma Discrimination Reduction (SDR) programs in the form of training and education. Programs are intended to decrease stigma and discrimination against people who have a mental health condition and increase knowledge about mental health topics. To determine the effectiveness of its SDR programs, Los Angeles County uses the California Institute of Behavioral Health Services' (CiBHS) SDR Program Participant Questionnaire, a brief, multiple choice, survey that assesses the impact of programs on participants': 1) attitudes and behavior toward persons with mental health conditions 2)

knowledge about stigma towards persons with mental health conditions 3) awareness of ways to support persons who may need mental health resources, as well as program quality and demographics.

This write-up discusses the results of data analyses performed on the questionnaires administered to assess SDR programs conducted during the 2023-2024 Fiscal Year (FY), from July 1, 2023, through June 30, 2024. In FY 23-24, (2,496) surveys were collected, down from (16,218) in FY 22-23. This change is most likely explained by a shift in program funding. In FY 22-23, the majority of SDR programs were provided by Promotores de Salud, which had its funding changed from SDR to Prevention in FY 23-24.

The majority, 63%, (see graph, Survey Language) of surveys submitted were in English.

Figure 76. Percentage of Languages for Surveys

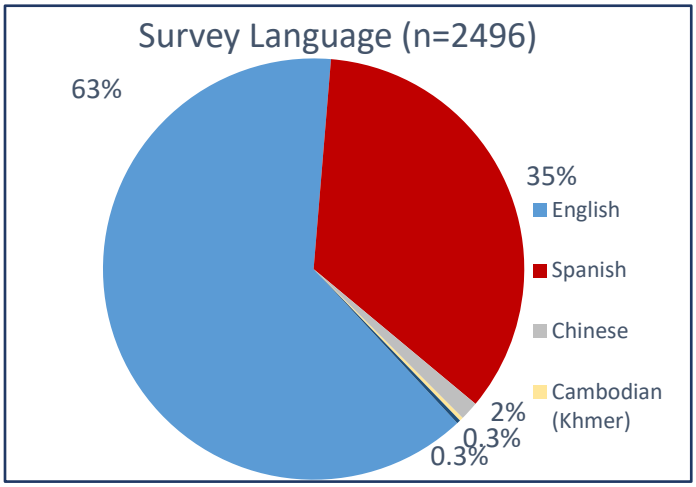


Figure 77. Age

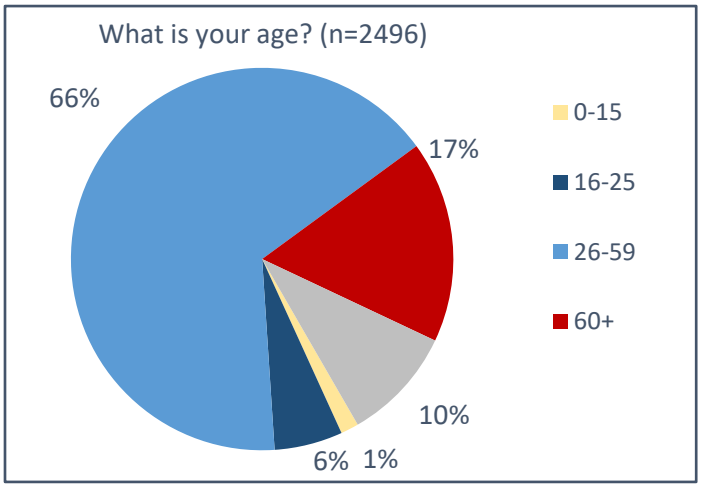


Figure 78. Veteran Status

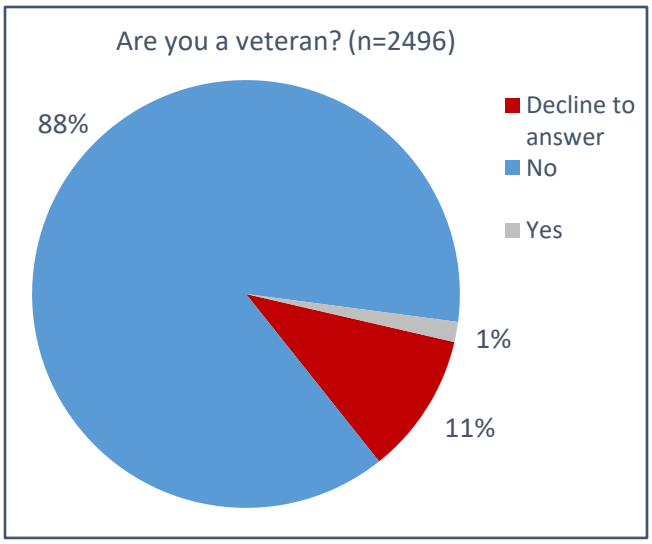


Figure 79. Sex Designation at Birth

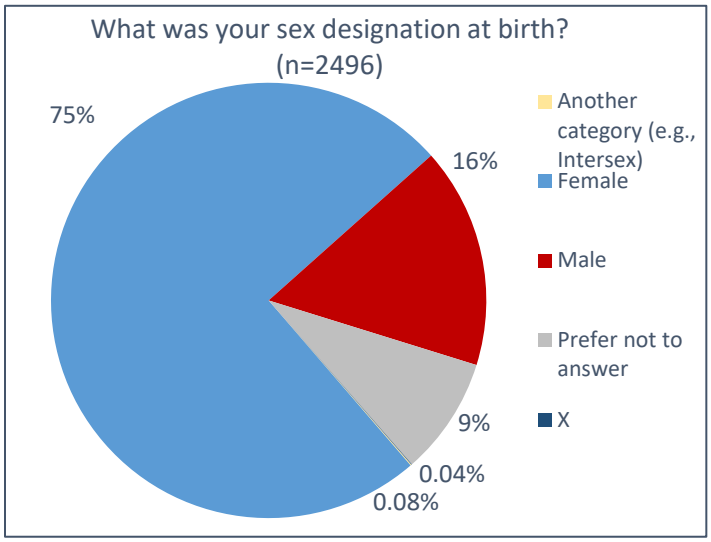


Figure 80. Disability Status

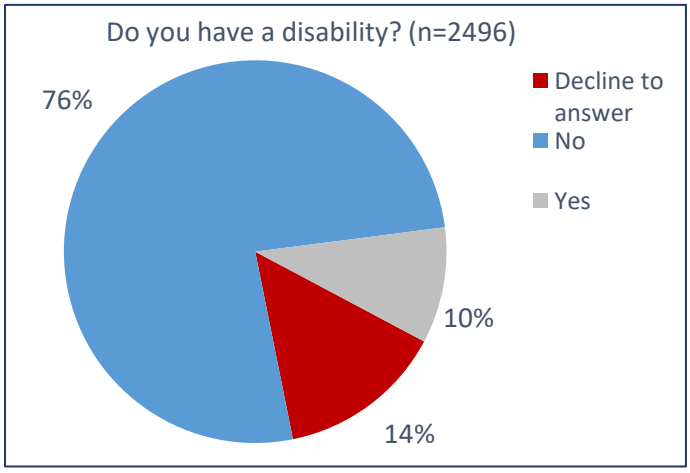


Table 79. Race (n=2,496)

Race	Number	Percentage
Native Hawaiian or Other Pacific Islander	8	.32%
American Indican or Alaska Native	29	1.16%
More than one race	113	4.53%
Black or African American	190	7.615
Asian	205	8.21%
Other	379	15.18%
Decline to Answer	696	27.88%
White	876	35.10%

Table 80. Languages Spoken at Home (n=2,496)

Language	Number	Percentage
Russian	2	.08%
Farsi	2	.08%
American Sign Language	2	.08%
Vietnamese	4	0.16%
Tagalog	4	0.16%
Japanese	4	0.16%
Arabic	4	0.16%
Other Chinese	6	0.24%
Cantonese	9	0.36%
Cambodian	17	0.68%
Armenian	19	0.76%
Other	21	0.84%
Korean	22	0.88%
Mandarin	47	1.88%
Decline to Answer	257	10.3%
Spanish	989	39.62%
English	1,087	43.55%

Table 81. Ethnicity (n=2,496)

Ethnicity	Number	Percentage
Vietnamese	7	0.28%
Armenian	8	0.32%
Puerto Rican (Hispanic/Latino)	11	0.44%
Middle Eastern	16	0.64%
Asian Indian/South Asian	18	0.72%
Cambodian	20	0.80%
Eastern European	26	1.04%
Filipino	29	1.16%
Korean	34	1.36%
South American (Hispanic/Latino)	42	1.68%
Other (Hispanic/Latino)	66	2.64%
Other	76	3.04%
Chinese	77	3.08%
African	80	3.21%
More than ethnicity	109	4.37%
Caribbean (Hispanic/Latino)	177	7.09%
European	181	7.25%
Central American (Hisapnic/Latino)	198	7.93%
Decline to answer	424	16.99%
Mexican/Mexican-American/Chicano (Hispanic/Latino)	897	35.94%

Table 82. Gender Identity (n=2,496)

Gender Identity	Number	Percentage
Another category (e.g. Two-Spirit)	3	0.12%
Man	392	15.71%
Non-binary (e.g. genderqueer or gender expansive)	12	0.48%
Not sure what this question means	1	0.04%
Transgender man/Transmasculine	16	0.64%
Transgender woman/Transfeminine	7	0.28%
Undecided/Unknown at this time	3	0.12%
Woman	1,869	74.88%
Prefer not to answer	201	8.05%

*Total number of gender identities selected may add up to more than 2,496 as participants are allowed to select more than one response.

Table 83. Sexual Identities (n=2,496)

Sexual Identity	Number	Percentage
Undecided/Unknown at this time	7	0.28%
Something else (e.g., queer, asexual)	23	0.92%
Not sure what this question means	51	2.04%
Heterosexual/straight	1,646	65.95%
Gay or Lesbian	44	1.76%
Bisexual or pansexual	60	2.40%
Prefer not to answer/prefer no labels	684	27.40%

*Total number of sexual identities selected may add up to more than 2,496 as participants are allowed to select more than one response.

Table 84. Disability (n=245)

Disability	Number
A chronic health condition, such as chronic pain	47
A mental disability	146
A physical/mobility disability	70
Another communication disability	4
Another type of disability	17
Difficulty hearing	12
Difficulty seeing	15
Decline to answer	15

*Total number of disabilities selected may add up to more than 245 as participants are allowed to select more than one response.

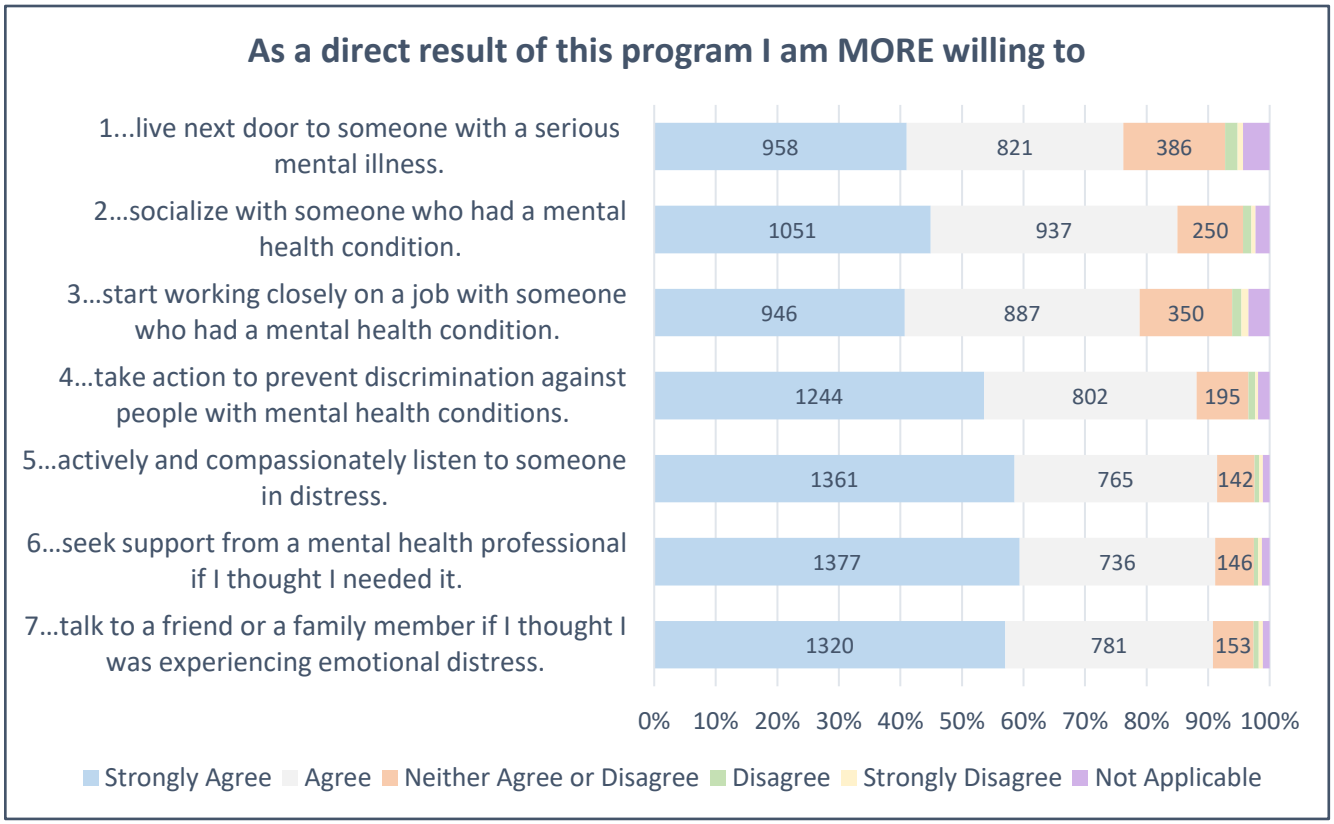
Changes in Behavior

Seven questionnaire items (see graph, Changes in Behavior, for items and results) assess the impact of SDR trainings on participants' willingness to engaging in behaviors that support persons with mental health concerns. Item ratings are: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree, or Not Applicable. Agreeing suggests the participant believes the program positively influenced their future behavior (e.g., increase in willingness to "seek support from a mental health professional if I thought I needed it") and disagreeing suggests the opposite. Results suggest the SDR programs: 1) decreased the likelihood of discriminating against persons who have a mental illness 2) increased the likelihood of acting in support of individuals who have a mental illness and 3) increased the likelihood of seeking support for themselves in times of need.

- On all 7 items, the majority of participants agreed the program had a positive influence, with a high of 91% agreeing or strongly Agreeing with items 5-7.

- Item 5, (59%) selected Strongly Agree and (32%) selected Agree, “As a direct result of this program I am MORE willing to actively and compassionately listen to someone in distress.”
- Item 6, (58%) selected Strongly Agree and (33%) selected Agree, “As a direct result of this program I am MORE willing to seek support from a mental health professional if I thought I needed it.”
- Item 7, (59%) selected Strongly Agree and (32%) selected Agree, “As a direct result of this program I am MORE willing to talk to a friend or family member if I thought I was experiencing emotional distress.”

Figure 81. Changes in Behavior



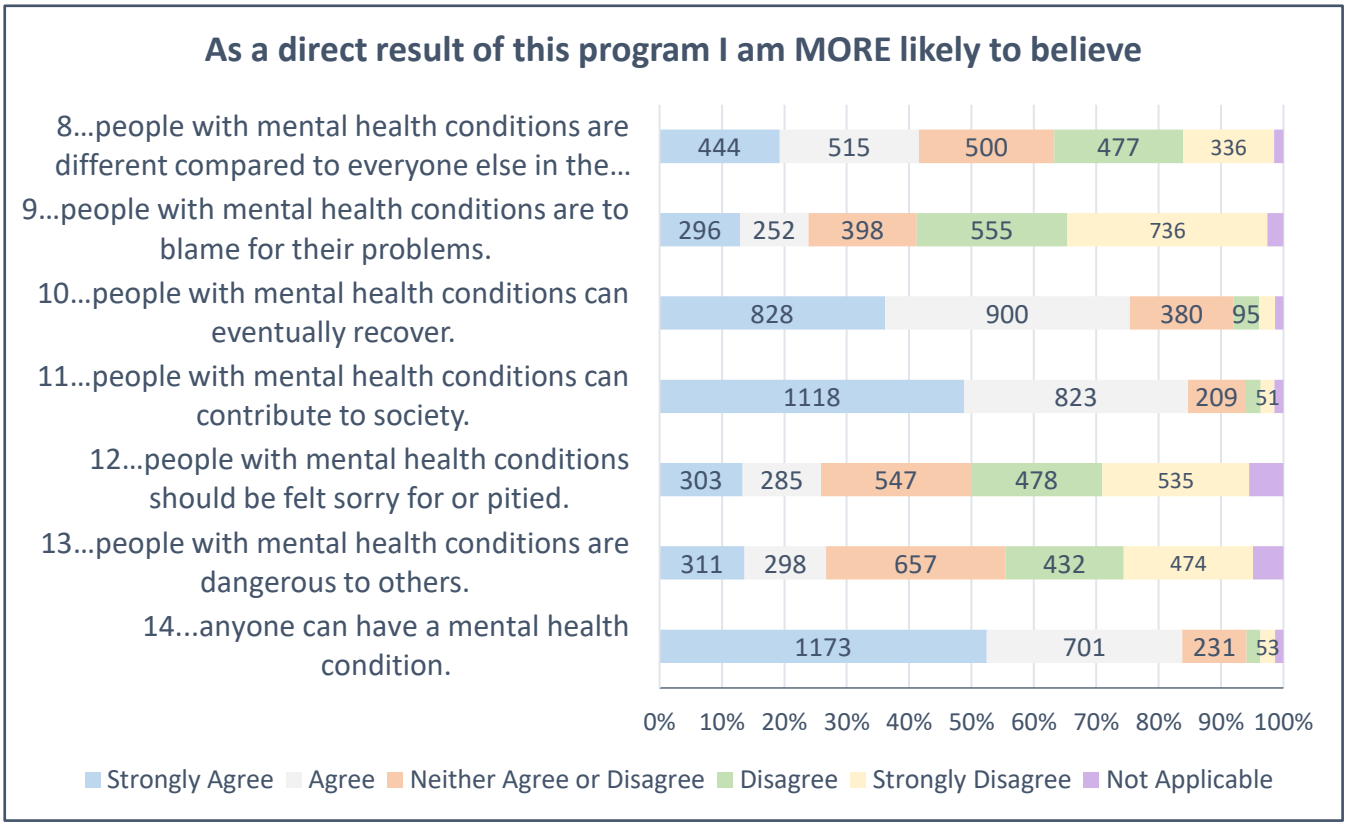
Changes in Knowledge and Beliefs

Seven items (see graph, Changes in Knowledge and Beliefs, for items and results) assess change resulting from attending an SDR programs in knowledge about mental illness and beliefs about people with mental illness. Items may be rated: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree, or Not Applicable. On items 8, 9, 10 and 13, disagreeing suggests the participant believes the program succeeded in helping the participant challenge negative stereotypes about people with mental health conditions, improve attitudes towards people with mental health conditions, or increase knowledge about mental health topics (e.g., decreasing the belief mentally ill people are dangerous) and agreeing suggests the opposite. On items 10,11, and 14 scoring is reversed. (e.g., increasing belief people with mental illness can eventually

recover). Results tended to suggest SDR trainings met the goals of increasing participants' knowledge about the topic of mental health and positively influenced beliefs about people who have a mental health condition.

- On four of 7 items, the majority of participants indicated the program had a positive influence, with a high of 85% Strongly Agreeing (49%) or Agreeing (36%), with item 11, "As a direct result of this program I am MORE likely to believe people with mental health conditions can contribute to society."
- On 2 items, many participants indicated the program had a positive influence, though not a majority. The phrasing of these items may play a role in their having lower levels of agreement. They are negatively worded and disagreeing with them indicates the program made an improvement, for example, item 12, "As a direct result of this program I am MORE likely to believe people with mental health conditions should be felt sorry for or pitied." Disagreeing suggests the program had a positive impact on knowledge and beliefs about people with mental health concerns. Of the 14 SDR program items, participants showed the least improvement on the 4 negatively worded items. Additionally, average disagreement (40%) with the 4 negatively phrased items was 41% lower than average agreement (85%) with the positively phrased ones.
    - This result is similar to the previous FY's, when average disagreement (48%) on the 4 negative items was 35% lower than average agreement (83%) with the positively phrased ones.

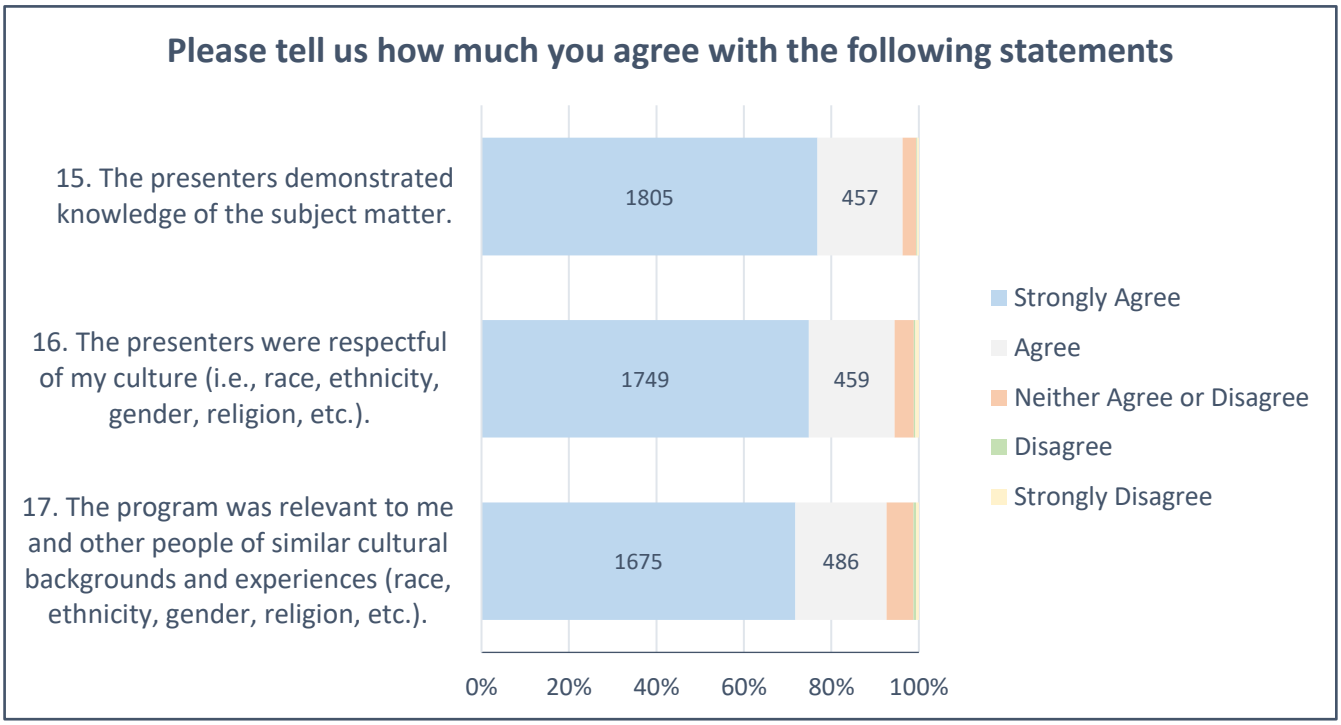
Figure 82. Changes in Knowledge and Beliefs



Three items (see Graph, Training Quality, for items and results) assess the quality of SDR trainers and programming. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, and Strongly Disagree. Agreeing suggests the participant had positive perceptions and disagreeing suggests the opposite. Participants tended to have very positive perceptions of the trainers and the programming quality:

- At least 93% of participants agreed or strongly agreed with every item.
- A high of 96% strongly agreed (77%) or agreed (19%) with item 15, “The presenters demonstrated knowledge of the subject matter.”
- These results are consistent with the previous FY’s, when at least 95% or participants agreed or strongly agreed with every item and a high of 97% agreed or strongly agreed with item 15.

Figure 83. Training Quality



PEI – Suicide Prevention

The 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.

In response to the needs in our community, the Los Angeles County Suicide Prevention Network, with support from LACDMH, has developed a strategic plan for suicide prevention to guide our efforts towards the goal of zero suicides in the County.

Some of the key elements to suicide prevention are:

- Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction;
- Promote early help seeking where people know the warning signs and resources and are confident to intervene with someone they care about or get help for themselves;
- Ensure a safe and compassionate response during and in response to crises by focusing on stabilization and linkages to services in the least restrictive setting; and
- Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death.

FY 2023-24 Suicide Prevention Programming, Data and Outcomes

Suicide Prevention Outcomes

Los Angeles County's Department of Mental Health implements Suicide Prevention (SP) programs in the form of training and education. Program participants included, but were not limited to: first responders, teachers, community members, parents, students, and clinicians.

To determine the effectiveness of its SP programs, Los Angeles County utilizes the California Institute of Behavioral Health Services' (CiBHS) SP Program Participant Questionnaire, a multiple-choice survey, which assesses the impact of programs on participants' attitudes, knowledge, and behaviors related to suicide, as well as program quality and participants' demographics. This write-up discusses the results of a data analyses performed on the 688 questionnaires received for SP programs conducted during the 2023-2024 Fiscal Year (FY).

Program Outcomes

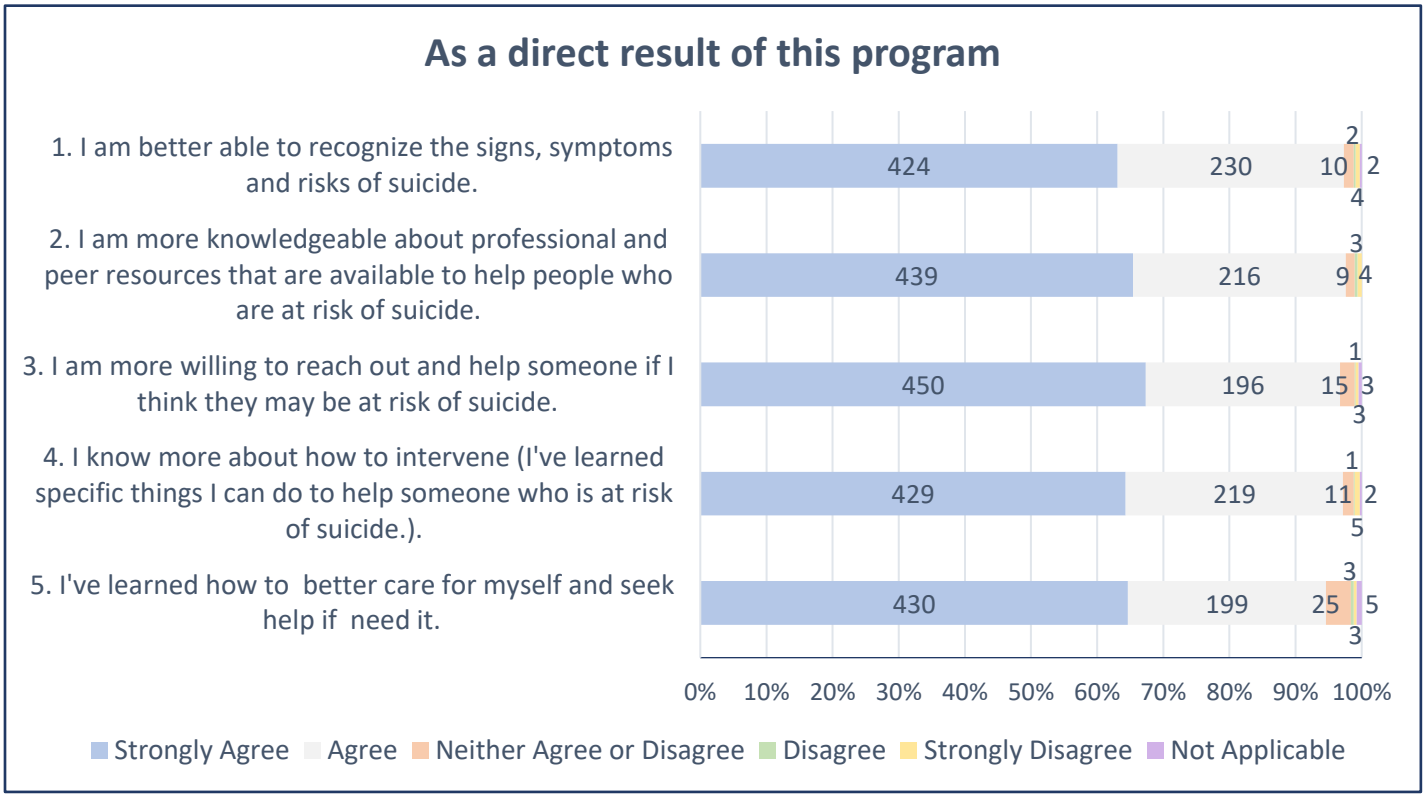
Changes in Attitudes, Knowledge, and Behavior

SP programs have three primary goals: 1) increasing knowledge about suicide and ways to help someone who may be at risk of suicide 2) increasing willingness to help someone who may be at risk of suicide 3) increasing the likelihood participants will seek support for themselves in times of need. The questionnaire has 5 items (see Graph, Changes in Attitudes, Knowledge, and Behavior, for items and results) assessing the success of SP programs in meeting their goals. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly

Disagree, or Not Applicable. Agreeing with an item suggests the program met a program goal(s), disagreeing suggests the opposite.

- At least 95% of the participants agreed or strongly agreed with every item suggesting that, overall, SP programs were quite successful in meeting their program goals.
- Participants had the highest rate of agreement with the 2nd item, as 98% strongly agreed (65%) or agreed (33%) with the statement, “As a direct result of this program I am MORE knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.”
- These results are identical to the previous fiscal year’s when, at least 95% of the participants agreed or strongly agreed with every item and participants had the highest rate of agreement with item two (98%).

Figure 84. Graph, Changes in Attitudes, Knowledge, and Behavior



Program Quality

The questionnaire includes three items (see Graph, Program Quality, for items and results) assessing the quality of SP Programs. Items may be rated: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree. Agreeing suggests the participant had positive perceptions about the programs and trainers, while disagreeing suggests the opposite.

- Participants tended to have highly positive views of the programs’ quality as at least 97% agreed or strongly agreed with every item.
- Participants agreed most with item 6, “The presenters demonstrated knowledge of the subject matter,” with 99% selecting Strongly Agree (77%) or Agree (23%).

- These results are identical to the previous fiscal year's when, at least 97% of the participants agreed or strongly agreed with every item and item 6 had the highest rate of agreement (99%).

Figure 85. Program Quality

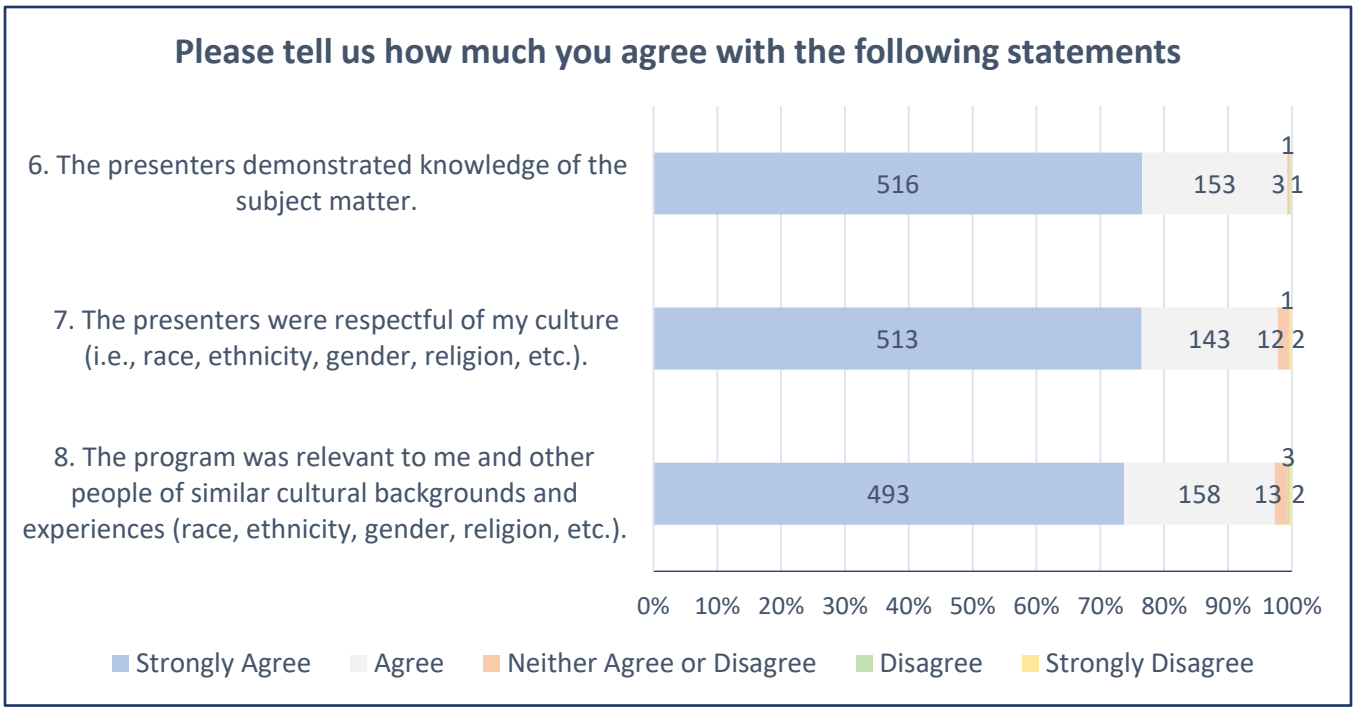


Figure 86. Veteran

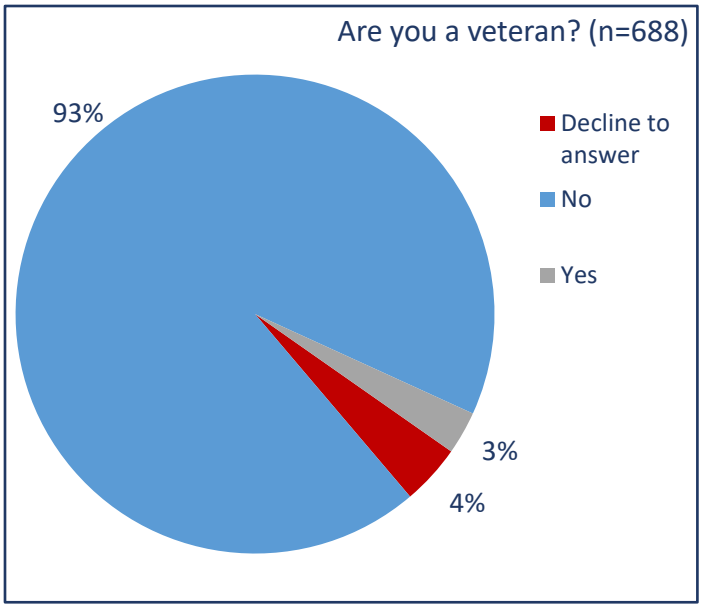


Figure 87. Age

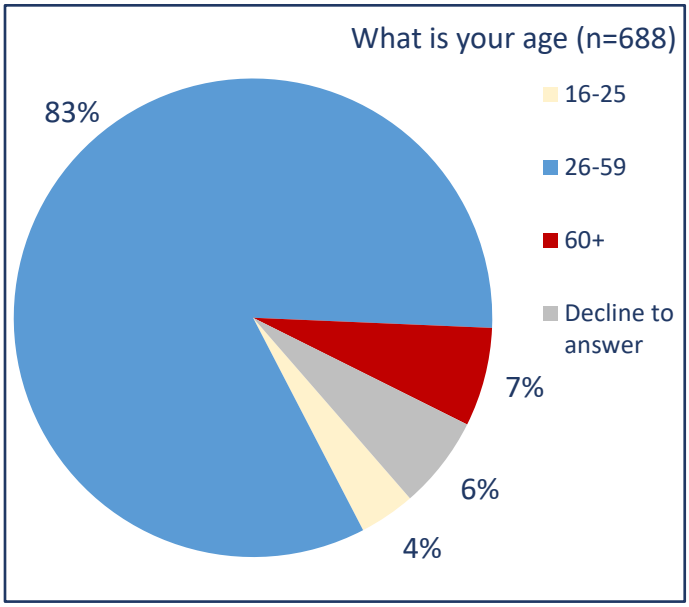


Figure 88. Sexual Designation

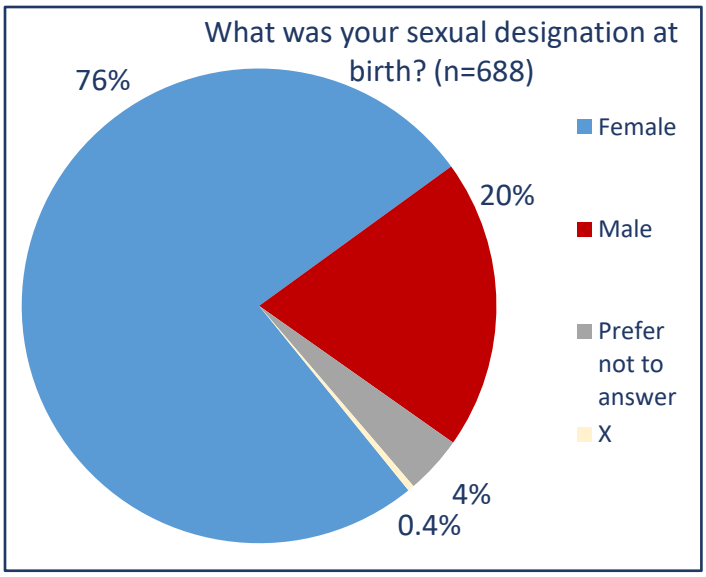


Figure 89. Disability

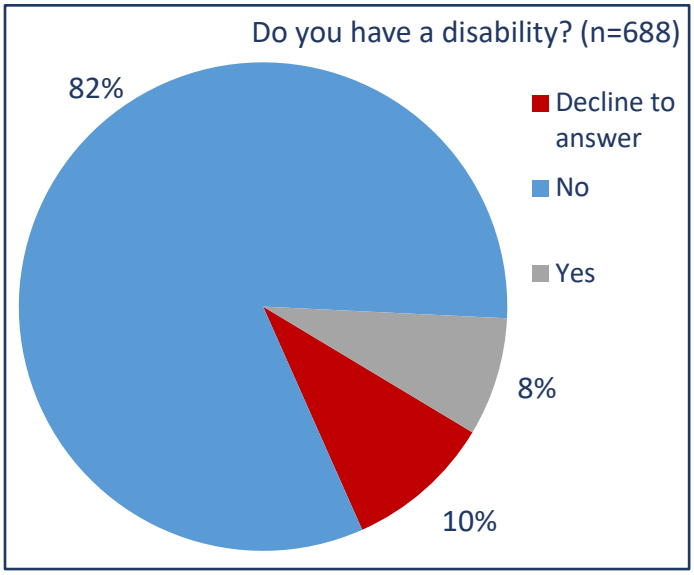


Figure 90. Race

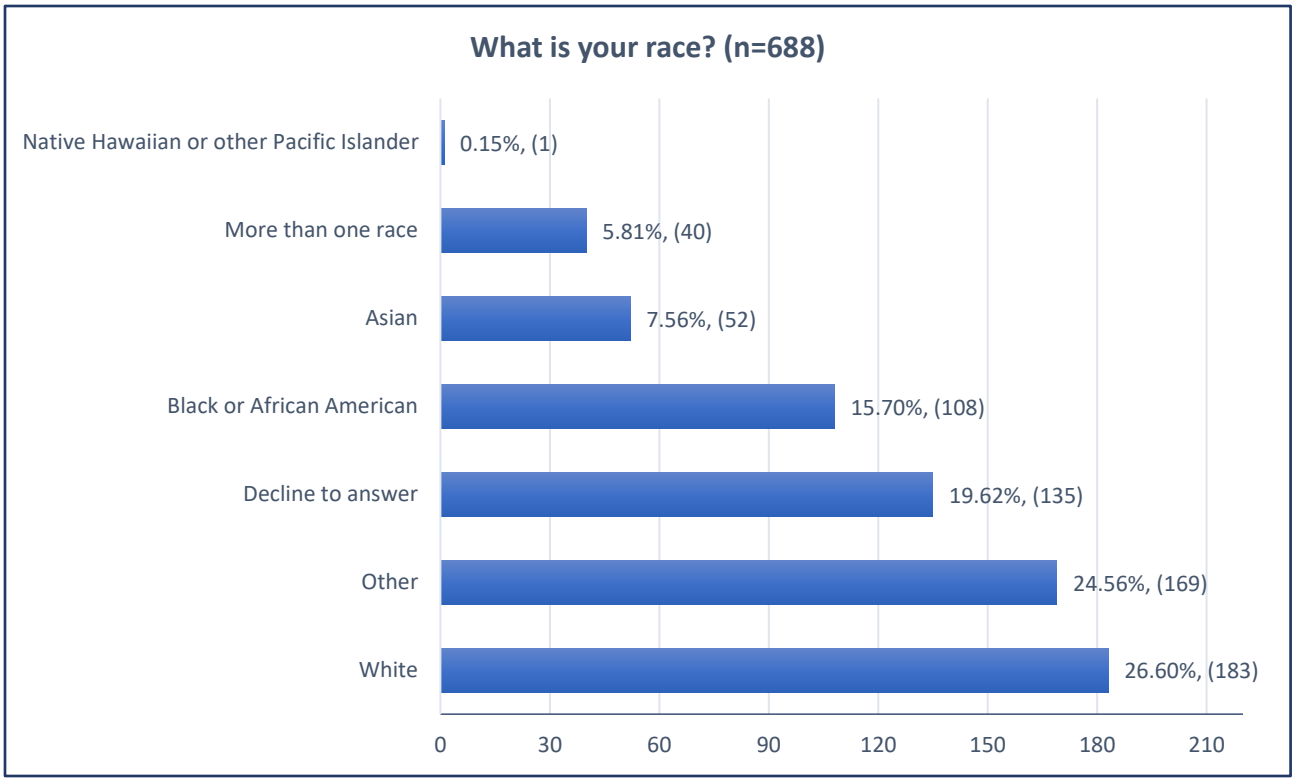


Figure 91. Ethnicity

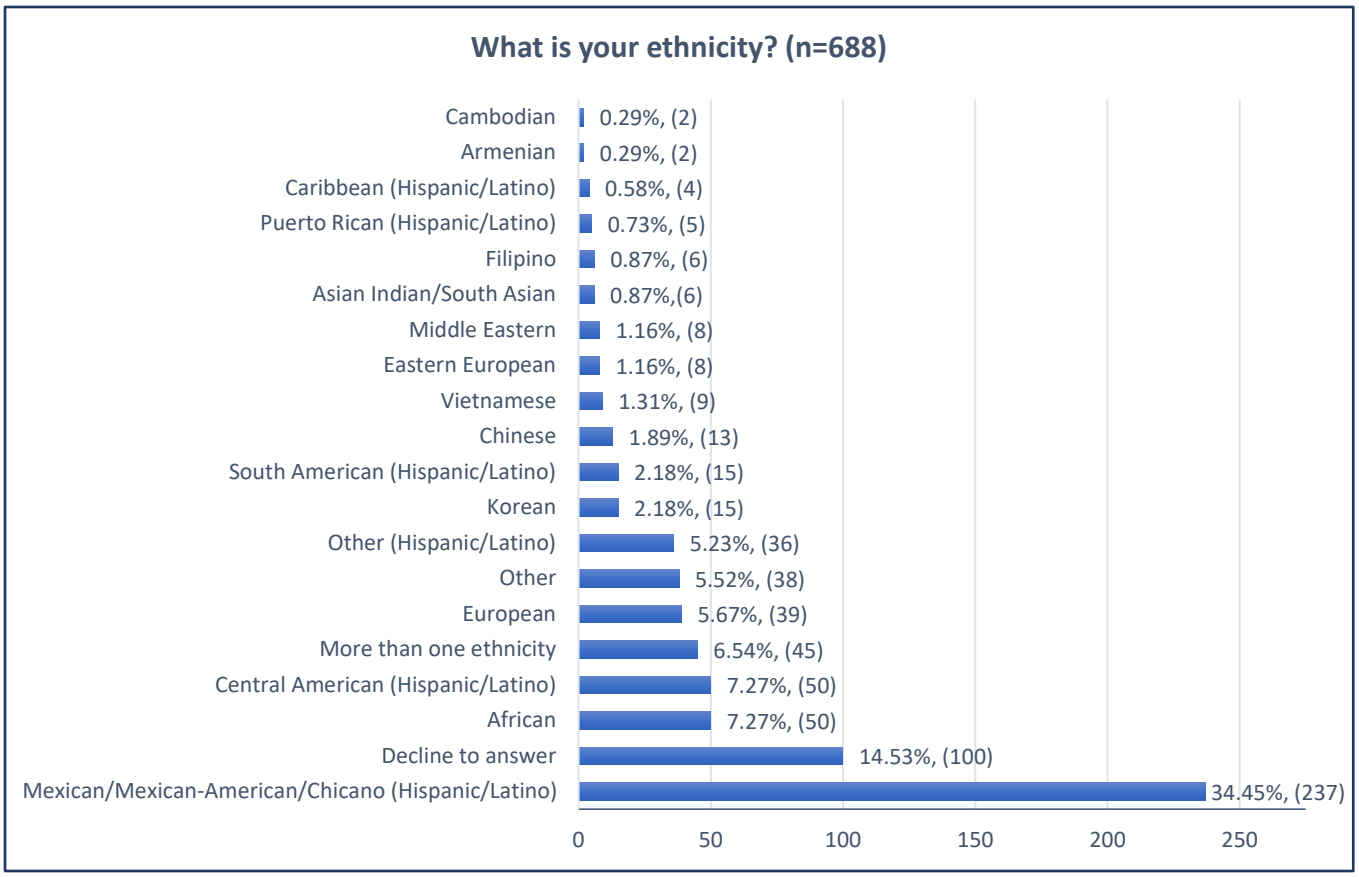


Figure 92. Language

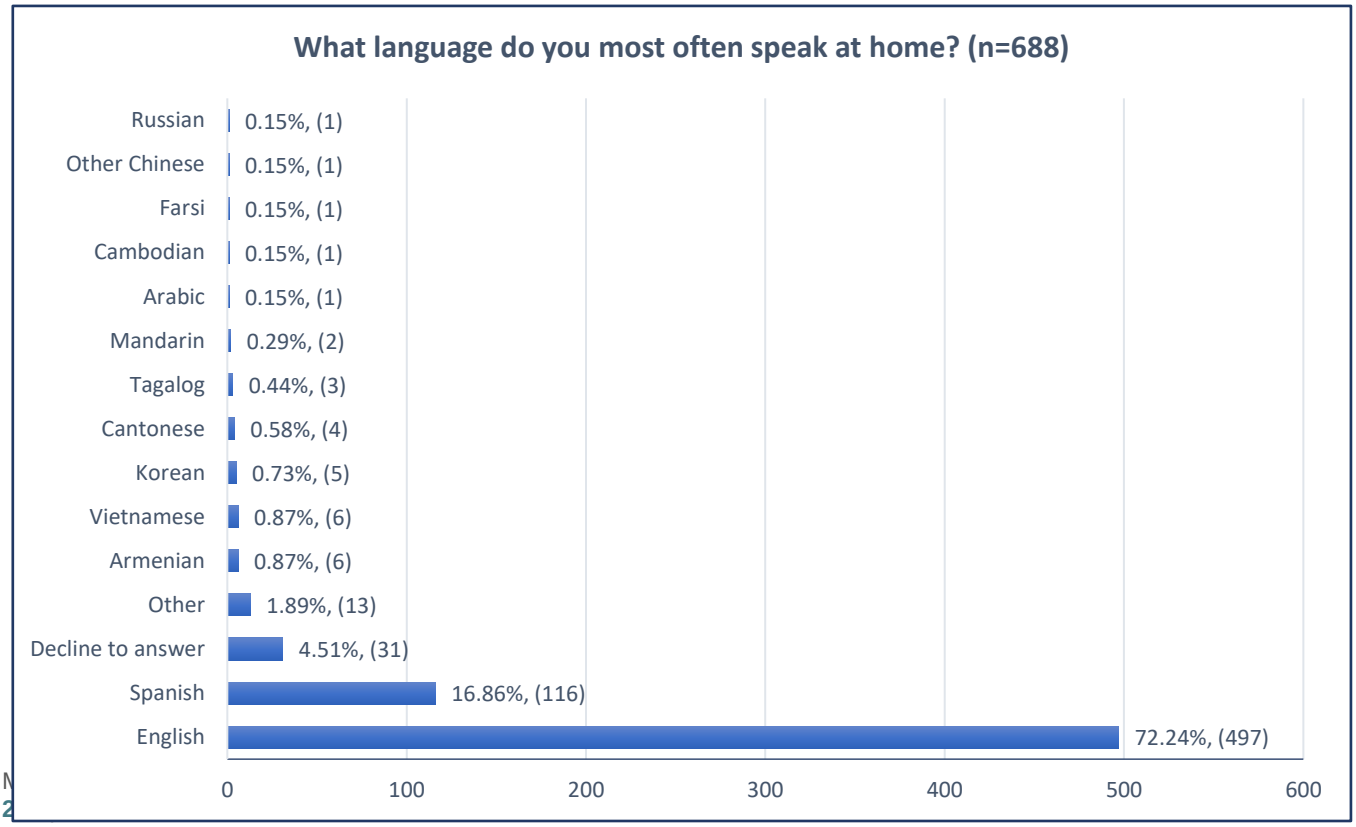
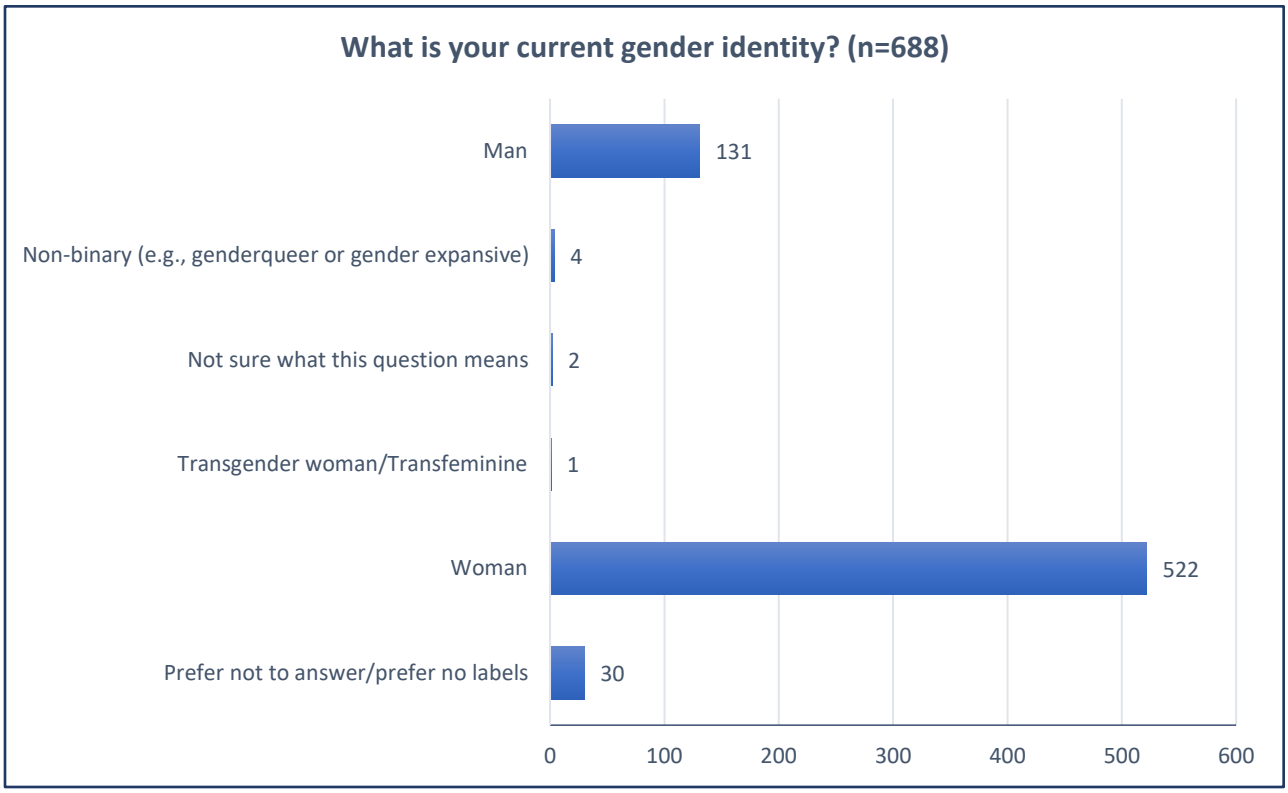
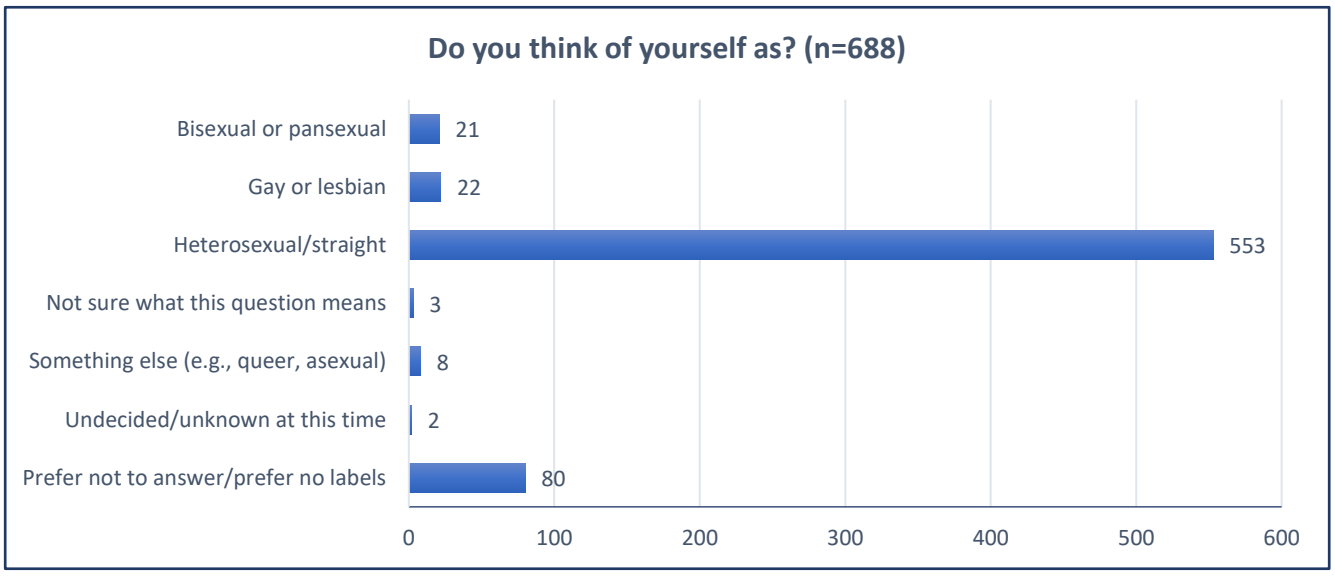


Figure 93. Gender Identity



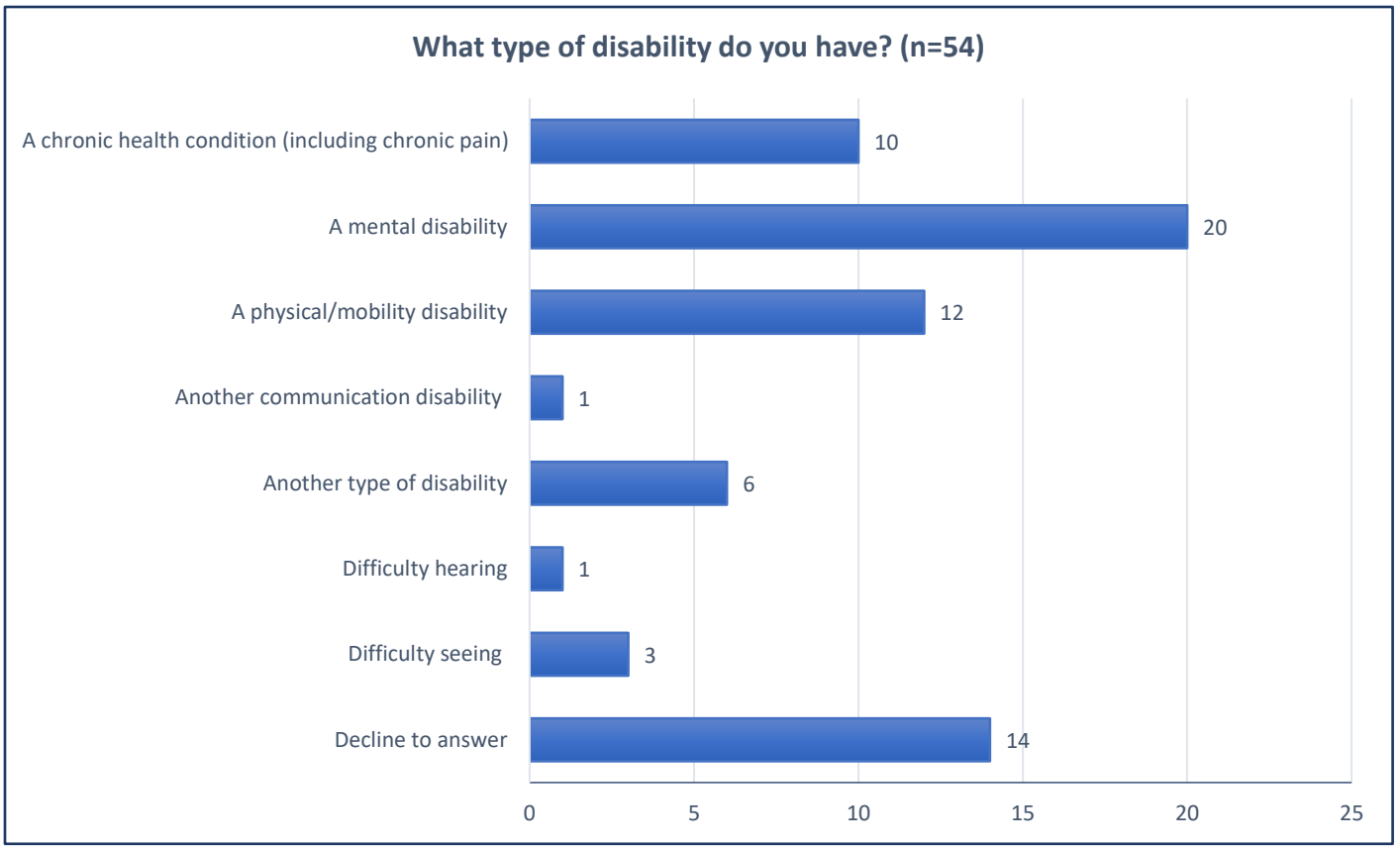
* Total number of gender identities selected may add up to more than 688 as participants are allowed to select more than one response.

Figure 94. Self Identify



*Total number of sexual identities selected may add up to more than 688 as participants are allowed to select more than one response.

Figure 95. Type of Disability



* Total number of disabilities selected may add up to more than 54 as participants are allowed to select more than one response

School Threat Assessment Team (START)

START has years of partnership with various threat management teams in the Los Angeles Community College District (LACCD), the largest community college system in the nation. Through its partnership with the Los Angeles County Sheriff's Department and the LACCD, START has established protocol for managing threats in educational settings. The services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. Additionally, START participates in LAUSD's Threat Assessment Response Partners (TARP) collaborative, and the higher education Threat Assessment Regional Group Evaluation Team (TARGET) to provide on-going consultations and trainings on threat cases. START will continue with its mission to be the driving force in establishing a safe, healthy school environment in the County.

Key Components of START include the following:

- **Training and program consultation:** START provides educational and training programs for select audiences, including school faculty, administrators, campus security, first responders, parents and students. These training programs are designed to improve understanding about the dynamics, behaviors and characteristics of school shooters, as

well as improving situational awareness and timely responses to improve campus safety and wellbeing.

- **Early screening and identification:** START provides case-by-case consultations for individuals or situations of concern. Educational institutions are supported in adopting a multidisciplinary approach to help prevent and mitigate potentially volatile situations.
- **Assessment:** START can assist schools in creating or completing a complete assessment of individual, familial, situational and social factors relevant to the perceived, implied or stated threat.
- **Intervention:** In collaboration with educational institutions and law enforcement agencies, START can provide appropriate responses to threats of violence. The response options can include further assessment and ongoing monitoring, counseling, psychiatric treatment, anger management training and arrest/detention.
- **Case Management and Monitoring:** START staff can also provide post-intervention services such as case consultation and management, linkages to relevant support services and periodic follow-ups and reviews.

START Campaign during FY 2023-24:

- Posted and pinned social media image #1 (classroom) to Facebook, Instagram, Twitter (week of 8/7/23)
- Posted and pinned PSA to Facebook, Instagram, Twitter (week of 8/14/23)
- Posted and pinned social media image #2 (teen texting) to Facebook, Instagram, Twitter (week of 8/21/23)
- Targeted media ads/buys on TikTok (ran for two weeks, starting 8/25/23)

Figure 96. Presentations/Trainings Provided

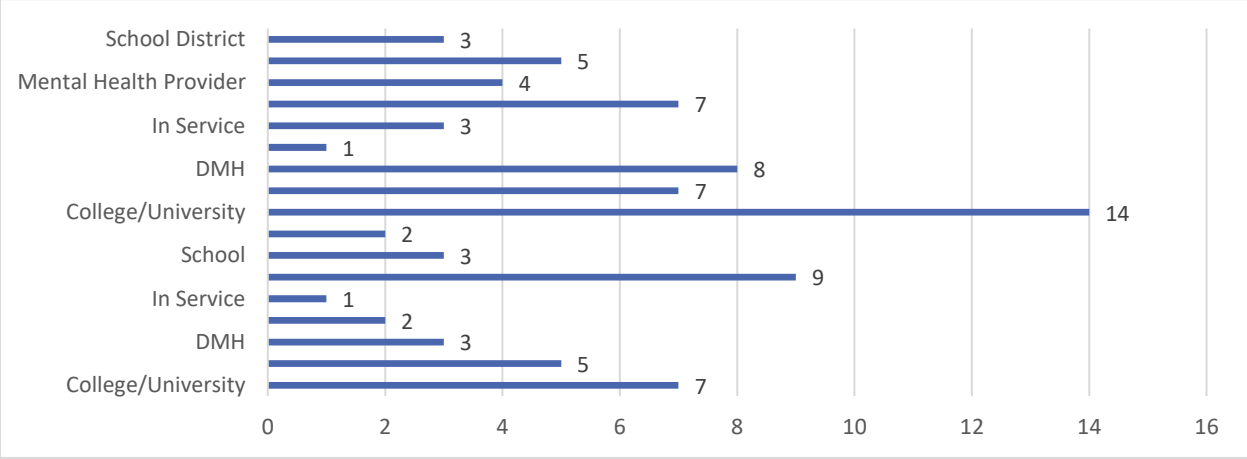


Figure 97. Presentation/Training Topics

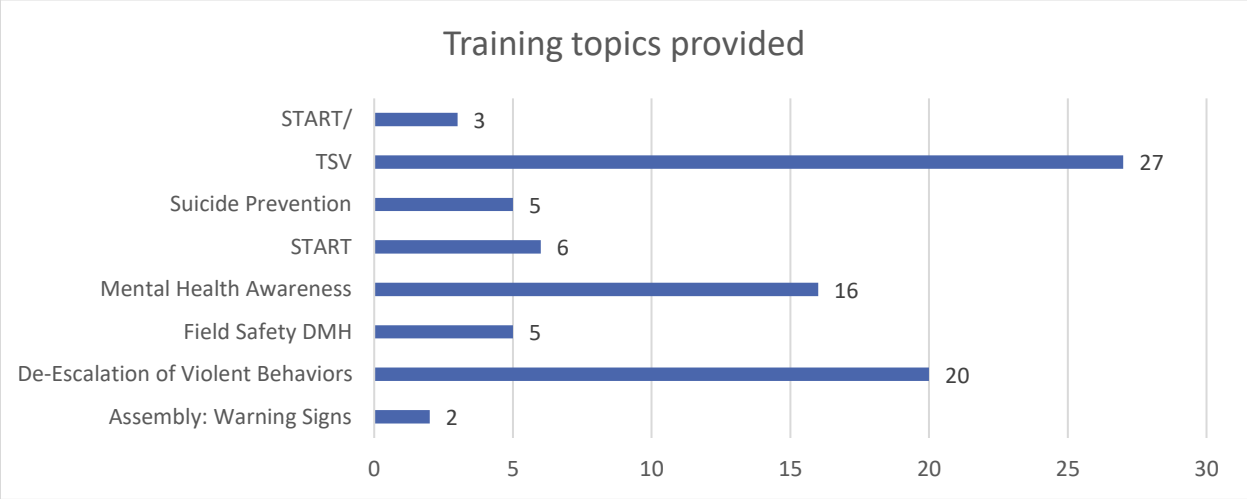


Figure 98. Program Referrals

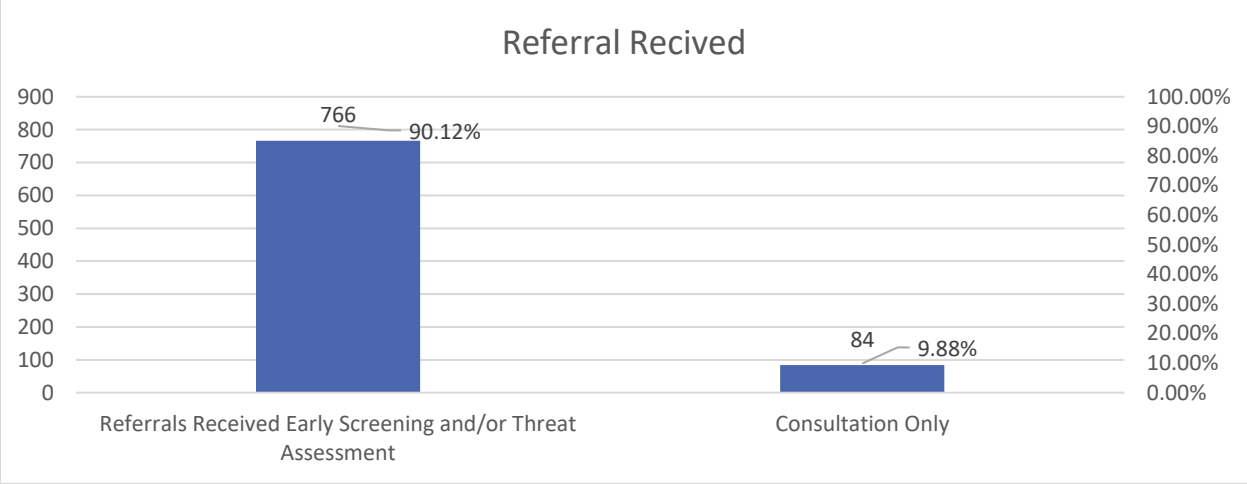


Figure 99. Referral Sources

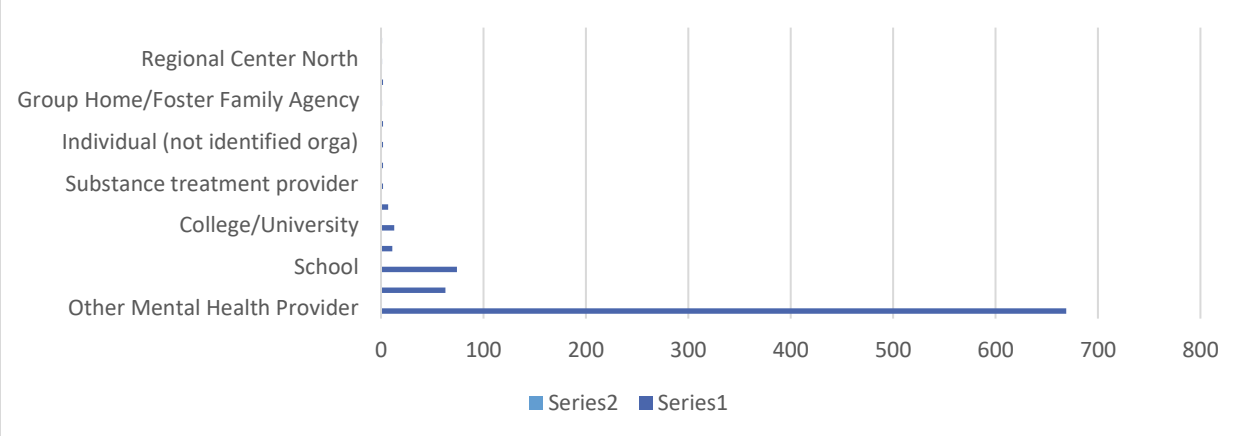


Figure 100. Referral Method

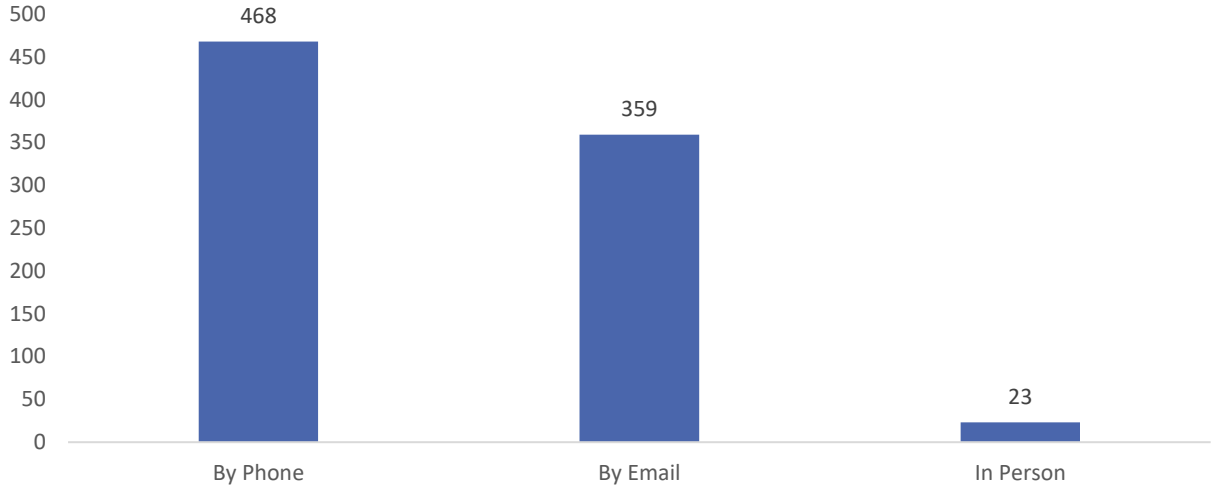


Figure 101. Interventions

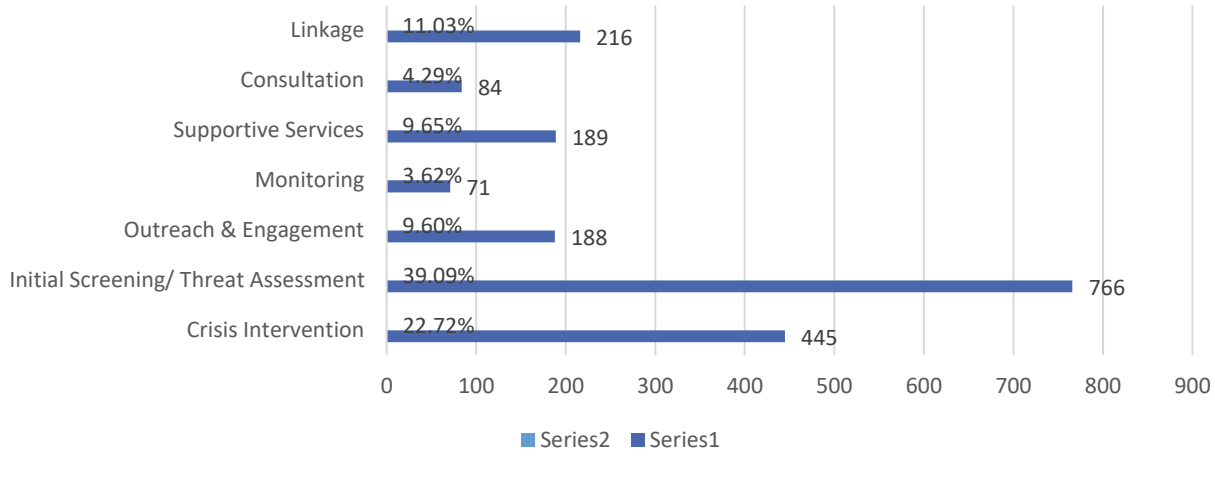
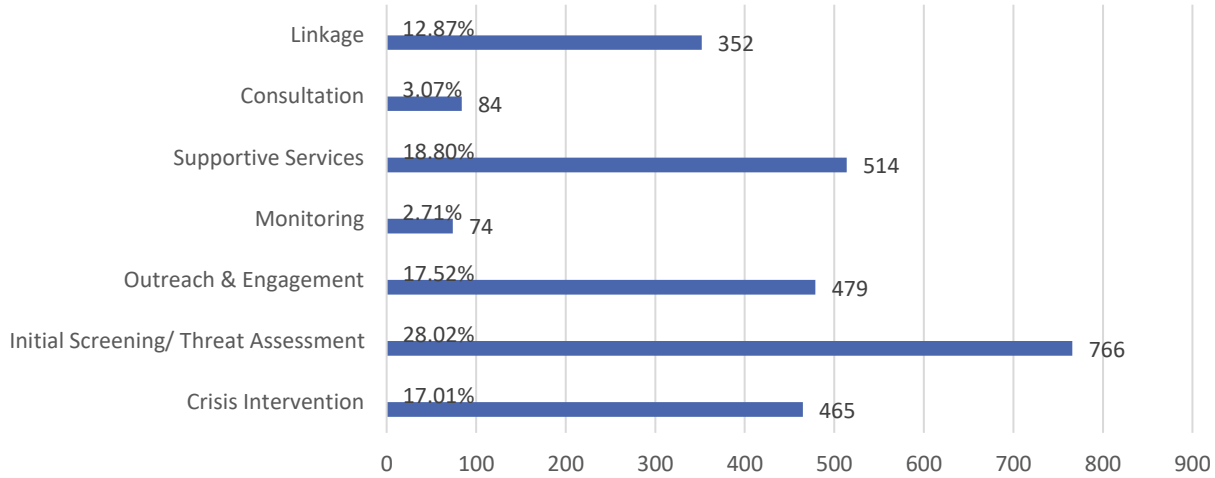


Figure 102. Post Intervention Services



Veteran Suicide Review Team (VSRT)

The purpose of the Veteran's Suicide Review Team (VSRT) of Los Angeles County is to conduct a thorough review of suicides occurring within the county. These reviews will be used to better understand why our residents take their own lives and to take action to prevent future suicides. The Veterans Suicide Review Team (VSRT) evaluates the circumstances leading to and surrounding the suicide deaths of veterans who died in Los Angeles County in order to develop and enhance system-level intervention and prevention measures to prevent suicide among veterans. The Department of Mental Health coordinates weekly Co-Chair meetings to review the outreach to the next of kin of the identified decedents, the decedent status is confirmed at the weekly meetings and any issues are resolved before the case review. The Department of Mental Health is the administrative lead and is responsible for coordinating the monthly case review meeting which is attended by the departments/ organizations named below:

- California Department of Veterans Affairs, Veterans Services Division
- Didi Hirsch Suicide Prevention Center, Suicide Prevention Crisis Line
- LA Suicide Prevention Network Peer, Faith-Based/Clergy representatives
- Los Angeles Homeless Services Association (LAHSA), Planning and Systems Department, Veteran Systems Coordinator
- U.S. Vets, Director of Behavioral Health
- Federal Bureau of Investigation (Los Angeles), Threat Management Coordinator
- Los Angeles County Fire Department, Director of Behavioral Health
- Los Angeles Police Department, Mental Evaluation Unit (MEU)
- Los Angeles County Chief Executive Office, Chief Information Office
- Los Angeles County District Attorney's office
- Los Angeles County Public Defender's office
- Los Angeles County Military and Veteran's Affairs
- Los Angeles County Sheriff's Department, Mental Evaluation Team (MET)
- Los Angeles County Department of Medical Examiner-Coroner
- Los Angeles County Department of Mental Health
- Los Angeles County Department of Children and Family Services, Risk Management Division
- Los Angeles County Department of Health Services, Twin Towers Correctional Facility, Olive View Medical Center
- Los Angeles County Department of Human Resources, Occupational Health & Leave Management Division
- Los Angeles County Department of Public Health
- Los Angeles County Department of Public Health, Substance Abuse Prevention and Control
- Los Angeles County Department of Public Social Services, CalWORKs and GAIN Program Division Program Policy
- Department of Health Services (DHS)

Partners in Suicide Prevention(PSP) / DMH staff are scribes at the case review meetings. DMH provides meeting space and provides training to the Co-Chairs and critical partners utilizing the leading Mortality Review Subject Matter Expert, to deliver the trainings.

The 988 Suicide & Crisis Lifeline

The 988 Suicide & Crisis Lifeline offers 24/7 call, text and chat access to trained crisis counselors who can help people experiencing suicidal, mental health crisis, substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about someone else who may need crisis support. Since July 16, 2022, the 988 Call Center for Los Angeles County has been operated by Didi Hirsch Mental Health Services, under contract with the Los Angeles County Department of Mental Health (DMH). The scope of the 988 crisis call center provider also includes leading efforts countywide to work with 911 public safety answering points (PSAPs) to divert behavioral health calls from 911 to 988.

Intended Outcomes

The 988 Call Center is intended to be a primary entry point to mental health resources for the community. The County seeks to expand the role of the 988 Call Center such that the responsibility for responding to mental health crises is shifted to mental health professionals and resources, instead of a law enforcement response. To that end we are seeking to:

1. Promote 988 to the public as a preferred resource to 911;
2. Shift appropriate calls placed to 911 to the 988 Call Center;
3. Ensure that calls to the 988 Call Center are successfully resolved without the need for law enforcement intervention; and
4. To the extent possible, ensure that calls unresolved by the 988 Call Center are provided further care by a civilian mental health mobile crisis team (FIT), and not by police/EMS first responders.

Key Activities FY 2023-24

1. To better inform and educate the community on the 988 Suicide & Crisis Lifeline, and the differences between the County of Los Angeles' emergency and resource phone numbers, DMH, in collaboration with the County of Los Angeles Fire Department (LACoFD), Sheriff's Department (LASD), City of Los Angeles Police Department (LAPD), 211, and Didi Hirsch Mental Health Services, launched the *Who Do I Call for Help?* awareness campaign. The campaign graphically and simply defines what each phone number (i.e., 911, 988, 211, and 1-800-854-7771) and its associated agency can provide when called. Materials for the *Who Do I Call for Help?* campaign include social media graphics, posters, bookmarks, and wallet-size cards, available in English and Spanish.

2. To facilitate the diversion of calls placed to 911 PSAPs to the 988 Call Center, DMH collaborated with Didi Hirsch and County law enforcement representatives through the Countywide Criminal Justice Coordinating Committee (CCJCC) to produce a Best Practices Guide for coordinating mental health and law enforcement in support of alternative crisis response. The guide includes a framework governing how calls placed to 911 PSAPs that primarily involve mental health concerns may be transferred to the 988 Call Center for handling by crisis counselors, and if necessary, in person civilian mobile crisis response teams. To date, 911-to-988 Call Diversion has only been implemented by LAPD covering the City of Los Angeles. DMH and Didi Hirsch are actively working with the LASD, Pomona Police Department, and South Gate Police Department to expand further, beginning with LASD Lancaster Station in November 2024.

3. In situations in which a call to the 988 Call Center cannot be resolved over the phone, DMH established a system to ensure that those callers could access a FIT team without having to make another call. DMH established a priority line, and trained over 200 988 Call Center agents to warm transfer callers to the priority line in order to request a FIT team response to the caller's location.

Figure 103. Service Comparison from 2023 to 2024

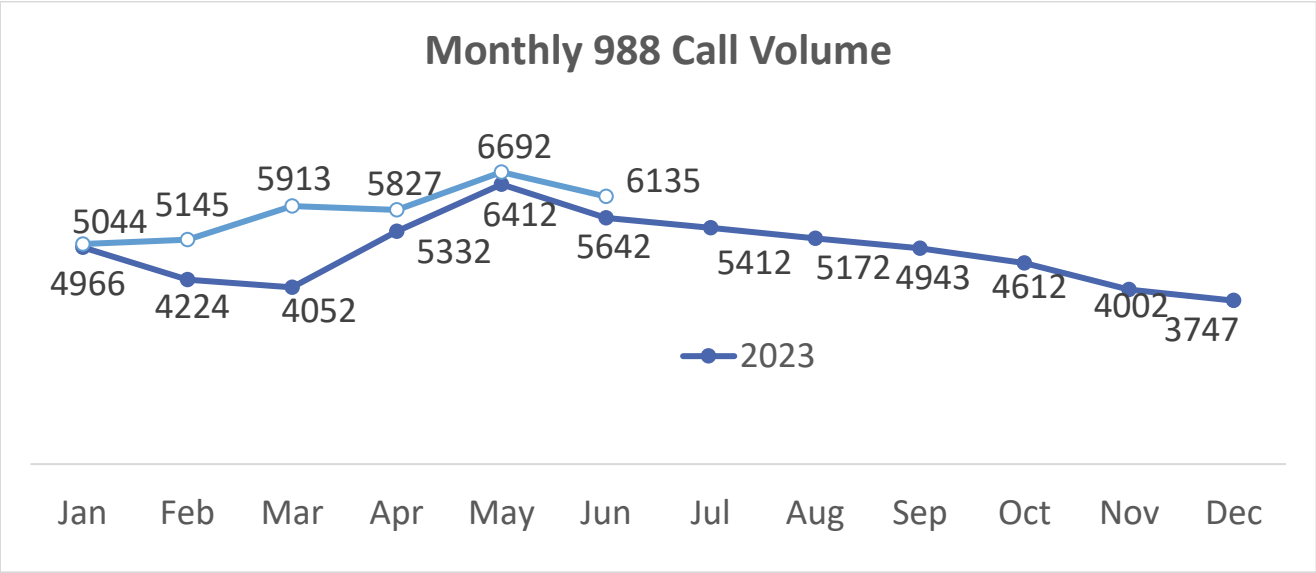


Figure 104. 988 Outcomes

98% RESOLVED OVER THE PHONE WITHOUT INTERVENTION

1% REFERRED TO 911

1% REFERRED TO DMH FIT TEAMS

(WARM TRANSFER FROM 988 TO LAC DMH HELP LINE)

Figure 105. LA County 988 Contacts by Gender and Sexual Orientation (January – March 2024)

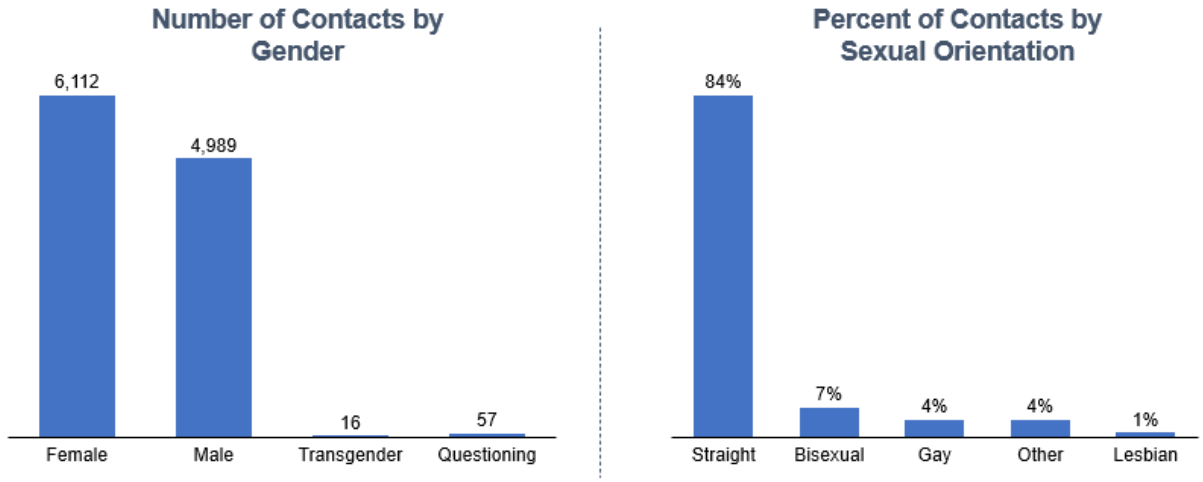


Figure 106. LA County 988 Percent of Contacts by Ethnicity (January – March 2024)

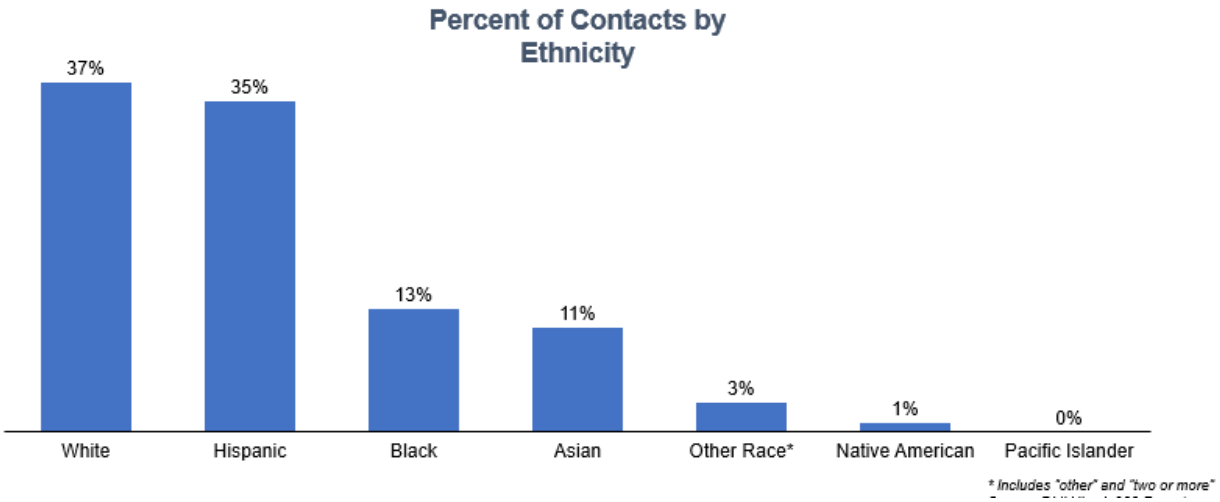


Figure 107. LA County 988 Percent of Contacts by Age (January – March 2024)

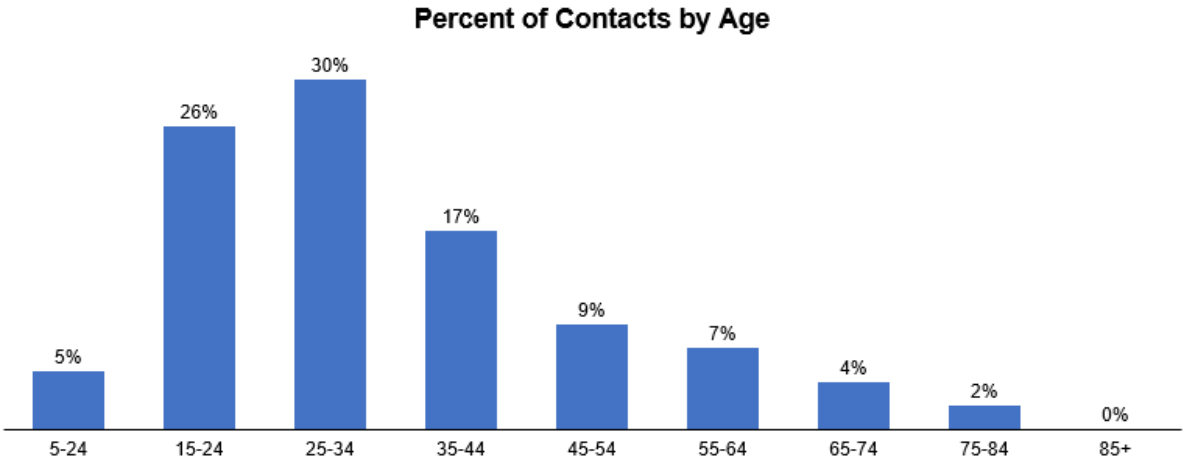


Figure 108. LA County 988 Top Concerns (January – March 2024)

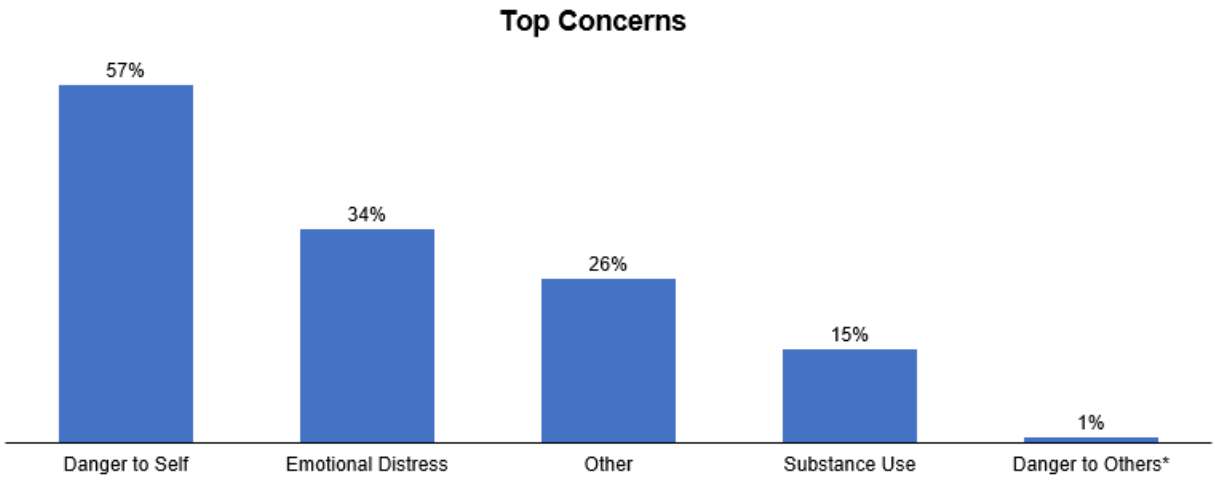
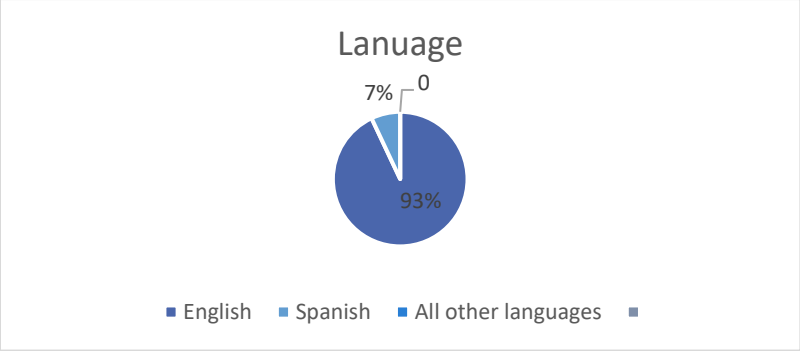


Figure 109. LA County 988 Language Capabilities (January – March 2024)



PEI – Outreach for Increasing Recognition of Early Signs of Mental Illness

The Department funds this function through CSS, specifically through Planning, Outreach and Engagement and through the work of Promotores/Promoter Community Mental Health Workers.

PEI – Access and Linkage to Treatment for Individuals with Serious Mental Illness/Serious Emotional Disturbance Seeking Services through PEI

The Department's provider network provides a full continuum of services and generally do not have PEI services in stand-alone buildings. Individuals presenting for services are assessed and referred according to need. Consequently, this PEI component does not apply to the Los Angeles County and cannot be reported on.

Innovation (INN)

The Innovation programs are designed to do one of the following:

- Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention (PEI).
- Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
- Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

Innovation can occur in virtually any aspect of the community mental health system, including administration, governance, and advocacy.

Innovation programs should result in one (or more) of the following:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Promote interagency and community collaboration related to mental health services or supports or outcomes.
- Increase access to mental health services.

Five percent (5%) of total funding for each county mental health program for Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) is reserved for Innovation. Innovation programs are short-term. At the end of the project a County must decide whether funding should continue using a different source (like CSS or PEI). Evaluation data is used to support decision-making. Evaluations can be qualitative, quantitative or a mix of both and can be formative or summative, outcome or process.

Projects for FY 2023-24	**Projects Continuing/Starting in FY 2025-26**
Innovation 8: Early Psychosis Learning Healthcare Network	Hollywood 2.0
Hollywood 2.0	Interim Housing Multidisciplinary Assessment & Treatment Teams
Interim Housing Multidisciplinary Assessment & Treatment Teams	Children's Community Care Village
New Innovation Project for Consideration: • P.A.T.H.W.A.Y.S. Providing Access to Treatment, Health, Wellness, and Youth Support • Transformation from Peer Resource Centers to Clubhouses • Support for FSP transformation	

Innovation 8: Early Psychosis Learning Healthcare Network

The Department received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for this multi-county 5-year project on December 17, 2018, and DMH entered a contract with UC Davis to execute this project as of July 1, 2020, after initial approval by the Human Subjects Research Committee on April 23, 2020. The Early Psychosis Learning Healthcare Network (LHCN) allows counties who use a variety of Coordinated Specialty Care

models to treat early psychosis to collect common outcome data. They can then use this outcome data to inform treatment and engage in cross-county learning.

Participation in this learning collaborative connects California counties with a national effort to promote evidence-based Coordinated Specialty Care models to effectively treat first episode psychosis and to collect common outcome data. It is a unique California effort to join a national movement to reduce the duration of untreated psychosis and improve the outcomes and lives of individuals experiencing a first psychotic break. Los Angeles County has expanded its population to also include those who are identified as at clinical high risk for experiencing a first psychotic episode.

Beehive is a tablet- and web-based application developed by the UC Davis-led Learning Healthcare Network that is being used by programs to collect client and clinician-reported outcome data and help clinicians, clinic management and County administration visualize client outcome data to help inform treatment and track clinic and Countywide program outcomes. The goals of the Statewide Early Psychosis Evaluation and LHCN are to increase the quality of mental health services including measurable outcomes, and to introduce a mental health practice or approach that is new to the overall mental health system.

Additional funding by the National Institutes of Health (NIH) obtained by UC Davis has allowed the project to further expand to add additional sites across the State. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

The Department's early psychosis coordinated specialty care model is the Portland Identification and Early Referral (PIER) program to identify and comprehensively treat individuals ages 12-25 who are at clinical high risk for psychosis (i.e., prodromal) or have experienced their first psychotic episode. Five (5) contractor teams have been trained in the PIER Model as of December 2019 and began community outreach and direct service in January 2020. As of August 31st, 2024, there are 102 clients enrolled at five (5) clinics across Los Angeles County.

Status of Implementation as of June 30th, 2024:

Stakeholder Advisory Committee and Multi-County Quarterly Leadership Meetings

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative from each participating EP program, and consumers and family members who have been, or are being served, by EP programs. Attendees receive updates and provide feedback on project elements biannually and collaborate on issues around Early Psychosis. Advisory Committee meetings during this reporting period were held remotely to allow for Statewide participation on November 29th, 2023, and June 26th, 2024.

During the November 29th, 2023 meeting, EPI-CAL staff gave a general overview of Beehive enrollment to date and compared information from the previous meeting held in June 2023. Many programs at this point have plateaued enrollment and some provider agencies have not integrated Beehive into their programs to the desired goals.

The Lived Experience Integration (LEI) team, a group of members with lived experience aiming to elevate the lives of persons with psychosis by improving psychosis care, research and public perception. Team members shared about upcoming meetings related to the LEI team as well as

the peer-moderated Discord which supports and provides resources to others living with psychosis.

EPI-CAL staff presented on fidelity reviews conducted at the provider sites. He shared the validity and reliability of the measures used. Challenges were brought up regarding the changes in the programs being evaluated which makes it necessary to continue to review sites on how CSC services are being delivered, so providers can continue to work on improving their fidelity to the CSC model.

EPI-CAL staff shared how several experiences reported on the Adverse Childhood Experiences (ACES) survey in Beehive by persons in Early Psychosis programs was associated with a poorer outlook on life, higher suicidal and homicidal ideation, more housing instability, poor family functioning, and higher nicotine and marijuana use. Persons that identify as LGBTQ also reported higher ACES scores. The importance of addressing ACEs with participants in Early Psychosis programs and targeting areas of family functioning in treatment was emphasized.

Supervisors from two EPI-CAL-participating programs shared their experience on how they integrated Beehive into their clinic and supervised staff on how to use it. They mentioned that it was important to set realistic expectations with consumers and not to overwhelm consumers with too many email or text links. Other supervisors shared that once clients were able to visualize their growth using Beehive, they were more accepting of Beehive being integrated into their clinical work. Supervisors also shared that Beehive should be part of weekly team meetings to address urgent clinical issues. The meeting ended with a discussion about funding streams and preliminary renewal plans.

During the June 26th, 2024, meeting, EPI-CAL staff gave an overview of enrollment over the LHCN and compared changes to enrollment from the previous meeting held on November 29th, 2023. There has been good progress made with our current EP programs including establishment of new programs in the LHCN. The next section covered consumer self-report of education, employment and social activities, and the relationship to overall life satisfaction. Preliminary data shows that younger consumers participate more in education while older consumers (27+) would engage in work or neither work nor school. Data also indicated higher life satisfaction with consumers that reported having positive social relationships and life outlook. Providers were encouraged to focus on improving education, employment and social satisfaction along with symptoms for recovery due to the outcomes of the data.

EPI-CAL staff presented results from consumer and provider interviews looking at benefits and barriers to Beehive. Benefits included mitigating risks via the alert system which allows providers to respond to urgent issues quickly, assisting the assessment process and encouraging consumers to be reflective of their experiences. Barriers included consumers feeling the surveys in Beehive took a long time to complete and some survey questions were triggering.

EPI-CAL staff gave an update on the Duration of Untreated Psychosis (DUP) project and encouraged providers to create and use a DUP form. Currently there are 23 consumers enrolled in the project across 8 different clinics, and the goal is to reach 100 consumers enrolled by Fall 2025. Staff also gave updates about the LEI team and changes to funding including the recent passage of Prop 1 and BH-CONNECT.

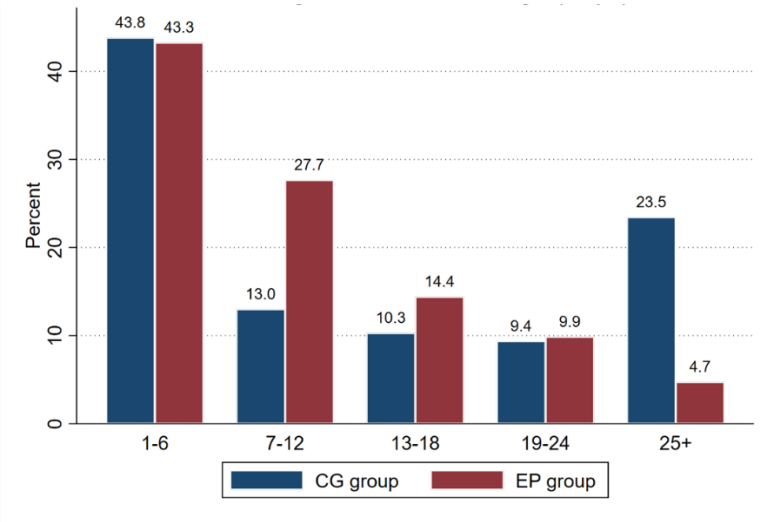
Cost and Utilization Data from Preliminary Analysis comparing Clients in Early Psychosis compared to Standard Care – First Round

The LHCN project examined the service utilization and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing "standard care," during a concurrent time frame in the same community. The primary goal of this component was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties. For Los Angeles, data from the CAPPS program was used in this analysis instead of PIER program data as CAPPS was active during the entire study period.

Length of Treatment

As summarized in Figure 1, it was observed that consumers in both groups remained in treatment for approximately one year (EP=11.1months CG=12.2months), but the average duration of treatment was significantly higher for CG consumers.

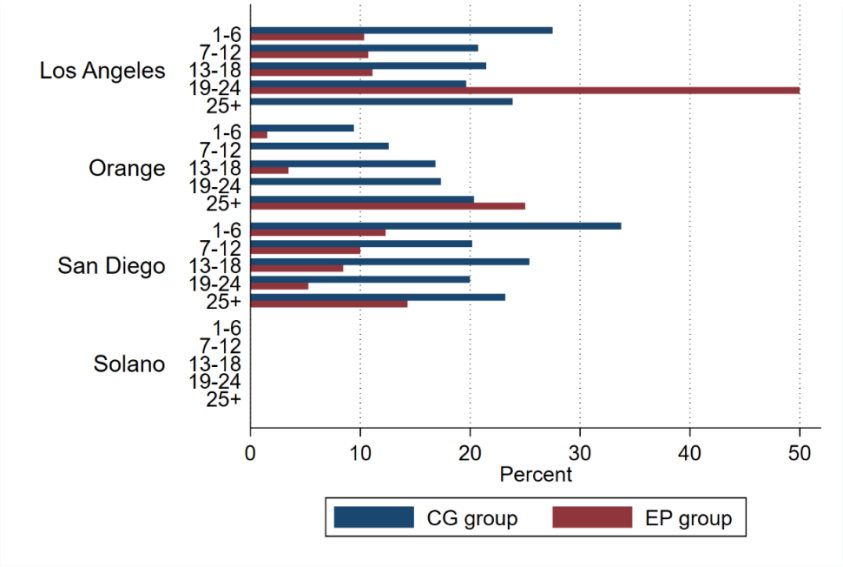
Figure 1: Percentage of Consumers ending treatment within each time period



Although the services provided in EP and CG programs was similar, consumers in the EP group received significantly more minutes of services across all time points. The most significant difference was in collateral services provided per month (EP=140min, EG=66min) and individual therapy (EP=239min, CG=188min) per person.

The use of Day Services/Crisis Stabilization services was rare in both groups, but the highest use of Day Services/Crisis Stabilization was observed in the CG group after 25 months of treatment. The CG consumers had more use of a 24-hour or hospitalization service at least once during their enrollment in services (EP=8.9%, CG=22.4%). The use of the 24 hour or inpatient services was highest in the first 6 months of treatment and after 25 months of treatment as seen in Figure 2.

Figure 2: Proportion of consumers using at least one 24-hour service



The data analysis shows that although more time is being given to consumers and collateral in EP programs, the need for higher level of care is significantly less when providing CSC services.

The mean age for youth in services that were analyzed was 17.8 years. 33.6% were female, 16.4% were non -Hispanic white, 11.8% were black, 6.7% were Asian, 58% were Latino, 2.5% were another race or ethnicity, 4.6% were an unknown race. The youth in the EP group were generally younger than the youth in the CG group. The EP group also had a higher portion of Latino and Asian consumers then the CG group. The EP and CG youth had similar outcome data as the adult EP and CG consumers where the EP youth utilized outpatient services more than the CG consumer, but the need for higher level of care was greater in the CG consumers.

Cost and Utilization Data from Preliminary Multicounty Integrated Evaluation – Second Round

Using preliminary data from the above analysis, EPI-CAL analyzed demographic data for EP and CG groups in order for ensure that both groups were comparable before further analysis.

Demographic Characteristics

The evaluation included 238 youth, 55 of whom were identified from the LACDMH CAPPS EP program (Table 1).

Table 1. Demographic Characteristics of Youth in Early Psychosis Programs

	Combined County Data (Los Angeles, Orange and San Diego)	**Los Angeles**
N	238	55
Age M (SD)	18.0 (2.9)	18.7 (2.9)
Age N (%)		
12-17 years	130 (54.6%)	23 (41.8%)

	Combined County Data (Los Angeles, Orange and San Diego)	Los Angeles
18-21 years	75 (31.5%)	21 (38.2%)
22-25 years	33 (13.9%)	11 (20.0%)
Gender N (%)		
Male	158 (66.4%)	33 (60.0%)
Female	80 (33.6%)	22 (40.0%)
Race/Ethnicity N (%)		
Non-Hispanic White	39 (16.4%)	8 (14.5%)
Black/African American	28 (11.8%)	4 (7.3%)
Asian	16 (6.7%)	1 (1.8%)
Latino	138 (58.0%)	36 (65.5%)
Other/ Unknown	17 (7.1%)	6 (10.9%)

Table 2 shows the difference in demographics between the EP and CG groups. The EP group was younger than the CG group. The groups also significantly differ in their Race and Ethnicity. The EP group consisted of a higher number of Asian and Latino consumers when compared to the CG group. The gender did not significantly differ from the EP and CG group.

Table 2. Demographic Characteristics of Youth in Early Psychosis Programs and a Comparison Group of Youth Receiving Usual Care

	Overall	EP	CG	P-Value
N	25,126	238	24,888	-
Age M (SD)	20.3 (4.0)	17.8 (2.9)	20.3 (4.0)	<.001
Age N (%)				<.001
12-17 years	6,834 (27.2%)	130 (54.6%)	6,704 (26.9%)	<.05
18-21 years	6,913 (27.5%)	75 (31.5%)	6,838 (27.5%)	*n.s.*
22-25 years	11,379 (45.3%)	33 (13.9%)	11,346 (45.6%)	<.05
Gender N (%)				0.163
Male	14,763 (58.8%)	158 (66.4%)	14,605 (58.7%)	*n.s.*
Female	10,245 (40.8%)	80 (33.6%)	10,165 (40.8%)	*n.s.*
Other/ Unknown	118 (<1%)	-	118 (<1%)	*n.s.*
Race/Ethnicity N (%)				<.001
Non-Hispanic White	3,459 (13.8%)	39 (16.4%)	3,420 (13.7%)	*n.s.*
Black/African American	4,141 (16.5%)	28 (11.8%)	4,113 (16.5%)	*n.s.*
Asian	850 (3.4%)	16 (6.7%)	834 (3.4%)	<.05
Latino	11,824 (47.1%)	138 (58.0%)	11,686 (47.0%)	<.05
Other/ Unknown	4,852 (19.3%)	17 (7.1%)	4,835 (19.4%)	<.05

Estimates of Service Utilization and Cost

Table 3 shows standardized estimates of service used in the 1st and 2nd years of treatment after the initial diagnosis of psychosis. The EP group used more outpatient services then compared to the CG group, but the inpatient services was greater with the CG group in the 1st year of treatment. The inpatient services did not significantly differ in the 2nd year of treatment, but the outpatient service utilization continued to be greater for the EP group.

Table 3. Standardized Annual Estimates of Service Use Among Youth Early Psychosis Programs Versus Usual Care in One and Two Years Following Initial Diagnosis of Psychosis

	EP		**CG**		**Difference**		**P-Value**
Year 1	Mean	SE	Mean	SE	Mean	SE	
Outpatient Visits	49.7	2.7	27.4	.2	22.3	2.7	<.001
Probability of Inpatient Use	.363	.030	.427	.003	-.064	.031	.020
Inpatient Days	7.7	1.2	6.5	.1	1.2	1.2	.136
Year 2							
Probability of Outpatient Use	.762	.030	.550	.003	.212	.031	<.001
Outpatient Visits	33.5	2.9	18.4	.2	15.1	2.9	<.001
Probability of Inpatient Use	.197	.030	.149	.002	.048	.030	.226
Inpatient Days	3.6	1.0	3.0	.1	.6	1.1	.437

Table 4 shows the cost utilization for EP and CG groups for the 1st and 2nd years of treatment. The EP group significantly used more funds in the 1st and 2nd years of treatment compared to the CG group, and there was no significant difference in the inpatient cost for EP and CG groups for both years.

Table 4. Standardized Annual Estimates of Costs Among Youth Early Psychosis Programs Versus Usual Care in One and Two Years Following Initial Diagnosis of Psychosis

	EP		**CG**		**Difference**		**P-Value**
Year 1	Mean	SE	Mean	SE	Mean	SE	
Outpatient Costs	$14,784	$1,012	$8,634	$81	$6,150	$1,017	<.001
Inpatient Costs	$7,457	$1,151	$6,254	$110	$1,203	$1,163	.136
Year 2							
Outpatient Costs	$9,393	$881	$5,320	$76	$4,073	$880	<.001
Inpatient Costs	$3,484	$1,010	$2,893	$100	$591	$1,014	.437

Summary

Youth in the CAPPS EP group had more outpatient and service cost in both years of treatment when compared to the youth in the CG group. There was no significant difference in the inpatient cost of service in both years, but the EP group did utilize fewer inpatient services in their first year of treatment as compared to the CG group.

Post-LHCN implementation questionnaires administered to program and county staff

Providers and consumers were asked to complete self-surveys prior to the implementation of Beehive that asked information about demographics and professional characteristics. Consumers were also asked about insight into illness, perceived utility of the application, satisfaction of treatment, treatment alliance and comfort with technology. Beehive training materials were then provided across EP programs to help with better understanding how data can impact treatment and outcomes.

Now post surveys will be given to providers that have successfully implemented Beehive into their programs. Thus far, 36 post survey packets have been completed across 9 EP programs. More providers and consumers across the State will be recruited once there has been enough time from Beehive implementation in their County. This data will be analyzed to better understand how providers and consumers are using the data to effectively impact treatment. Exploratory analysis will be conducted to see the expertise of clinicians using Beehive with consumers.

LHCN enrollment and follow up completion rates for LHCN app in all EP programs

Figure 3 shows the LHCN progress towards EPI-CAL enrollment goals as of May 30th, 2024. If consumers complete the End User License Agreement (EULA) and agree to have their information shared with UC Davis and NIH for research purposes, then they are enrolled. If consumers decide not to share their data with UC Davis and NIH, their data will only be used for quality assurance. The goal was to have 1364 consumers enrolled by this point. In Summer 2022, LHCN staff created a revised enrollment goal based on current enrollment rates. The revised enrollment goal was 498 consumers enrolled. The current enrollment is 597 individuals across all diagnoses, including 436 diagnosed with FEP and an additional 268 consumers that have enrolled, but have not completed their Beehive registration or started their surveys.

Figure 3: LHCN Progress Towards EPI-CAL Enrollment Targets

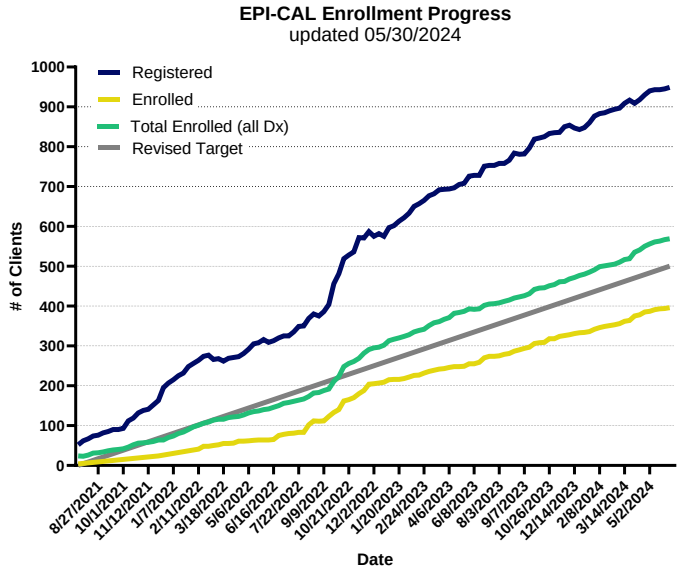


Figure 4 shows all registered consumers regardless of EULA completion. This figure shows room for growth if the consumers become willing to share their data for research purposes. Some sites do not have a bar graph because they do not have any registered users. The goal is to have 70% of consumers agree to data sharing that are also registered in Beehive.

Figure 4: Proportion of Data Sharing with UCD for Research by Site

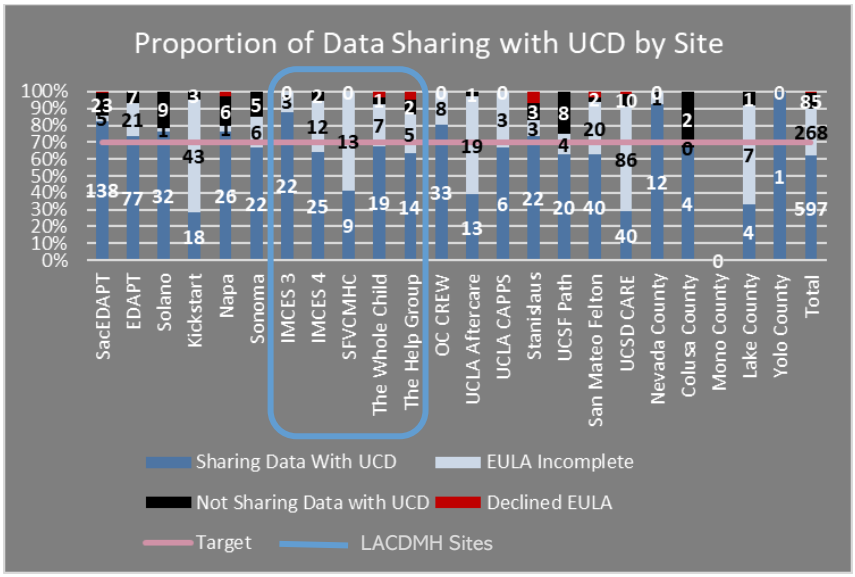
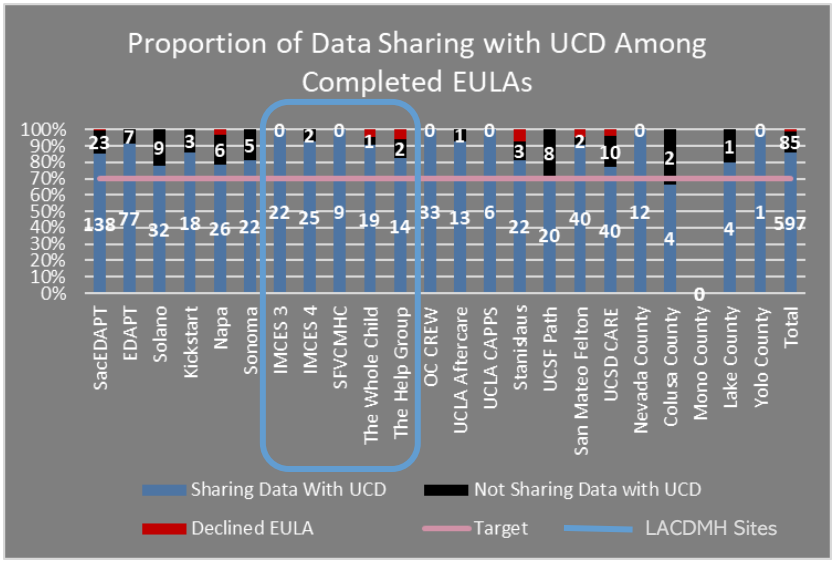


Figure 5 shows the amount of consumers that have agreed to share their data with UC Davis for research purposes. EPI-CAL has exceeded its goal of 70% as it has 88% of consumers willing to share their data for research with 83% of consumers willing to share their data with NIH.

Figure 5: Proportion of Data Sharing with UCD for Research among Completed EULAs



Progress of data collection in all EP programs

23 EPI-CAL clinics have registered 1339 consumers in Beehive as of May 30th, 2024. 51% of the consumers have completed their EULA and are enrolled.

Figure 6 shows survey completion by time point for individuals that have agreed to share their data with UC Davis. Consumers can complete surveys at any point during their enrollment. Consumers might not be able to complete some surveys such as baseline surveys if they were enrolled in Beehive after they were already receiving treatment. 97% of consumers have completed at least one survey in Beehive. Of those clients that have agreed to share their data with UC Davis 95% of consumers have completed at least one survey.

Figure 6: Survey Completion Rates Across EPI-CAL Network

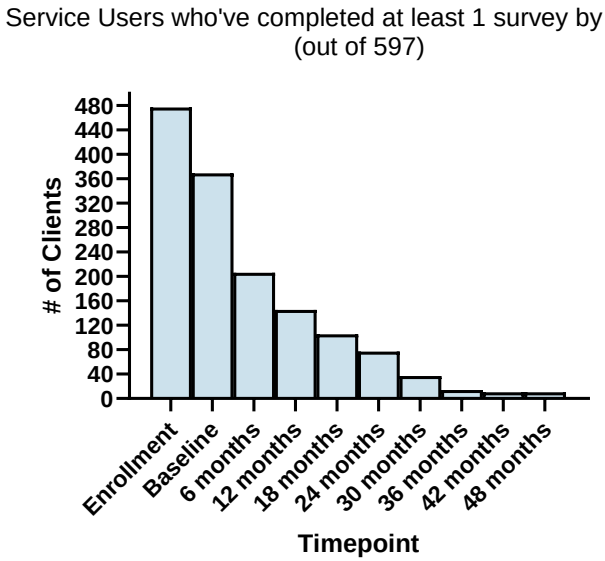


Table 5 indicates all demographic information completed by consumers when initially enrolling into Beehive. More demographic information will be shared once there are more consumers endorsing a specific demographic.

Table 5: Demographic Data from all Participating EPI-CAL Clinics

EPI-CAL Combined Demographics, n = 597 (through 05/30/2024)		
Display Language	**N**	**%**
English	583	98%
Spanish	12	2%
Missing	<5	<1%
Age	**N**	**%**
<12	<5	<1%
12-17	202	34%
18-23	279	47%
≥24	114	19%
Sex at Birth	**N**	**%**
Female	293	50%
Male	293	49%
Intersex	<5	<1%
None of these describe me	<5	<1%
Prefer not to respond	<5	<1%
Gender	**N**	**%**
Female	252	42%

EPI-CAL Combined Demographics, n = 597 (through 05/30/2024)		
Male	281	47%
Non-binary	24	4%
Transgender	9	2%
Queer	<5	<1%
Questioning or unsure of gender identity	5	1%
Other	7	1%
Prefer not to say	15	3%
Missing	<5	<1%
Pronouns	**N**	**%**
He/Him	253	42%
She/Her	213	36%
They/Them	27	5%
Other	5	1%
Missing	99	17%
Race	**N**	**%**
African/African American/Black	70	12%
Asian	61	10%
American Indian/Alaskan Native	<5	<1%
Hispanic/Latinx Only	192	32%
White/Caucasian	182	30%
More than one race	51	9%
Unsure/Don't Know	12	2%
Missing	<5	<1%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	215	54%
Yes - I identify as Hispanic/Latinx	321	36%
Unsure/Don't know	57	10%
Missing	<5	<1%

Table 6 indicates consumer diagnosis which providers are required to enter when enrolling consumers into Beehive. Consumers are categorized as Clinical High Risk (CHR) or First Episode Psychosis (FEP). There is a separate column for consumers which do not have a confirmed CHR or FEP status.

Table 6: Client Diagnoses from all Participating EPI-CAL Clinics

EPI-CAL Combined Diagnoses, n = 597 (through 05/30/2024)	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	35	6%
Genetic Risk and Deterioration Syndrome (GRDS)	<5	<1%
Other	73	12%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset during intoxication	7	1%
Mood disorders with psychotic features	75	13%

EPI-CAL Combined Diagnoses, n = 597 (through 05/30/2024)	N	%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	39	7%
Schizophrenia	86	15%
Schizophreniform Disorder	12	2%
Delusional Disorder	<5	<1%
Brief Psychotic Disorder	<5	<1%
Other Specified Schizophrenia Spectrum Disorder	17	3%
Unspecified Psychosis	74	13%
Other FEP	90	15%
CHR or FEP Status Not Confirmed	61	10%
*Anxiety Disorders**	*17*	*3%*
*Mood Disorders**	*40*	*7%*
*Other Diagnoses**	*26*	*4%*
Not enough Information	<5	<1%
Missing	20	3%

**Individuals may be counted more than once for these diagnoses*

Final Report evaluating the impact of the Learning Health Care Network on Early Psychosis services at DMH

This project contains three levels of data (program level data, county level data and qualitative data). Some of the qualitative data is described here, but most of it was presented in prior reports. This report is focused on providing client level data via self-report, Primary Support Person (PSP) report and clinician report. Data is collected at baseline and then every six months afterwards. Baseline data is referring to surveys completed at start of treatment or intake date, and not at enrollment in Beehive which occurs after the intake. Clients can complete surveys at any point in treatment after they have been enrolled into Beehive, but they would not be able to complete baseline bundles if they were enrolled more then six months after intake date.

Table 7 indicates all data domains collected in Beehive including which domain is rated at baseline or longitudinally, every six months after baseline. The table also indicates who completes the domain as it is important to differentiate is the data was collected as a self-report by client or clinician.

Table 7: Beehive Surveys by Timepoint and Respondent Type

Respondent	Measure	Timepoint	
		Enrollment	Every 6 months (including Baseline)
Client	Registration Demographics	1*	0*
Client	EPI-CAL Baseline Only Questions	1	0
Client	Primary Caregiver background	1	0
Client	Adverse Childhood Experiences (ACES)	1	0
Client	Demographics & Background	0	1
Client	Education	0	1
Client	Employment and Related Activities	0	1
Client	Social Relationships	0	1
Client	SCORE-15	0	1

Respondent	Measure	Timepoint	
		Enrollment	Every 6 months (including Baseline)
Client	Legal Involvement and Related	0	1
Client	Substance Use	0	1
Client	Medications	0	1
Client	Intent to Attend and Complete Treatment Scale	0	1
Client	Modified Colorado Symptom Index	0	1
Client	Questionnaire about the Process of Recovery (QPR)	0	1
Client	Life Outlook	0	1
Client	Hospitalizations	0	1
Client	Life Events Checklist (LEC-5) & PTSD Checklist for DSM-5 (PCL-5)	0	1
Client	Child and Adolescent Trauma Screen (CATS)	0	1
Clinician	Pathways to Care	1	0
Clinician	Diagnosis and DUP	0	1
Clinician	Family Involvement	0	1
Clinician	Risk to Self/Others	0	1
Clinician	Health	0	1
Clinician	Medications	0	1
Clinician	Service Use	0	1
Clinician	Functioning	0	1
Clinician	Symptoms	0	1
PSP *	Baseline Only Questions	1	0
PSP	Demographics & Background	0	1
PSP	Legal Interactions & Related	0	1
PSP	SCORE-15	0	1
PSP	Burden Assessment Scale	0	1
PSP	Modified Colorado Symptom Index	0	1
PSP	Medications	0	1

* PSP = Primary support person; 0 = not available; 1 = available

Qualitative Reviews:

It has also been shown in research that when outcome measure data has been used during treatment with providers and consumers, the treatment outcome has been positive. A qualitative review is continuing to be assessed to see if the Beehive platform in conjunction with treatment for EP shows the same findings. Thus far positive experience with the Beehive platform has been the main theme of the qualitative interviews. Providers have shared that the Beehive platform has improved clinical work, supported in supervision and helped with gathering data for reports. Providers also shared that the urgent clinical issues alert has been helpful in being able to identify clinical risks and provide timely support to consumers. Providers also reported that the outcome measures completed during the initial assessment often helped to inform the completion of the assessment process and develop supportive and relevant treatment plans. Providers reported that they are using the Beehive data in session with consumers to help with psychoeducation, to prioritize topics for conversation and to set goals and review progress. As reported by providers, consumers have found the process of completing surveys to be reflective of their symptoms and personal progress during treatment.

In Los Angeles County 6 providers and 3 consumers completed the qualitative interview thus far, and they have reported similar findings as reported above. Los Angeles County providers also reported that often consumers might not report issues directly in session, but they will indicate concerns on the surveys. This allows the clinician to address the concern with consumers even when consumers are not ready to discuss the problem directly.

Challenges of Data Collection:

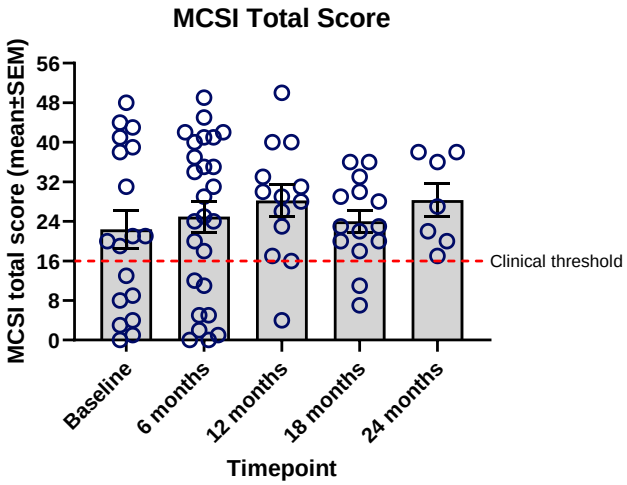
Providers have reported that younger consumers or consumers with developmental disorders such as autism spectrum disorders (ASD) have struggled to understand the concepts brought up in the surveys. This has been despite the surveys being validated for the population. Providers and consumers have also reported that the surveys have been time consuming and burdensome as they go along with an extensive assessment process. There have been some concerns about how culture impacts how consumers might answer questions. Other concerns have been related to consumers being guarded in answering questions at the beginning of treatment, having a lack of insight about symptoms and negative symptoms impacting responses on surveys.

Consumer Level Data collected through Beehive

One goal of the data collected in Beehive is to conduct a statewide evaluation to clarify the effects of the EP program on consumers. By this, we can show that consumers using the EP program in California are showing a significant reduction in symptoms and improvements in functioning and quality of life. As of this report, there have been 134 consumers registered in Beehive in Los Angeles County.

First the Modified Colorado Symptom Index (MCSI) was analyzed. Figure 7 shows that 61 Los Angeles County EP program participants have completed a total of 105 MCSI surveys. There is a wide range of individual scoring (blue circles) at all time points for Los Angeles County EP consumers, which may explain a moderate change in scores.

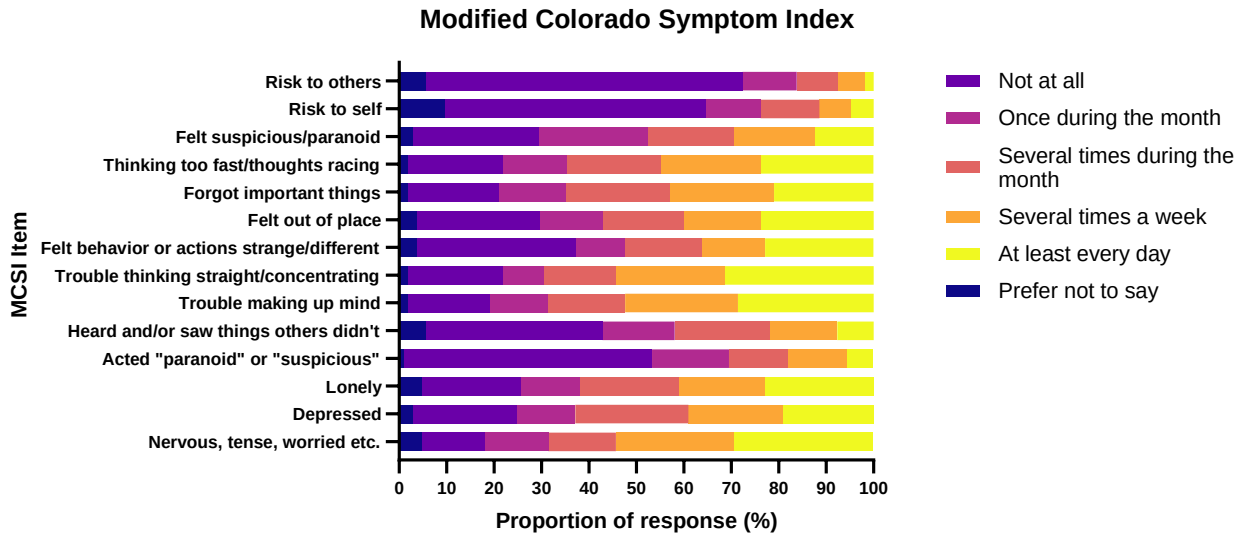
Figure 7: Los Angeles County Current MCSI scores



61 clients completed 105 MCSI surveys; a subset of clients completed the MCSI more than one timepoint. A total of 94 surveys were completed at baseline to 24 months. We are only showing surveys that did not have a "prefer not to say" response and could be scored.

Each item on the MCSI was also assessed to see which items were most frequently endorsed by consumers. Figure 8 shows data for all Counties. Generally, symptoms most frequently endorsed were cognitive symptoms (trouble thinking straight/concentrating, trouble making up mind, forgot important things). Anxiety was also frequently endorsed by clients.

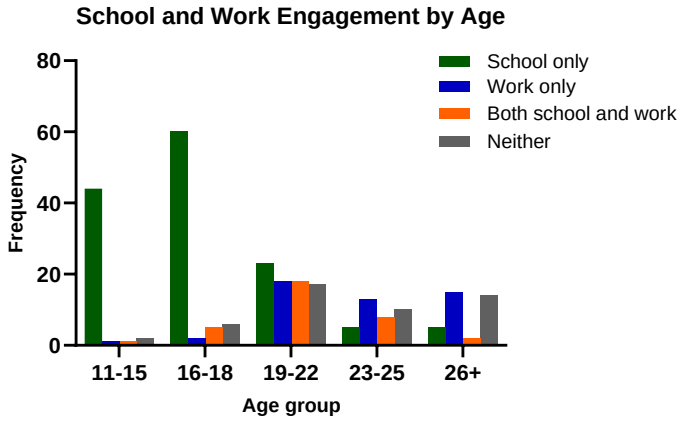
Figure 8: Symptom frequency endorsed on MCSI



School/Employment and Life Satisfaction:

Consumers were also assessed on satisfaction with life and social goals at the beginning of treatment. These self-report items have been followed over time. In Figure 9, younger consumers report being engaged in school more frequently while young adults reporting being engaged in work. Satisfaction with social activities, school and work was a positive indicator of positive life outlook and functioning for consumers.

Figure 9: School and Work Functioning by age



Medication Taking Behavior:

In EP services medication taking and family support are key factors. Often side effects of medication can impact medication taking behavior. It is important for clinical staff to communicate

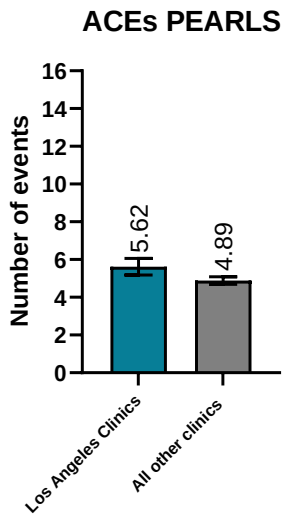
side effects of the medication to consumers, PSPs and other support persons for consumers to understand how medication can impact initial and long-term functioning. Any consumers that endorsed taking at least one prescribed medication were administered a modified version of the Glasgow Antipsychotic Side-effect Scale (GASS). Discrepancies with consumer and PSPs was considered, and clinician report regarding medication was also evaluated. It was found that consumers reporting higher side-effects with medication reported higher concerns that medication could do more harm than good. Medication efficacy would often go down if communication regarding side-effects was not shared with consumers and PSPs during the treatment process. It is important for consumers and families to receive good and consistent communication regarding medication and side-effects to have positive outcomes during EP treatment.

Adverse Childhood Experiences and Family Functioning:

Trauma can often impact psychosis and lead to poor outcomes across multiple domains. This should be addressed during clinical care and assessed during assessment. Approximately 80% of persons with serious mental illness report having some type of trauma experience in life. Not assessing and addressing the trauma in treatment can lead to worsening of symptoms. The Pediatric Adverse Childhood Experiences (ACEs) screening and Related Life-events Screener (PEARLS) in Beehive is used to evaluate traumatic events and symptoms of trauma to better understand the impact it might have on psychotic symptoms.

Based on the data, Figure 10 shows consumers in EP services in all counties report an average of 4.9 adverse life events, however Los Angeles County consumers report an average of 5.62 adverse life events. Persons reporting higher scores on the ACES have a lower life satisfaction outlook and higher suicidal and homicidal ideation. Lower housing stability was also reported with consumers that had higher scores on the ACES. Consumers that report having higher traumatic symptoms have also reported having more modulation in their psychotic symptoms. This has also placed higher levels of stress and lower reported satisfaction with family functioning. It is important to address trauma in treatment as unaddressed trauma can lead to lower levels of success in life and completion of the EP program.

Figure 10: Adverse Childhood Experiences and Related Life-events



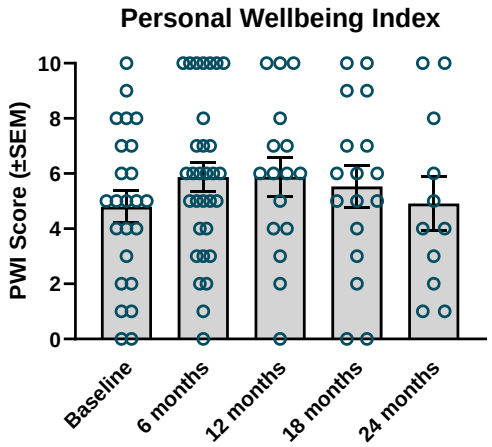
Substance Use:

Consumers that had higher scores on the ACES reported a higher use of nicotine and marijuana. There were no significant changes with alcohol use and other drug data was not reported enough to conduct a proper analysis.

Overall Life Outlook:

The next survey examined was the self-reported overall life satisfaction. This was one question asking consumers how satisfied they are with their life with a score ranging from 0 to 10. In Figure 11, Los Angeles County did not have a significant difference in scores when compared to the State.

Figure 11: Los Angeles County Clients Overall Life Outlook



65 clients completed 107 Life Outlook surveys across all timepoints; a subset of clients completed the PWI more than one timepoint. A total of 99 surveys were completed at baseline to 24 months.

Final Report detailing all program-level, county level outcomes data collected

Los Angeles County has submitted its complete retrospective data set to the EPI-CAL staff and has met with the EPI-CAL staff to discuss the Perspective data analysis and when it will be delivered.

An overall draft report has been submitted detailing all activities effective as of Spring 2019. The overall summary report summarizes the progress of the EPI-CAL team and all participating counties. The three levels of data collected for the LHCN are county level, program level and quantitative data, and the summary report has been broken down into these three sections in a separate report that was submitted on May 12th, 2024.

Discussion and Next Steps

The EPI-CAL team has met all goals that it has set out, and it continues to add other funding streams and counties to the project. This has been one of the first projects to include Universities and Counties to work together to improve the mental health services being provided. Beehive trainings have been completed with all the original starting counties as well as some new added counties. Data is continuing to be gathered and improvements to the Beehive system is being completed with feedback from providers and consumers. Some updates coming are edits to completed surveys and new visualizations. More threshold languages are also being entered to the Beehive system.

The LHCN is a growing network which is allowing more counties to join the network. Although new counties will not be able to provide initial feedback, they will be able to join the network ready to start. New counties can start inputting data without waiting for the completion and development of Beehive. The training process has also been refined and now synchronous and asynchronous trainings can be completed by all programs. Detailed analysis is continuing to be completed and given back to providers. With more counties joining the LHCN the data set will grow and provide feedback to consumers unique to the region that is joining. Information is continuing to be provided to providers to support more enrollment into the Beehive system, and numbers are being

analyzed to see why original projections of enrolled clients are not being met. Cost utilization analysis will continue to conduct as more information and data is being provided, and counties currently not part of the network will be onboarded as they are ready to join.

Fiscal Year 2023-24 is the last year this program was funded under the Innovation plan.

Hollywood 2.0

In year two of the Hollywood 2.0 pilot project, LACDMH focused our efforts on bringing the community stakeholders' voted assets and resources to life turning our vision into reality in Hollywood.

Service Delivery

The H20 pilot is inspired by the public mental health system in Trieste, Italy which incorporates a community-based approach to support individuals living with severe mental illness. This method is fundamentally different from existing services in the Department of Mental Health (DMH) in two keyways:

1. Mental health care is approached in a holistic manner on a continuum rather than siloed programs or services; and
2. There is a heavy focus on psychosocial rehabilitation vs. mere symptom reduction.

Unlike existing services in DMH where programs serve specific focal populations with distinct criteria for referral, acceptance etc., a full array of services and supports have been integrated in the H20 pilot in the form of the Hollywood Mental Health Cooperative which will operate as a clinic without walls. This approach allows increased flexibility to navigate individuals to the appropriate resource (e.g. housing, food, respite, employment, etc.) and care (e.g. intensive field services, urgent care, outpatient clinic etc.). The Hollywood Mental Health Cooperative is an innovative treatment team approach combining outpatient and intensive field services, in partnership with the community, that centers around an individual's needs. New clinic space has been identified to house both teams in Spring 2025. The Hollywood Mental Health Cooperative has served 1,608 clients since its formation in 2023.

Housing

A variety of housing options have been identified to address the various needs of individuals living with SMI in Hollywood.H20's interim housing sites continue to operate at full capacity. 104 clients are currently housed at Mark Twain and Hollywood Walk of Fame. 32 clients have moved to Permanent Supportive Housing from these interim sites. 60 clients are housed at A New Dawn board and care. Integration of groups, community outings and meaningful activities continue to be a priority at each of the housing sites. Heart Forward has recently helped Mark Twain residents establish a community garden. LACDMH has also executed their contract with Anew Dawn for Highly Enriched Residential Care Services (HERCS). This contract provides enhanced staffing, services, and supports to create a non-institutional, highly enriched environment. Collaboration across county departments is underway at each of the housing sites as well. DMH is partnered

with DPH and Homeless Health Care (HHCLA) to provide substance abuse services at Mark Twain and Anew Dawn. HHCLA provides individual and group substance abuse counseling, screening, and linkage to detox or residential treatment. Starting in August, DMH has also partnered with DPSS to provide low barrier linkage to Cal Fresh and General Relief benefits at Anew Dawn, and Mark Twain.

UCC/24 Peer Respite

The Hollywood Respite and Recovery Center is an innovative housing model that includes UCC services and a 24-hour peer respite in one location. LACDMH is revising the original solicitation posted on 5/28/24 in effort to increase bids. Finding property in the Hollywood area within a short timeframe has been one of the main deterrents for agencies applying. LACDMH has worked internally to address the issue and is revising the solicitation to include that we will sublet the current Hollywood Mental Health Center location that will be vacated in Spring for this use. The revised solicitation is anticipated to be posted winter FY 24/25.

Clubhouse

Fountain House has begun accepting their first cohort of referrals for the Hollywood Clubhouse and currently have 26 members enrolled. They have outreached to various H20 housing sites and community meetings to provide information on becoming a Clubhouse member. Fountain House has signed a lease for a long-term space and anticipate moving in summer 2025.

Employment/Education

LACDMH released the solicitation for the Supported Employment contract on 7/12/24. Proposals are currently under review with the goal of awarding the contract in winter FY24/25. The H20 leads from the LACDMH's Housing and Job Development Division held their first employment ad hoc committee meeting with the Hollywood 2.0 provider groups on 8/21/24 to strengthen the employment and education knowledge for both LACDMH staff and community-based providers in Hollywood.

Media Campaign

The contract with media firm IDEO was executed on 7/24/24. IDEO has conducted interviews, site visits, and hosted a kickoff in effort to develop an initial H20 awareness campaign. The campaign is set to be released on 1/6/25.

Evaluation

The evaluation contract with RAND was executed on May 31, 2024. RAND is currently developing their research proposals to submit to both the Institutional Review Board (IRB) and DMH's Human Subjects Research Committee (HSRC) for approval. DMH has developed a H20 activity log that collects outcome data after each Hollywood Mental Health Cooperative client contact. RAND has begun attending H20 specific events and held an evaluation kickoff with key players from the department and Hollywood 4WRD on July 24, 2024. RAND will be turning in their H20 evaluation plan to the department within the next month as the evaluation is anticipated to begin late fall of Fiscal Year (FY) 2024-25. As the evaluation commences, outcomes and annual reports will regularly be added to our DMH H20 dashboard and website.

Interim Housing Multidisciplinary Assessment & Treatment Teams (IHOP)

LA County DMH received approval for the Interim Housing Multidisciplinary Assessment and Treatment Teams Innovations project (heretofore known as the Interim Housing Outreach Program-IHOP) in June of 2023. The program is a collaborative project between LA County Departments of Mental Health (DMH), Public Health-Substance Abuse Prevention and Control (DPH-SAPC), and Health Services-Housing for Health (DHS-HFH). The goal of the program is to increase access to quality mental health, substance misuse, and physical health services for interim housing residents; address and stabilize areas of functional impairment; facilitate transition to permanent housing, improve health outcomes; and prevent returns to homelessness.

Specialty mental health services for the IHOP include outreach & engagement, triage, peer support, screening/assessment, individual and/or group rehabilitation and therapy, medication evaluation/administration, intensive case management, and crisis intervention.

Substance use disorder (SUD) treatment is delivered by DPH-SAPC and includes individual and group support sessions, psychoeducation on substance use, linkage to medication for addiction treatment (MAT), and harm reduction services, (e.g. fentanyl test strips, naloxone, syringe services etc.). For residents in need of more intensive SUD services, the IHOP teams are able to facilitate admission to detox and residential treatment programs.

Support for clients with physical health needs is delivered by DHS-HFH Clinical Nurses and Occupational Therapists who provide short-term, physical health care services including but not limited to: wound care, medication administration and support with activities of daily living/independent activities of daily living (ADL/IADL), until a dedicated In-Home Supportive Services (IHSS) provider can be established.

The first phase of IHOP implementation began in FY 23/24 and primarily focused on four areas: 1.) Establishing the Administrative Infrastructure for the Program; 2.) Recruitment & Hiring; 3.) Establishment of a Project Evaluator; and 4.) Commencement of Treatment Services at Interim Housing Sites. This report provides an update on the implementation of the Interim Outreach Housing Program in FY23-24 to date, and expectations for FY 25-26.

Establishment of Program Administrative Infrastructure

As a collaborative project between three of the largest community health departments in the nation serving the largest county in the nation, the IHOP program required significant administrative structure and formal agreements to initiate key components of the project. Below is a high-level summary of our progress during the first phase of IHOP:

- The project was approved by the LA County Board of Supervisors and incorporated into the DMH line budget during the mid-year budget adjustments in December 2023.
- A memorandum of understanding was established to specify service and fiscal responsibilities for DHS-HFH and DMH for IHOP and to outline the evaluation parameters for DHS-HFH. The MOU was executed on 10/24/24.
- A memorandum of understanding was established to specify service and fiscal responsibilities for DPH-SAPC and DMH for IHOP. The MOU was and executed on 11/26/24.

- A memorandum of understanding was established for data integration/ingestion agreement between DMH, DHS-HFH and DPH-SAPC and LA County Chief Information Office (CIO) to support the Interim Housing Outreach Program's impact and effectiveness using data from the County's integrated InfoHub. The MOU was drafted and received preliminary approval from DMH Counsel. The draft is currently under review by CIO.
- DMH, DHS-HFH and DPH-SAPC established cross agency workgroup meetings to plan program workflows, referrals pathways, operations and problem solve implementation barriers
- DMH, DHS-HFH and DPH-SAPC initiated IHOP kick-off meetings with the Los Angeles Homeless Service Authority (LAHSA) leadership and LA County interim housing directors to introduce the IHOP program and services
- DMH, DHS-HFH and DPH-SAPC established regional meetings with interim housing operators in service areas 4 and 6 to introduce the IHOP program and services
- DMH, DHS-HFH and DPH-SAPC and LAHSA established monthly interim housing funders meetings to discuss IHOP progress, problem solve concerns and/or case conference on complex resident concerns
- Developed IHOP marketing material including a multi-agency brochure highlighting services and access points and a slide deck to educate IHOP stakeholders.
- To address the extensive care coordination needs required by the 3 participating departments it was necessary to identify a shared technology platform for IHOP. NetSmart offered a care coordination solution (CareManager) that has data integration capability with the DMH electronic health record (EHR) system and the capacity for interoperability with the DPH-SAPC and the DHS-HFH EHR. Because DMH had already implemented a CareManager with the launch of the County's CARE Court program, the platform's ability to support care coordination had been vetted and the exiting contractual relationship with DMH increased the accessibility as a solution for IHOP. The respective departments agreed to use CareManager for IHOP and incorporated data use agreements within their respective MOUs. Planning meetings with the respective Departments and the NetSmart team to establish workflows, data dictionaries etc. began August 5, 2024 the IHOP CareManager go-live date was December 2, 2024. Due to the fact that the DHS-HFH commenced their service portion of the IHOP program prior to DMH and DPH-SAPC, the IHOP team is currently working to enter all IHOP data pre CareManager Go-Live.
- The combined IHOP program includes 228 FTEs comprised of administrative, clinical and paraprofessional staff, operating across all eight service planning areas of LA County. Finding office space to house the administrative, central triage center and regional teams was, and remains a significant lift. Thus far space has been secured for the Central Triage Center and service areas 2,4,5, 6 and 8, with space identified though not yet finalized for the remaining three service areas. The IHOP teams are co-located with DHS-HFH and DPH-SAPC in Skid Row in Service Area 4, at the Martin Luther King Jr. Behavioral Health Center in Service Area 6, the DMH Administrative Office in Canoga Park in Service Area 2, and at the Edelman Westside Office in West LA in Service Area 5. We have identified space in Service Area 3 at the East San Gabriel Mental Health Clinic in the City of Covina, in Service Area 7 at the City of Commerce Human Resources building, and in Service Area 8 at South Mental Health Center.

Recruitment & Hiring

Due to nationwide labor shortage in the mental health and homeless services field, a significant amount of energy was focused on the recruitment, hiring and retention of staff for the IHOP project across all 3v departments. Below is a summary of progress to date:

- Under the delegated authority granted by LA County's Emergency Declaration on Homelessness Ordinance position authority was granted to hire on the 170 full-time equivalent (FTE) positions in March 2024 paving the way to recruit and hire program leadership.
- The Program Manager for the North County operations of the IHOP program was hired in April 2024.
- Under the delegated authority granted by LA County's Emergency Declaration on Homelessness the program began an aggressive recruitment and hiring campaign which created efficiencies in the County hiring processes and allowed for targeted recruitment of candidates interested in working in the homeless services. Recruitment efforts were focused on the identification of high-quality candidates with cultural competence to address the needs of communities served by IHOP.
- DMH's hiring plan for the mental health component of IHOP included 3 phases starting with program leadership and phasing in regional teams to align with the point in time homeless count. Phase 1 included the staff for service areas 4 & 6 (which respectively have the highest rates of homelessness in the county) and the program's centralized triage center (CTC). Phase 2 included supervisors for service areas 1,2,3,5,7 and 8 and focused on direct service staff for service area 2 (which is the most populous service area in the county and has the 3rd largest population of people experiencing homelessness) and service areas 5 and 8. Phase 3 includes hiring of all remaining direct service staff for service areas 1,3, and 7. To date DMH has made employment offers to 129 of the 170 positions allocated for this project. Of these, 68 staff have on-boarded and actively providing services, 61 candidates are pending HR processing. We are actively recruiting for the remaining 41 positions using traditional civil service exams and emergency appointments to accelerate program implementation.
- The DPH-SAPC staff completed hiring on 23 of 28 Client Engagement and Navigation Service (CENS) staff. These individuals are actively working in the IHOP program and DPH-SAPC is recruiting for the remaining 5 positions. Due to a nationwide shortage of mental health professionals DPH has had some difficulty recruiting the 16 Psychiatric Social Worker positions allocated to IHOP. To address this DMH is combining hiring efforts with DPH to support recruitment including joint hiring fairs and direct recruitment at local universities.
- The DHS-HFH component of the IHOP program received their grant from the managed care organizations (LA Care and Healthnet) prior to the MHSA-INN project approval. As such, DHS hired ~90% of their staff and has been actively providing functional assessments, connecting individuals to transitional/health care to support activities of daily living since October 2023.

Establishment of Project Evaluator

Using the delegated authority granted by LA County's Declaration on Homelessness the Department received approval to enter into a sole source contract with California Policy Lab (CPL) and the Regents of the University of California Los Angeles (UCLA) for the evaluation of the IHOP project. CPL was selected due to their vast experience working with the complex matrix of service

providers, systems and policies in LA County's homeless services system. A draft statement of work for the project evaluation has been developed and is currently under review by CPL-UCLA.

Commencement of Treatment Services at Interim Housing Sites
As previously noted, the DHS-HFH portion of IHOP has been actively engaged in the provision of services to interim housing residents in service planning area 4 since October 2023. DMH & DPH-SAPC began providing services in collaboration with our DHS partners in October 2024 following recruitment, hiring and onboarding of staff. The program is now fully operational in service areas 4 & 6, which respectively represent the highest portion of people experiencing homelessness in the county. While hiring and onboarding efforts have been underway DMH & DPH-SAPC began delivering services to high acuity interim housing residents in service area 2 with a plan to fully go-live in Service Area 2 March 1, 2025. The next roll-out of regional IHOP teams will be in service area 8 followed by 5,3,7 and 1. The program is expected to be operational in all eight service planning areas by June 20, 2025.

Since inception (with DHS-HFH being the only service provider beginning October 2023) the IHOP program has received over 1200 referrals. To date, 597 referrals were submitted in FY23/24, and 717 referrals were submitted in FY24/25.

Expectations for FY 25-26
For the balance of FY 24/25 and continuing in FY 25/26, the IHOP program will continue its focus on service delivery and full implementation of the program. Priority goals for FY25/26 are as follows:

- Recruitment and hiring of remaining IHOP staff including DPH clinicians for inpatient SUD treatment.
- Ongoing identification of training needs for IHOP staff and establishment of a learning pathway for IHOP direct service staff.
- Full execution of the contract with CPL-UCLA for the evaluation of the IHOP project
- Full execution of the MOU with LA County Chief Information Office for the evaluation of the IHOP project
- Establishment of IHOP logic model to include relevant inputs, activities, outputs and desired outcomes for all participating departments
- Establishment of metrics and baseline measures to support the program evaluation
- Establishment of key performance indicators for the IHOP project to include service delivery and process goals
- Development of a public facing IHOP performance dashboard
- Ongoing refinement of the IHOP project via analysis of data and iterative adjustments to program operations and/or workflows

Children's Community Care Village

This Innovation project was approved by the MHSA Oversight and Accountability Commission on November 17, 2023. The duration of the project is five (5) years. The project is scheduled to launch in FY 2024-25.

The proposed project will provide a continuum of mental health services and resources to help improve the health, wellbeing, and social value indices of the children and families

in SA 6 by creating new mental health programs that do not currently exist in Los Angeles County and co-locating them with enhanced existing programs all in one location.

The LACDMH provides specialty mental health services for children through a network of directly operated and contracted community outpatient clinics across the County. LACDMH has identified a community-based non-profit organization, Kedren Health, Inc. (Kedren), a Community Mental Health Center, to partner with for this Innovation proposal because of its long and deep ties to the local community as well as their experience with the array of mental health services for children.

The CCCV will demonstrate the first of its kind, best practice "village" concept dedicated to children and families that will include the delivery of the new services listed below and include the existing children and youth services at Kedren (i.e., acute inpatient, FQHC and outpatient programs). These services/programs will be integrated into new programs to ensure a full continuum of care is available to provide our clients with the right care at the right time and right place. New services include:

- Intensive Case Management with an assigned care coordinator for each family as part of a Continuity of Care and Treatment Team to coordinate care among the continuum and ensure child and family voice and access to the most appropriate level of care.
- A full spectrum of children and youth mental health outpatient services including outpatient care and Integrated Comprehensive and Intensive Care for children.
- A children and youth crisis residential treatment program (The first and only CRTP in LA County dedicated to children and youth).
- A children and youth crisis stabilization unit.
- On-site transitional housing for children and families in crisis to include units for parent-child interactive therapy.

These new services will integrate and augment with the existing services on the same campus and surrounding network of services that are not funded with MHSA which includes but is not limited to:

- An inpatient acute psychiatric hospital,
- Federally Qualified Healthcare Center (FQHC) for primary and specialty care,
- Inpatient and outpatient pharmacy,
- Social services linkages,
- Community integration and reintegration programs,
- Parental supports and treatment for mental health and substance use,
- Transitional housing for families experiencing homelessness, and
- Work and life skill development programs.

Collectively, these services are designed to increase access to care, minimize disruption in the life of the child, youth, and family, and directly address some of the needs outlined in this proposal:

- Improve access to health and mental health resources.
- Address the needs of children, youth, and families with limited access to transportation.
- Reduce homelessness.
- Improved success in school.
- Reduce incidence of neglect and abuse by assuring timely access to care in times of crisis.

For a full copy of the proposal, please the DMH website, MHSA announcement page: MHSA Announcements - Department of Mental Health (lacounty.gov)

The following is an Innovation Project for consideration: The Behavioral Health Services Act (BHSA) Transformation Project

DMH is seeking support to join an already approved Statewide INN project to provide consultation, technical assistance and support for DMH and its providers as they transition from MHSA to BHSA. DMH is focused on supporting transformation of Prevention, Full Service Partnership, and Client Run Centers.

Transformation from Peer Resource Centers to Clubhouses

According to the approval of Proposition 1 and ongoing stakeholder feedback, the Los Angeles County Department of Mental Health (LACDMH) proposes this Innovation project to redesign the system in preparation for the county's transition to BHSA and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative. The purpose of this INN Project is to transform the existing Peer Resource Centers into the Clubhouse model, assuring alignment with BHSA and BH Connect.

To support and facilitate this system-wide transformation, LACDMH plans to contract with a consultant to assess the system's readiness for these changes, evaluate and identify effective strategies, and successfully redesign and implement the Clubhouse model.

Through the proposed Innovation project, LACDMH seeks to transform the existing Peer Resource Centers into Clubhouses that utilize the International Standards for Clubhouse Programs that are defined by Clubhouse International, https://clubhouse-intl.org/wp-content/uploads/2020/12/standards_2020_eng.pdf. This includes obtaining and maintaining Clubhouse International Accreditation.

This project proposal aims to implement a promising community-driven practice or approach that has proven successful in a non-mental health context and adapt it for the mental health system.

The project will establish clubhouses by supporting, educating, and providing centralized technical assistance to providers. The goal is to phase in an expansion of billable revenue streams, ensuring that Peer-led locations can sustain essential prevention and early intervention programs within our community.

P.A.T.H.W.A.Y.S. Providing Access to Treatment, Health, Wellness, and Youth Support

Following the approval of Proposition 1 and the imminent centralization of MHSA Prevention funds at the state level, counties are now positioned to apply for a deferral of fund reversion by submitting a strategic extension proposal. The Los Angeles County Department of Mental Health can capitalize on this development to propose a three-year extension aimed at enhancing Equity Workforce Capacity and piloting a Non-Traditional Medi-Cal Billing Contracting Demonstration.

With the impending centralization of Prevention funds back to the State, many DMH funded Non-Traditional prevention programs are at risk. Prevention Contractors/CBO's don't have the infrastructure to provide full range of specialty mental health services however provide a lot of case management and rehabilitative types of services. The LAC Board of Supervisors (BOS) priorities include equitable contracting processes that bring in small businesses to contract with LAC, this effort aligns with supporting small CBOs in capacity and infrastructure building to provide sustainable services within their communities.

The Prevention Division proposes targeted one-time funding and technical assistance (TA) to strengthen programs with proven outcomes. This initiative aims to enhance organizational capacity, achieve Medi-Cal certification, and ensure the long-term sustainability of these programs by claiming Medi-Cal. Thus, the Prevention Division is proposing a pathway ending in new CBOs contracting with the Department to deliver claimable services, through a contract that is not the traditional SD M/C contract.

Consultation Services for Full Service Partnership Transformation

The FSP program provides a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness. This project will allow for technical assistance and support for outpatient providers transitioning to become Full Service Partnership providers and will support any newly contracted Full Service Partnership providers.

Workforce Education and Training (WET)

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

The County will transfer funds from its CSS account into the WET account to fund the following WET categories:

- Training and Technical Assistance
- Residency and Internship
- Financial Incentive
- Mental Health Career Pathway

Training and Technical Assistance

1. Public Mental Health Partnership: UCLA Public Partnership for Wellbeing Agreement - UCLA Affiliation Agreement

The Public Mental Health Partnership (PMHP) focuses on training and technical assistance for the Full-Service Partnership (FSP) and HOME Teams run by LACDMH. Since inception, the PMHP has created a large library of virtual trainings and resources that are now organized and housed on the Wellbeing for LA Learning Center website. These resources, while customized to meet the needs of the FSP and HOME Teams individually, can be applied across programs to help build key skills and promote best practices for supporting individuals experiencing homelessness.

During FY 2023-24, the PMHP delivered 332 live trainings representing 641.5 training hours delivered to 12,523 participants. The training team provided trainings on a wide variety of topics, including Person Centeredness, Cultural Humility, and Psychiatric Disorders & Symptoms. The training topics that were delivered to the most participants in FY 2023-24 included Manualized Evidence-Based Practices (1,748 participants) and Crises & Safety Intervention (1,436 participants). In addition, 13,038 PMHP Anytime Trainings were completed during the reporting period.

Table 85. Public Mental Health Partnership Trainings FY 2023-24

Topic Name	Number of Trainings	Training Hours	Number of Participants
Manualized Evidence-Based Practices	24	63.5	1748
Crisis & Safety Intervention	21	70.5	1436
Service Delivery Skills	35	43	1294
Team-Based Clinical Services	51	79	1159
Continuous Quality Improvement	73	73	1157
Person Centeredness	19	55	1076
Co-Occurring Disorders	15	43.5	553
Cultural Humility	14	43	605

Topic Name	Number of Trainings	Training Hours	Number of Participants
Ethical Issues	5	12	393
Provider Wellbeing	36	35	763
Trauma	14	46	1025
Psychiatric Disorders & Symptoms	11	45	602
Everyday Functioning	3	5	136
Persistent & Committed Engagement	7	12	468
Whole Person Care	4	16	111
TOTAL:	332	641.5	12,526

2. Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T) (UCLA Partnership for Wellbeing Agreement)

During FY23-24, the focus for BASIC-T was on the recruitment of early career neuropsychologists and a proof-of-concept fellow who will lay the foundation for the Psychology Training Program arm of BASIC-T. In addition, BASIC-T continues to work with LACDMH to finalize the Pearson digital assessment contract, enabling LACDMH to utilize the most technologically advanced and up-to-date instrumentation. In the past year, the Cognitive Advocacy Series produced a foundational curriculum that can now be advanced and co-developed with input from LACDMH psychologists on the most relevant topics to their local practices. BASIC-T has assisted LACDMH psychologists and their trainees in conducting much needed psycho-diagnostic assessments and cognitive screeners for their clients, which has helped to tailor interventions in more appropriate ways for their most complex and vulnerable clients seen in clinics.

As part of the revitalization of the disciplinary specialty of psychology within LACDMH, BASIC-T has restructured and launched both the Psychology Training Program and Workforce Development and Continuing Education Program. Specifically, BASIC-T has worked this year to recruit and deploy early career neuropsychologists (ECN), and will continue to do so on a rolling basis for each of the four pilot sites in Service Areas 2, 4, 6, and 8 (Valley Coordinated Children's Services, Northeast Mental Health Center, Augustus F. Hawkins Mental Health Center now housed within the new Mark Ridley-Thomas Behavioral Health Center at the Martin Luther King, Jr. Hospital, and Specialized Foster Care headquartered in Torrance, respectively). As young professionals, these ECN will inject new assessment expertise into the LACDMH infrastructure, helping to establish a more systematic approach to assessing clients within the specialty public mental health system. This will support evidence-based treatment decisions and enable more consistent tracking of client outcomes

BASIC-T has established weekly technical support sessions, program development, and didactic instruction in a train-the-trainer model for current LACDMH psychologists and their trainees, allowing community psychologists to conduct screening and triage assessments in a graduated and scaled fashion with their clients, thereby directly addressing the current backlog of assessment service requests within their service area. In addition, a triage system was created as a way to bridge current assessment needs with the incoming dedicated BASIC-T fellow and early-entry neuropsychologists. At Valley Coordinated Children's Services, BASIC-T began by meeting current LACDMH psychologists "where they are" and providing tailored foundational trainings in the assessment of children, adolescents, and transitional age youth with the goal of growing and extending assessment competencies over time.

Overall, BASIC-T has established weekly roundtable case conferences for its supervising and staff psychologists focused on expanding their current scope of practice to include greater familiarity with a number of neurocognitive assessment screening procedures, as well as psycho-diagnostic assessment instrumentation to assist with the triage, differential diagnosis, and targeted treatment planning of local LACDMH clients. Along these lines, BASIC-T has collaboratively started a journal club to 1) foster ongoing education regarding emerging assessment approaches that are culturally and linguistically responsive, 2) address the need for greater competency benchmarks in the provision of clinical supervision by psychologists specifically focused on assessment, and 3) facilitate discussion on topics drawn directly from LACDMH psychologists based on their unique needs in seeking to expand their knowledge-base in assessment more broadly.

Finally, BASIC-T developed and produced the initial wave of online content for the launch of its Cognitive Advocacy Series (CAS), a curated list of topics relevant to the assessment of LACDMH clients across the lifespan. Assessment topics now available within the CAS include:

- ADHD
- Autism Spectrum Disorder
- Cognition in Adulthood and Older Age
- Mild vs Major Neurocognitive Disorders and the Role of Functional Impairment
- Cultural and Linguistic Considerations When Assessing Latine Patients
- Bilingual Assessment Paradigms
- Structural Competency in Assessment Practices of the Individual
- Practical Recommendations for Therapeutic Interventions with People With
- Cognitive Impairments
- Psychological Assessment: Neuropsychology 101
- The Impact of Mood on Cognition
- Bilingualism and the Impact on the Brain: From Childhood to Adulthood
- Delivering Feedback for Neurocognitive Assessments
- Cultural Neuroscience and Its Applicability to Clinical Practice

The CAS will be available through the Wellbeing for LA Learning Center for asynchronous didactic learning and serves as an online resource for both current and future LACDMH psychologists in perpetuity to facilitate their ongoing training in better serving a more diverse client population inclusive of those who suffer from neurocognitive disorders in the context of broader mental health challenges. Additional CAS topics will be drawn directly from LACDMH Pilot Site participants and produced in the coming year to help further address ecologically derived assessment topics that impact everyday local clients as they move through LACDMH services in their journey toward healing and wellbeing.

Other Services Delivered Through the UCLA Public Partnership for Wellbeing include:

DMH + UCLA General Medical Education (GME)

Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the 16 trainees provided a total of 12,928 patient visits during their public psychiatry rotations.

ADULT PSYCHIATRY RESIDENCY TRAINING PROGRAM

This fiscal year, GME continued expanding learning opportunities for adult psychiatry residents in LACDMH clinics and updated logistics for residents rotating at Edelman given the move to Culver City. GME successfully accommodated the move of Edelman to Culver City into the residents' schedules and offered the HOME program as an elective for the PGY- 4 residents. Residents appreciated the experience of working with LACDMH and their feedback has been consistently positive.

CHILD PSYCHIATRY FELLOWSHIP PROGRAM

The Child Psychiatry Fellowship Program focuses on providing an enriching clinical rotation embedded in the community to enhance learning in child psychiatry. This year, child psychiatry trainees were exposed to community child psychiatry, including the multiple systems that compromise access to quality mental health care. Their LACDMH rotation at Augustus Hawkins continues to be the highest rated outpatient clinical rotation for the second-year child psychiatry fellows, in large part due to exceptional teaching by knowledgeable medical directors. Training exposure to the beloved LACDMH rotation at Augustus Hawkins resulted in 4/7 graduating fellows this year accepting jobs as community child psychiatrists.

GERIATRIC PSYCHIATRY FELLOWSHIP PROGRAM

The Geriatric Psychiatry Fellowship Program continued to provide training opportunities for its fellows while administering high quality integrative geriatric care to home-bound older adults through participation in the DMH geriatric home-based care program. All three geriatric psychiatry fellows reported this rotation as high value to understanding the impact of older adults' home life on their mental and cognitive health.

FORENSIC PSYCHIATRY FELLOWSHIP PROGRAM

The Forensic Psychiatry Fellowship Program continued to provide unique educational experiences for fellows and provide them with opportunities to serve LACDMH forensic populations (e.g., individuals moving from incarceration to treatment settings).

Table 86. Outcomes FY 2023/2024

NCSP of patient visits*	**# Fellows/Residents**	**Est. #**
Adult Psychiatrist/Researcher	2	1,070
GME		
Adult Psychiatry Residency	7	2,513
Child Psychiatry Fellowship	4	3,172
Geriatric Psychiatry Fellowship	2	2,190
Forensic Psychiatry Fellowship	3	5,053
Total	16	12,928

*Total number of patient visits from FY2020 through FY2024.
**In FY2023-24, GME trainees provided 3,378 patient visits.

LACDMH + SEMEL INSTITUTE NATIONAL CLINICIAN SCHOLARS PROGRAM (NCSP) PROFESSIONAL TRAINEES

Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher.

NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with DMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a Ph.D. The program provides training in partnered research, quality improvement, health services, and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country.

DMH funds one fellowship slot at a time (new fellows eligible every two years). In FY 23-24, the department was able to fund and onboard a second fellow with additional funding provided in part by the PPFW contract.

Scholars Program activities include:

- Participating in coursework, the equivalent of a master's program or auditing as an option.
- Conducting up to 20% clinical work with DMH and participate in leadership activities.
- Conducting 1-4 projects, at least 1 of which is in partnership with DMH.
- Participating in a policy elective their second year when possible.
- Attending annual NCSP meetings and other local and national meetings.
- Access to research funds and a mentorship team

For FY 2024-25:

- The department hopes to begin the planning for the roll out of a Public Psychiatry rotation: **UCLA-LACDMH Public Psychiatry Clinical Fellowship Program.** Modeled after the University of California, San Francisco (UCSF) public psychiatry fellowship program, this new rotation would follow the structure and curriculum of leading public psychiatry fellowships.
- In FY24-25 the department will also implement a new project that will support the Office of the Public Guardian's existing infrastructure and ensure it is capable to respond to the pressing demand for conservatorship assessments in Los Angeles County.
- The department is currently working to develop a new Statement of Work for the Integrated Care Conference.

3. **Interpreter Training Program (ITP)**

The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services, and also to monolingual English-speaking mental health providers wishing to learn how to better utilize interpreter services. 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. The program has offered Introduction to Interpreting

in MH Settings as well as Increasing Mental Health Clinical Terminology trainings. The FY 2023/2024 outcomes for the Interpreter Training Program showed a total of 136 attendees.

4. Learning Management System

The Department has developed an online registration and training tracking system called EventsHub that manages registration, transcripts, certificates and payment for trainings and conferences coordinated by the Department. EventsHub is fully operational with most, if not all, clinical training administratively processed by the system inclusive of posting, registration, e-ticket, and other training logistics important for tracking purposes. Enhancement and maintenance of EventsHub continues through the following FYs.

5. Licensure Preparation Program (MSW, MFT, LPCC, PSY)

In an effort to increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 of licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors, and Psychologists. During FY 2023/2024, the Department subsidized 88 individuals across these professions, with 69% self-identifying from an un- or under- served community, and 71% speaking a LAC threshold language in addition to English.

6. Academy of Cognitive Therapy

Individual Cognitive Behavioral Therapy (Ind CBT) is one of the most frequently utilized evidence-based practice (EBP), with considerable research supporting its effectiveness and adaptability in clinical practice. Ind CBT integrates the rationale and techniques from both cognitive therapy and behavioral therapy, thereby challenging automatic negative thoughts with more direct methods of behavioral therapy. Ind CBT helps individuals deal with their difficulties by changing their thinking patterns, behaviors, and emotional responses. Treatment focuses on identifying more positive reinforcing thoughts to elicit a more desired behavior. The Ind CBT program targets its services to consumers age 16 years and older throughout LAC. Specifically, this EBP will treat transition-age youth dealing with early onset of mental illness; adults facing traumatic experiences which lead to depression, anxiety, or post-traumatic stress disorder; and older adults to prevent or alleviate depressive symptomology. The treatment is intended for consumers seeking services to address depression, anxiety, or trauma in an individual or group setting consisting of 18 to 56 weeks of treatment sessions. The Ind CBT training program is offered to clinicians from both DMH directly operated programs and legal entity providers.

Table. 87 Academy of Cognitive Therapy Outcomes for FY 2023-24

Training Cohort # and Completion Date	# of Clinicians Completed
49 - 07/10/23	35
50 - 10/30/23	31
51 - 01/03/24	39
52 - 03/04/24	43
53 - 06/26/24	37
TOTAL	185

7. **Staff Development Training and Recruitment**

Historically, public mental health systems across the county have experienced ongoing staffing shortages. Especially in recent years with the COVID-19 pandemic and its aftermath, the staffing shortage has expanded and been slow to recover. The Department will fund new programs targeting further professional skill development of its existing workforce along with increased recruitment efforts and a possible additional financial incentive recruitment program.

Residency and Internship

1. Psychiatric Residency Program: Charles Drew University Agreement

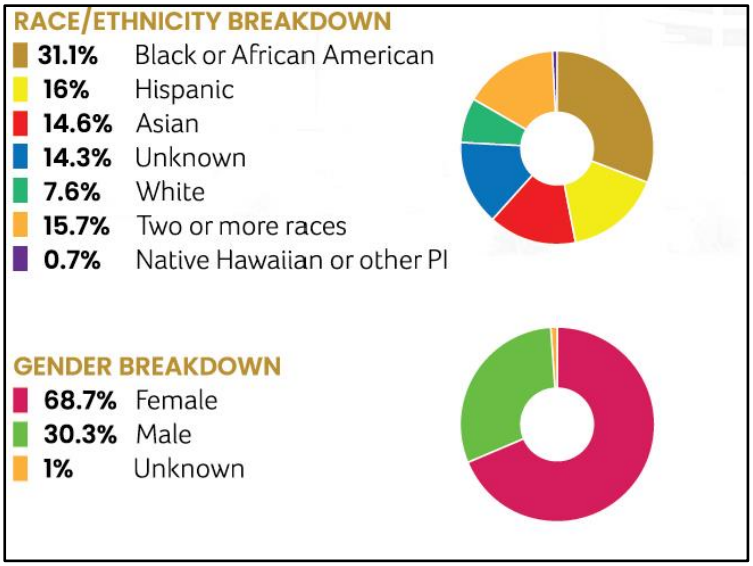
The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County.

The first class started in Academic Year 2018-2019 and at the program's capacity, we will have 24 trainees ranging from Post Graduate Year I to IV.

Table 88. Number of Psychiatric Residents Per Program Year - Outcomes for FY 2023-24

Year	Number of Psychiatric Residents
PGY-1	6
PGY-2	6
PGY-3	6
PGY-4	6
PGY-5	2
Total:	**26 psychiatric residents**

Figure 110. Psychiatric Residents Race/Ethnicity Outcomes for FY 2023-24



CDU Clinical Rotations:

PGY-1: 6 Psychiatric Residents

- 1 month of university onboarding is done at CDU
- VA Long Beach (Inpatient Psychiatry): 2 months
- VA Long Beach (Inpatient Psychiatry): 2 months
- Rancho Los Amigos (Inpatient Medicine): 2 months
- Rancho Los Amigos (Neurology): 2 months
- Kedren (Outpatient Medicine): 2 months
- Harbor-UCLA (Emergency Psychiatry): 1 month
- Harbor-UCLA (Inpatient Psychiatry): 1 month

PGY-2: 6 Psychiatric Residents

- VA Long Beach (Inpatient Psychiatry): 2 months
- VA Long Beach (Substance Abuse): 2 months
- VA Long Beach (Geriatric Psychiatry): 1 month
- Harbor-UCLA (Consultation and Liaison): 2 months
- Harbor-UCLA (Inpatient Psychiatry): 1 month Kedren (Inpatient Psychiatry): 3 months
- Resnick Neuro-psych Hospital UCLA (Child and Adolescent Psychiatry): 2 months

The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.

PGY-3: 6 Psychiatric Residents

Rotations in DMH Directly Operated Clinics and Programs:

- Augustus F. Hawkins MHC
- West Central MHC
- Women's Community & Reintegration Center
- Homeless Outreach & Mobile Engagement
- Hollywood 2.0
- Harbor UCLA Medical Center HIV Clinic
- CDU Didactics Training

PGY-4: 6 Psychiatric Residents

Rotations in DMH Directly Operated Clinics and Programs:

- Augustus F. Hawkins MHC
- West Central MHC
- Harbor UCLA Medical Center HIV Clinic
- Street Psychiatry/HOME Team and Disaster Service
- Psychiatric Emergency Department
- Hollywood 2.0
- Collaborative Care/Telepsychiatry
- Transcranial Magnetic System (Multiple DOs)
- CDU Didactics Training

PGY-5: 2 Psychiatric Residents (CHILD)-STATE FUNDED

- Compton MHC
- CDU Didactics Training

2. Pathways to Health Meaningful Health Careers Academy

This program is also a component of the Charles R. Drew Affiliation Agreement.

Providing academic and community internship initiative to prepare young people for health careers with a partnership between the following:

- Los Angeles County Departments of Public Health and Mental Health
- Charles R. Drew University of Medicine and Science (CDU) in South Los Angeles
- Coachman Moore and Associates, Inc.
- Local community partners

Key Components

Summer academic enrichment.

- Introduction to public health course
- Introduction to Mental/behavioral health course
- "Rites of Passage"
- Literacy, math, and science tutoring
- College preparation workshops for students

Fall community-based internship.

- Tutoring and mentorship
- SAT Preparation or Math/Science Enrichment courses

Financial Incentive

1. Stipend Allocation for MSWs, MFTs, LCCs, Psychologists, Psych Techs

DMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists hired before July 1, 2024, who have not participated in or have received funds from the MH Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of up to $250,000. During FY 2023/2024, 38 mental health psychiatrists participated in this program. Based on the MOU between Los Angeles County and UAPD, adopted by the Board on June 25, 2024, all eligible psychiatrists hired after July 1, 2024, will receive a maximum annual amount of up to $50,000 for a period of two years which equate to a lifetime total of up to $100,000.

2. MHSA Relocation Expense Reimbursement

Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by DMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves DMH within one-year from employment

start date, the full reimbursement amount must be repaid. During FY 2023-24, no individuals were awarded.

3. MHP Recruitment Incentive Program

This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system hired after July 1, 2024. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in DMH and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $25,000 will be granted consisting of $12,500 upon completion of the first year of continuous service at DMH, and an additional payment of $12,500 upon completion of the second year of continuous service. During FY 2023/2024, 3 individuals participated in this financial opportunity.

4. Stipend Program for Direct Service Programs

LACDMH provides students with education stipends in the amount of $18,500 in exchange for a contractual work commitment (a minimum of 1 year) to secure employment in a Los Angeles County specialty public mental health program/agency. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County. Program eligibility includes Psychologists, MSWs, MFTs, LPCCs, Psychiatric Technicians and PNPs students in the final year of their educational degree program.

During FY 2023-24, 164 stipends were awarded. The contracted fiscal intermediary provided stipend recipients job seeking assistance as well as follow up to ensure contractual work service commitment was met; work commitment extensions may be given on a case-by-case basis.

Figure111. Stipend Recipients Ethnicity and Language Capacity for FY 2023-24

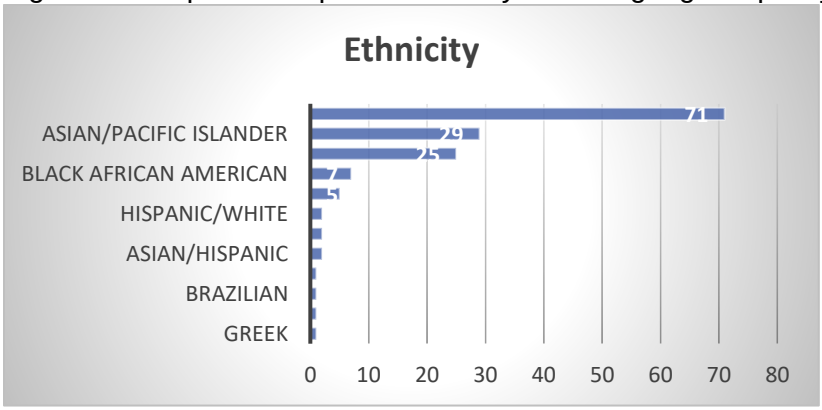
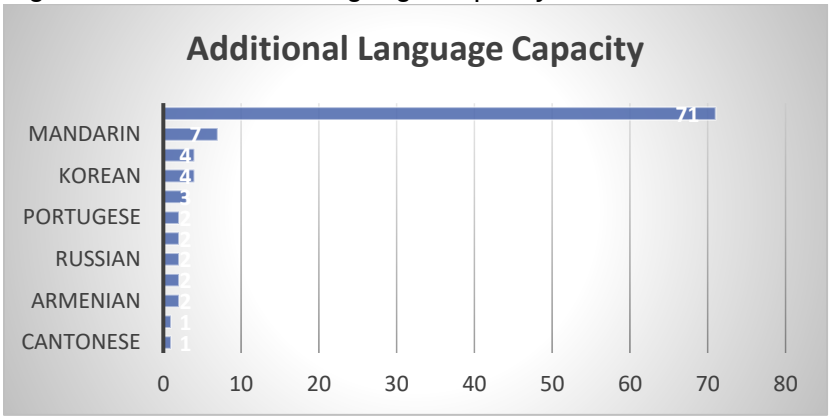


Figure 112. Additional Language Capacity for FY 2023-24



5. MHSA WET Regional Partnership Match

Pending the availability of additional MHSA WET Regional Partnership funding from the State, the Department may be required to provide a 33% local match to accept and implement recruitment or retention efforts required in future FY.

Mental Health Career Pathway

1. Intensive Mental Health Recovery Specialist Training Program

Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a contracted mental health provider. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Two Cohorts were delivered during FY 2023-24 with 37 individuals completing the training. At least 50% of enrolled participants are bilingual or bicultural, representing unserved and underserved communities. 67% of the participants identified as having lived experience with mental illness/substance abuse. 44% indicated they had a family member with mental illness/substance abuse and 22% indicated as having both lived experience and having a family member with mental illness/substance abuse. Of those who completed the training, 43% have secured employment. All were employed in the mental health field except for two people. DMH will not continue this program after this FY.

2. Parent Partners Training Program

This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.

The Parent Partners Training Program (PPTA) provides mandated "Essential Skills" training to LA County Parent Partners through the 72-hour PPTA Essential Skills training, Continuing Education for all LAC Parent Partners, Reflective Practice Training for supervisors and also conducts PPTA Certification Exam and PPTA training evaluation.

During FY 2023/2024, the PPTA provided mandated "Essential Skills" training included over 288 hours of training for more than 100 Parent Partners.

Starting in FY 2024/2025, the PPTA was approved to begin a multi-year contract to provide 100 Continuing Education trainings per year. This contract is currently budgeted through FY 2025/2026.

The PPTA has also just received funding for the application to be an SB803 Medi-Cal Peer Support Specialist core trainer.
The PPTA continues to be an approved SB803 Specialty trainer for Parent, Caregiver, Family Member Peer trainer and funding was approved to cover the cost of training approval renewal for 2 more years.

Upcoming plans for FY 2024/2025 and FY 2025/2026: The PPTA will strive toward continued efforts to evolve and align the peer training with all emerging local and national standards as well as ongoing evaluation of the trainees and PPTA curriculum.

3. Continuum of Care Reform

Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. This legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, the Department utilized MHSA WET to deliver training to these populations. Such training included topics such as Introduction to Mental Health, Diagnosis/Assessment, and Self-Care, etc.

4. Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates and caregivers for employment in the public mental health system. As such, during FY 2022-2023, the Department delivered the following trainings:

a. Recovery Practices for Organizations

This 8-hour interactive and skill-based training is intended for participants to examine how they presently view recovery and resilience and the significance of implementation of such tenets in the work practice. One key objective is to support integration at the organizational level of the practices of recovery and resilience services. Hands-on activities provide opportunities for the application of recovery and resilient understandings and tenets essential to consumer service delivery and relevant to work co-worker relationships. Another key objective is to provide staff with an understanding of the important role of peer support in recovery services and

outcomes. Interventions and strategies to sustain recovery and resilient culture and services are included in the training. In FY 2023/2024, three (3) trainings were provided to the Peer Support Specialists working in the LACDMH Emergency Outreach and Triage Division (EOTD) and a total of 66 Mental Health Community Health Workers/Peer Support Specialists have completed this training.

b. Recovery Practices for Leaders

This training is a 2-day dynamic and experiential training that provides leaders with the principles and practices for creating and sustaining a recovery and resilient-oriented service environment. Participants will gain hands-on experience on how to use several recovery and resilient leadership tools and strategies for leading and coaching peer support specialists as well as every other professional staff member on their entire team. The training also provides leaders with an opportunity to reflect and review personally and confidentially their leadership style. Each leader is to develop a vision statement, a Professional Resilient Employee Plan (PREP), and a Resilient Action Plan to implement recovery and resilient principles transcending to their teams and embedded in resilient leadership practice. In FY 2023/2024, one (1) training was provided to LACDMH EOTD leadership, and a total of 13 EOTD managers and supervisors have completed this training.

c. Recovery Principles in Law and Ethics for Peer Support Specialists

This training provided participants with a working knowledge of the fundamental legal and ethical guidelines that inform peer support services. Participants gained an understanding of the recovery principles behind the ethics and laws related to providing peer support services in the behavioral health system. As a culminating event for the course, participants improved their skills on appropriate legal and ethical based decision-making in various peer support scenarios. In FY 2023/2024, two (2) trainings were provided and a total of 40 Mental Health Community Health Workers/Peer Support Specialists have completed this training.

d. Peer Certification Exam Preparation Training

The Peer Certification Exam Preparation training is a virtual online 8 hour training (4 hrs x 2 days) that reviews core competency topics and applicability to Peer Support Specialist practices covered in the exam. In addition, the training provides test-taking tools, strategies, and materials important for preparing participants in exam taking. As a result, the training is intended to increase Peer confidence, competence, and skills necessary for obtaining the Peer Support Specialist Certification. In FY 2023/2024, two (2) trainings were provided and a total of 43 Mental Health Community Health Workers/Peer Support Specialists have completed this training.

e. Resilient Culture Playbook Workshop

This is an 8-hour interactive and skill-based training is intended for participants to examine how they presently view recovery and resilience and the significance of implementation of such tenets in the work practice. One key objective is to support integration at the organizational level the practices of recovery and resilience services. Hands-on activities provide opportunities for application of recovery and resilient understandings and tenets essential to consumer service delivery and relevant to work co-worker relationships. Another key objective is to provide staff with an understanding of the important role of peer support in recovery services and outcomes. Interventions and strategies to sustain recovery and resilient culture and services are included in the training. In FY 2023/2024, three (3) trainings were

provided and a total of 23 Mental Health Community Health Workers/Peer Support Specialists have completed this training.

f. Suicide Peer-Vention

Suicide Peer-vention is a 4-hour workshop designed to touch upon both suicide prevention and suicide intervention skills within the purview of a peer support interaction. This course focuses on how to share empathy as the peer support specialist walks alongside a person who is experiencing a profound sense of lost hope. In this module, we focus on empowering interactions and connections to hope found in the words and strengths of the person in crisis. The peer supporter will develop the skills to have difficult and life-saving conversations through a recovery and resilience orientation. The course is also supporting development of skills in how to get present and stay mindfully connected to support the person for safety-for-now until additional supports are available. In FY 2023/2024, two (2) trainings were provided and a total of 53 Mental Health Community Health Workers/Peer Support Specialists completed this training.

g. Crisis Response Training/Recovery Responders-Providing Peer Support in Crisis Services

This is a 40-hour competency-based course. The dynamic and interactive learning experience includes principles and practices characterized by trauma informed care, cultural humility, situational, social and safety awareness, crisis communication skills, as well as utilizing the Suicide Peer-vention approach. Participants were provided with specialized recovery and resilience tools to use in crisis services. In FY 2023/2024, two (2) trainings were provided and a total of 29 Mental Health Community Health Workers/Peer Support Specialists completed this training.

Capital Facilities and Technological Needs (CFTN)

Capital Facilities and Technological Needs means projects for the acquisition and development of land and the construction or renovation of buildings or the development, maintenance or improvement of information technology for the provision of Mental Health Services Act administration, services, and supports. Capital Facilities and Technological Needs does not include housing projects.

The County transferred funds from its CSS account into the CFTN account to fund capital facilities and technological needs projects.

Capital Facilities

Projects – Fiscal Year 2023-24

Capital facilities projects encompasses several key stages, each of which plays a crucial role in the successful development and implementation of a facility project. During FY 2023-24, the following facilities have incurred either design fees, project management fees, construction fees and/or plan checks using *Capital Project – Tenant Improvement/New Facilities*:

- Jacqueline Avant Children and Family Center
- Olive View Children's Crisis Stabilization Unit
- LA General Urgent Care Center.

Upcoming Projects – Fiscal Year 2025-26

- Capital Project - Tenant Improvement/New Facilities: funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs which includes the purchasing of equipment and furniture.
- The Crisis Residential Treatment Program (CRTP), Crisis Stabilization Unit (CSU), and Mental Health Hub (MHH) on the High Desert campus are envisioned to be facilities that will allow for geographic equity and balance, as well as advancing racial equity by providing a needed resource in a community where many of the residents are disadvantaged. They are vital elements to the High Desert Campus along with the current operating High Desert Regional Health Center (HDRHC) and Mental Health Urgent Care Center (MHUCC).
- Jacqueline Avant Transition Age Youth (TAY) Center: The proposed Jacqueline Avant TAY Center on the MLK Healthcare Campus in Willowbrook will expand current TAY services in Service Area 6 of the county and will be a needed addition to the continuum of care that currently exists at the Behavioral Health Center across the street. TAY programs at the new center will provide an array of mental health and supportive services for TAY who are homeless or at-risk of homelessness. These services include mental health support and case management, as well as access to showers, washer and dryers, hot food, clothing, computers and charging stations.

- LA General Medical Center-MH UCC _Exodus
- East San Gabriel Valley Remodeling
- Jacqueline Avant Children and Family Center Third Floor Refurbishment
- Olive View Children and Youth Mental Health Hub and Crisis Stabilization Unit Refurbishment
- Children's Community Care Village – Kedren
- TAY Wellness Center

Technological Needs

Projects – Fiscal Year 2023-24

- Integrated Behavioral Health Information System (IBHIS) – Netsmart: Support data and claiming systems and Electronic Health Records
- IBHIS Microsoft Agreement
- Call Center Modernization
- Technology Improvements

Continuing Projects for Fiscal Year 2025-26 include

- Integrated Behavioral Health Information System
- Technological Improvement

VII. EXHIBITS

A. Exhibit A – Budget

MHSA Funding Summary for Fiscal Year 2025-26

	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Total
A. Estimated FY 2025-26 Funding						
1. Estimated Unspent Funds	585,236,148	269,164,210	247,789,209	85,496,965	96,939,478	1,284,626,010
2. Prudent Reserve	123,500,000	24,000,000				147,500,000
3. Estimated New FY2025-26 Funding	517,955,500	131,090,000	37,079,000	530,000	1,531,000	688,185,500
4. Transfer in FY2025/26 Annual Update	(45,000,000)			25,000,000	20,000,000	-
5. Estimated Available Funding for FY2025/26	1,181,691,648	424,254,210	284,868,209	111,026,965	118,470,478	2,120,311,510
B. Estimated FY2025/26 MHSA Expenditures	672,679,944	203,322,386	132,355,339	28,491,571	56,990,524	1,093,839,764
C. Estimated FY2025/26 Unspent Fund Balance	509,011,704	220,931,824	152,512,870	82,535,394	61,479,954	1,026,471,746

Community Services and Supports Programs

	Fiscal Year 2025/26					
	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
CSS Programs						
1. Full Service Partnerships	184,963,680	94,253,582	63,924,925		24,386,719	2,398,454
2. Outpatient Care Services	421,273,988	199,137,892	167,772,370		46,419,324	7,944,402
3. Alternative Crisis Services	183,058,515	134,444,859	42,132,302		3,533,135	2,948,219
4 Planning Outreach & Engagement	6,736,324	6,736,324	-		-	-
5 Linkage Services	158,119,775	41,596,778	105,040,333		45,428	11,437,235
6 Housing	126,276,839	119,983,830	5,906,854		21,832	364,323
CSS Administration	76,526,679	76,526,679				
Total CSS Program Estimated Expenditures	1,156,955,799	672,679,944	384,776,783	0	74,406,439	25,092,633

Prevention and Early Intervention Programs

	Fiscal Year 2025/26					
	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						
1. Suicide Prevention	2,697,000	2,697,000				
2. Stigma Discrimination Reduction Program	14,138,379	14,138,379				
3. Prevention including Outreach Services	125,437,542	125,437,542				
4 Early Intervention	105,253,530	34,553,067	40,372,188		29,755,565	572,709
PEI Administration	26,496,396	26,496,396				
Total PEI Program Estimated Expenditures	274,022,848	203,322,386	40,372,188	0	29,755,565	572,709

Innovation Projects

	Fiscal Year 2025/26					
	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 Projects						
1. Hollywood Mental Health Cooperative (formally known Hollywood 2.0 project)	41,392,704	32,468,917	5,150,872		3,433,915	339,000
2. Interim Housing Multidisciplinary Assessment & Treatment Teams	37,276,769	32,117,769	2,949,000		1,966,000	244,000
3. Children's Community Care Village including Capital Project	62,953,080	54,693,244	4,129,918		4,129,918	
INN Administration	13,075,409	13,075,409				
Total INN Project Estimated Expenditures	154,697,962	132,355,339	12,229,790	-	9,529,833	583,000

Workforce Education and Training (WET) Programs

	Fiscal Year 2025/26					
	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	9,281,077	9,281,077				
2. Mental Health Career Pathway	450,898	450,898				
3. Residency	2,963,430	2,963,430				
4. Financial Incentive	12,937,084	12,937,084				
WET Administration	2,859,082	2,859,082				
Total WET Program Estimated Expenditures	28,491,571	28,491,571	0	0	0	0

Capital Facilities Technological Needs (CFTN) Projects

	Fiscal Year 2025/26					
	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. Capital Project -Tenant Improvement/New Facilities	5,000,000	5,000,000				
2. LA General Medical Center-MH UCC _Exodus	6,248,000	6,248,000				
3. Children's Community Care Village-Kedren	15,000,000	15,000,000				
4. TAY Wellness Ctr	7,200,000	7,200,000				
5. High Desert Crisis Residential Treatment Program	1,607,000	1,607,000				
6. High Desert Crisis Stabilization Unit	834,000	834,000				
7. High Desert Mental Health Hub	834,000	834,000				
8. East San Gabriel Valley Remodeling	591,000	591,000				
9. Jacqueline Avant Children and Family Center Third Fl Refurb	438,000	438,000				
10. OV Children and Youth MH Hub and Crisis Stabilizn Unit Rfurb	1,300,000	1,300,000				
CFTN Programs - Technological Needs Projects						
11. Integrated Behavioral Health Information System	12,134,000	12,134,000				
12. Technological Improvement	4,363,000	4,363,000				
CFTN Administration	1,441,524	1,441,524				
Total CFTN Program Estimated Expenditures	56,990,524	56,990,524	-	-	-	-

B. Exhibit B – MHSA County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

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

Local Mental Health Director	County Auditor-Controller
Name: Lisa H. Wong, Psy.D.	Name: Oscar Valdez
Telephone Number: (213) 974-6670	Telephone Number: (213) 974-8302
E-mail: LWong@dmh.lacounty.gov	E-mail: OValdez@auditor.lacounty.gov
Local Mental Health Mailing Address: County of Los Angeles - Department of Mental Health 510 S. Vermont Avenue, 22nd floor Los Angeles, CA 90020	

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

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

Lisa H. Wong, Psy.D.
Local Mental Health Director

Signature

3/12/2025
Date

I hereby certify that for the fiscal year ended June 30, 2024, 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 December 12, 2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MHSA funds may not be loaned to a county general fund or any other county fund.

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

Oscar Valdez
County Auditor Controller (PRINT)

Oscar Valdez - Auditor-Controller
2025.03.14 08:49:02 -07'00'

Signature

Date

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

C. Exhibit C – Behavioral Health Commission (BHC) Letter

BEHAVIORAL HEALTH COMMISSION
Advocacy, Accountability, and Oversight in Action

Michael Molina
Chair

Brittney Weissman
1st Vice Chair

Jaqueline Sandoval
2nd Vice Chair

Victor Manalo and Kathleen Austria
Members-At-Large

April 24, 2025

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

Lisa H. Wong, Psy.D.
Director, Department of Mental Health
510 South Vermont Avenue
Los Angeles, California 90020

Dear Supervisors and Director Wong:

MENTAL HEALTH SERVICES ACT (MHSA) PUBLIC HEARING:
MHSA ANNUAL UPDATE 2025-2026

On April 10, 2025, the Behavioral Health Commission (Commission) held its Public Hearing relative to the Mental Health Services Act (MHSA) Annual Update 2025-2026. The Department of Mental Health (LACDMH) submitted their Annual Update on March 10, 2025, for a 30-day Comment Period. A total of 65 members of the public participated at the April 10th Hearing (both in-person and via online) and 9 persons provided Public Comment. This letter provides a summary of the comments received by members of the public and subsequent input by the members of the Commission.

Stakeholder Participation

LACDMH continued to improve efforts to engage stakeholders throughout the Community Planning Process. One hundred community and institutional representatives were invited to participate in the formation of a Community Planning Team. This team met for nine consecutive months. The Commission was concerned, however, by the noticeable decline in participation at the Public Hearing. In previous years, many more stakeholders, including representatives of the Service Areas and Underserved Cultural Communities, participated and provided public comment.

Annual Update Statistics

The Annual Update included a detailed review of pertinent statistical information identifying services provided by Supervisorial District and Service Area. Statistics were also provided to show services offered by ethnic/language demographic and age group.

Address: 510 S. Vermont Ave., Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: dmh.lacounty.gov/about/mental-health-commission/

LACDMH is commended for its clear and thorough presentation of demographic information as recommended by the Commission last year.

Public Hearing Participation

A robust outreach was conducted by LACDMH, particularly our Commission staff, to invite members of the public to participate in the April 10th Public Hearing. The Commission database includes 8,169 individuals and organizations that were invited to the meeting.

Issues Addressed by members of the Public and Commissioners

Unspent Funds

Concern was raised in Public Comment relative to a significant balance of projected unspent funds (budgeted at $1.432 Billion). The County's underserved communities continue to seek behavioral health assistance. Additionally, we remain under emergency order in our response to the unhoused. It is essential to use these funds in an efficient and urgent manner.

Recommendation

The Commission requests quarterly progress reports relative to the unspent balance and, in particular, identify methods to spend these funds in a timely manner.

Increased Community Engagement

Despite the deployment of an enhanced Community Planning Team, concern still exists that community engagement is lacking throughout the process. In particular, the absence of most of the Service Area Leadership Teams (SALTs) and Underserved Cultural Communities (USCCs) in the Public Hearing process was noticeable. Also, soliciting stakeholder response by means of conventional surveys was noticeably low. It led the Commission to speculate whether these groups were, in fact, fully engaged in the process.

Recommendation

DMH staff is requested to consider innovative methods to encourage and entice stakeholders to participate in a fuller way. Options to consider include meeting times and locations. The Commission requests staff to provide an update at an upcoming meeting on methods used to seek a more robust level of participation.

Interdepartmental Collaboration

The various County agencies and departments involved in the MHSA process continues to grow. Attention is needed to facilitate good and productive communication among these agencies. For example, the transition to the Behavioral Health Services Act (BHSA) requires the Commission to expand its expertise to include the Substance Use community (SUD) through the Department of Public Health's Substance Use and Prevention Control (SAPC). Additionally, the Board of Supervisors recently took steps to establish a new County-led Homeless initiative.

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E-mail: MHCommission@dmh.lacounty.gov **Website**: dmh.lacounty.gov/about/mental-health-commission/

Recommendation
Cross-sector alignment must be facilitated in order to provide a thorough and productive disbursement of MHSA funds throughout the pertinent agencies. The Commission seeks regular briefings from LACDMH staff on the process to achieve collaboration among the County's departments.

Other Issues Addressed:

a. There appears to be a lack of engagement with the 88 independent cities in Los Angeles County relative to the MHSA process, particularly as it relates to the County's unhoused communities. More collaboration needs to be identified.
b. There is a call for more attention to better inclusivity and dignity in language used in LACDMH printed materials. An example of dignified language is the suggestion to use the term "unhoused" rather than "homeless."
c. Commissioners are concerned relative to the overall low participation to programs such as the department's Full Service Partnership (FSP) compared to the size of the County's population.
d. LACDMH is encouraged to collaborate with the Department of Public Health, the Sheriff's Department and other pertinent agencies to improve programs which lead to Suicide Prevention, wellness and postvention efforts. A model can be found in the Santa Clarita Valley Suicide Prevention Committee.
e. LACDMH is asked to further develop the powerful Early Childhood Mental Health Consultation Model with emphasis on 3–5-year-olds attending public or private preschools, modeling research from the Georgetown Model.
f. Using the Foster Youth Independence (FYI) Program of Santa Clarita as a model, LACDMH is requested to consider implementation of a Foster Care Allies and Case Management Program, in collaboration with the Department of Children and Family Services.

We thank the Board of Supervisors for your careful consideration of this Annual Update and, once again, commend our LACDMH leadership and team for the tremendous effort to produce this report. We look forward to continued collaboration with your offices as we seek to implement these recommendations.
Sincerely,

Michael Molina, Chair
Los Angeles County Behavioral Health Commission

Address: 510 S. Vermont Ave., Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: dmh.lacounty.gov/about/mental-health-commission/

D. Exhibit D – LACDMH Response to BHC Letter

DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

Curley L. Bonds, M.D.
Chief Medical Officer

Rimmi Hundal, M.A.
Chief Deputy Director

April 30, 2025

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

Michael Molina
Chair, Behavioral Health Commission
510 South Vermont Avenue
Los Angeles, California 90020

Dear Supervisors and Commissioner Molina:

RESPONSE TO BEHAVIORAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT ANNUAL UPDATE, FISCAL YEAR 2025-26

On April 25, 2025, the Los Angeles County Behavioral Health Commission (Commission) submitted a letter outlining their comments and questions to the Los Angeles County Board of Supervisors (Board) and the Los Angeles County Department of Mental Health (LACDMH) pertaining to the April 10, 2025, public hearing on the Mental Health Services Act (MHSA) Annual Update, Fiscal Year (FY) 2025-26.

Thank you for the Commission's commendation for the successful completion of this year's planning process, along with its collaboration, support, and active engagement throughout. The recommendations from the Commission will be considered and integrated as LACDMH initiates its planning for the Behavioral Health Services Act (BHSA) Integrated Plan, FYs 2026-2027 through 2028-2029. The LACDMH MHSA Administration leadership is committed to providing continuous updates on the recommendations and the progress of the BHSA implementation plans.

The Commission provided recommendations focused on the following three key themes:

1. Unspent Funds
2. Increased Community Engagement
3. Interdepartmental Collaboration

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The following are LACDMH's responses to the Commission's recommendations:

Unspent Funds
The Commission noted the amount of the unspent balance and is requesting quarterly progress reports to include methods to spend these funds in a timely manner. LACDMH has a plan to address the unspent balance which includes the shift of dollars to the MHSA components: Capital Facilities and Technological Needs and Workforce Education and Training, in the next fiscal year. LACDMH will work with finance to provide quarterly updates.

Increased Community Engagement
The Commission is requesting staff to provide an update at an upcoming meeting on methods used to seek a more robust level of participation as well as increase its outreach to a broader community. In past years, LACDMH has set a standard for itself beyond what is required from the State to ensure transparency and access for the community into the planning process.

LACDMH is collaborating with Substance Abuse Prevention and Control (SAPC), and together we are reaching out directly to a broader range of stakeholders. Additionally, we will strengthen our partnership with the Service Area Leadership teams and Underserved Cultural Communities to ensure diverse representation. The MHSA team continues to explore innovative strategies to engage youth and others who may not be able to attend during regular meeting times, ensuring they receive updates and have opportunities to provide input. We look forward to partnering with the Commission as we strive to engage a wider audience and encourage greater participation.

Interdepartmental Collaboration
The Commission recommends a cross-sector alignment be facilitated in order to provide a thorough and productive disbursement of MHSA funds throughout the pertinent agencies. In addition, the Commission is seeking regular briefings from LACDMH staff on the process to achieve collaboration among the County's departments.

LACDMH currently partners and provides MHSA funds to several County departments to achieve its overall goals. Such departments include: Children and Family Services, Health Services, Library, Military and Veterans Affairs, Public Health and Sheriff. LACDMH is partnering with SAPC to develop the BHSA Integrated Plan and have already begun meeting. As we transition to the BHSA we will continue to engage and collaborate with our county partners which each have representation in the County planning process.

In addition to the three key themes, other issues were addressed:

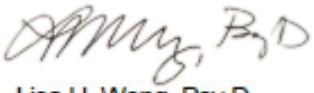
a. Limited engagement with the 88 independent cities in LA County on MHSA, especially around unhoused communities; more collaboration needed. A meeting has already been arranged with the MHSA Coordinator and Commissioner Victor Manalo to discuss strategies to reach out to cities.
b. Need for more inclusive and respectful language in LACDMH materials, e.g., "unhoused" instead of "homeless." LACDMH will prioritize inclusivity and dignity in the language used in materials developed by the Department and will advocate for use of inclusive language with State and other contributing partners to the report.
c. Concerns over low participation in programs like Full-Service Partnership relative to the County's population. LACDMH would like to acknowledge the Full-Service Partnership program reached 500 additional consumers this year and it will continue to grow under BHSA.
d. Encouraged to partner with Public Health, Sheriff's Department, and others to enhance suicide prevention, wellness, and postvention efforts, modeled after Santa Clarita Valley. LACDMH has actively worked with many other County departments and partner agencies to strengthen Suicide Prevention and wellness efforts. Partners include but are not limited to the Department of Public Health, Department of Parks and Recreation (DPR), the Sherriff's Department, the Los Angeles County Office of Education (LACOE), the Office of Violence Prevention (OVE) and community providers such as Didi Hirsch. Efforts include work with the Youth Advisory Board, the Veteran Suicide Review team, and collaborating with "Striving for Zero" program with Department of Public Health, Didi Hirsch, and LACOE.
e. Asked to expand the Early Childhood Mental Health Consultation model, focusing on 3-5 year-olds in preschools, based on the Georgetown Model. The California Youth Behavioral Health Initiative (CYBHI) offers a timely opportunity for Local Education Agencies (LEAs) to expand access to services by leveraging Medi-Cal fee schedule funding. To support long-term sustainability and equity, LACDMH is committed to supporting LEAs interested in implementing the Early Childhood Mental Health Consultation (ECMHC) model, with a focus on children ages 3-5.
f. Recommended to develop a Foster Care Allies and Case Management program, inspired by Santa Clarita's Foster Youth Independence (FYI) program, in collaboration with the Department of Children and Family Services. LACDMH shares the Commission's commitment to improving outcomes for foster youth and ensuring that comprehensive, community-based supports are accessible and responsive. We appreciate the Commission's reference to the FYI program in Santa Clarita as a promising practice and agree that dedicated case management and peer ally support tailored to foster youth is a powerful and effective approach. Examples of LACDMH led programming that align with the Commission's vision include the Antelope Valley Community Family Resource Centers (CFRCs) and the Prevention and Aftercare (P&A) Networks. These programs provide critical

prevention and early intervention services throughout the County. These programs are designed to meet families where they are, offering trauma-informed, culturally relevant services that include navigation assistance, and case management. Case management is a core component of these programs and aligns closely with the model the Commission has elevated.

I remain committed to collaborating with stakeholders, partners, and the Commission to ensure that our MHSA resources support those most in need in leading healthy, independent, and fulfilling lives.

If there are any questions, you may contact me at lwong@dmh.lacounty.gov or Kalene Gilbert, MHSA Services Coordinator, at kgilbert@dmh.lacounty.gov.

Respectfully submitted,



Lisa H. Wong, Psy.D.
Director

LHW:RH:JB:KG:RR

VIII. APPENDICES

Appendix A – Medi-Cal Data

CY 2023 MEDI-CAL ENROLLED BY GENDER

Male	Female	Total
2,112,466	2,393,629	4,506,095
46.9%	53.1%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

CY 2023 MEDI-CAL ENROLLED BY AGE

Age 00-18	Age 19-44	Age 45-64	Age 65+	Total
1,346,480	1,691,593	960,400	507,621	4,506,095
29.9%	37.5%	21.3%	11.3%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

CY 2023 MEDI-CAL ENROLLED BY ETHNICITY

African American	Asian	Latino	Native American	White	Not Reported	Total
436,740	413,293	2,615,305	6,688	585,378	448,691	4,506,095
9.7%	9.2%	58.0%	0.1%	13.0%	10.0%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

CY 2023 Medi-Cal Enrolled By Primary Language

Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other Non-Eng	Russian	Spanish	Tagalog	Vietnamese	Total
6,229	91,924	8,607	43,403	2,638,861	15,931	35,915	53,422	2,080	5,425	29,571	1,451,889	10,066	29,566	4,422,889
0.1%	2.1%	0.2%	1.0%	59.7%	0.4%	0.8%	1.2%	0.0%	0.1%	0.7%	32.8%	0.2%	0.7%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

Appendix B – Public Hearing Agenda, Presentation and Transcripts

Public Hearing Agenda

L.A. COUNTY BEHAVIORAL HEALTH COMMISSION
"Advocacy, Accountability, and Oversight in Action"

Commissioners by Supervisorial District

District	1st	2nd	3rd	4th	5th
Supervisor	**Hilda L. Solis**	**Holly J. Mitchell**	**Lindsey P. Horvath**	**Janice Hahn**	**Kathryn Barger**
Commissioners	Susan Friedman	Kathleen Austria	Stacy Dalgleish	Victor Manalo	Lawrence Schallert
	Imelda Padilla-Frausto	Erica Holmes	Thomas Roache	Michael Molina	Brittney Weissman
	Bennett W. Root, Jr.	Reba Stevens	Jaqueline Sandoval	Marilyn Sanabria	Vacant

LA County Board Supervisor (BOS) Kathryn Barger, Tyler Cash (BOS Alternate)

Michael Molina, Chair, Presiding

April 10, 2025

AGENDA

1. **CALL TO ORDER**
2. **ROLL CALL/WELCOME**
3. **NEW BUSINESS**
   a. *2025-2026 Upcoming Board Election Process – Ratification of Nomination Committee Appointment. Committee Members: Commissioners Molina and Weissman*
4. **STANDING ITEMS**
   a. *Department of Public Health (DPH) Substance Abuse and Prevention Control (SAPC) Updates – Dr. Gary Tsai, SAPC Director*
   b. *DMH - Mental Health Services Act (MHSA) Annual Updates FY 2025-26 – Kalene Gilbert, LCSW*
5. **PUBLIC COMMENT**
6. **BHC RESPONSE TO MHSA ANNUAL UPDATES FY 2025-26**

ADJOURNMENT - Next meeting: May 8, 2025, at 11:00am.

PUBLIC ACCESS INFORMATION ON NEXT PAGE

MHSA Annual Updates FY2025-26 Public Hearing

NOTICE IS HEREBY GIVEN that the Behavioral Health (BH) Commission MSHA Annual Updates FY2025-26 Public Hearing will be held on **April 10, 2025, at 11:00a.m.** Members of the public will have the opportunity to provide public comment, please see access options listed below.

Date	April 10, 2025
Start Time	11:00 a.m.
Location	510 South Vermont Avenue, 9th Floor, Level (T), Los Angeles, Ca 90020. Free validated parking is available at 523 Shatto Place, Los Angeles, CA 90020. When entering structure, take a parking ticket and bring it with you to the meeting. Security will validate your ticket.

NOTICE: All Commission meetings are recorded (video and audio)

ACCESS OPTIONS

To watch the live broadcast, click this MS Teams Link or use this shorten link or https://bit.ly/3RlZlsF or scan this QR code above.
To listen and to make public comment in English, please call 844-291-6362, enter participant code 4972277
To listen and to make public comment in Spanish, please call 888-204-5987, enter participant code 9639884
To listen and to make public comment in Korean, please call 866-434-5269, enter participant code 6699393
American Sign Language (ASL), please click this MS Teams link or https://bit.ly/3RlZlsF
Live Closed Captioning (CART), please click the BHC Live Closed Captioning

In addition to in person or calling in on the day of the meeting, members of the public can address the Commission in written form.

- **Electronic Mail (Email):** Email your public comment to mhcommission@dmh.lacounty.gov. Email must be received one day prior to meeting date.
- **Regular Mail:** Mail your public comment to L.A. County Behavioral Health Commission, 510 S. Vermont Ave., 22-111, Los Angeles, CA 90020. Mail must be received five days prior to meeting date.

If you need accommodations beyond what is listed above, please contact the BHC support staff at 213-947-6487or 213-948-2463 at least 5 days before the meeting to request additional accommodations. You can also submit this request by email to mhcommission@dmh.lacounty.gov .

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Public Hearing Presentation

1

2

MENTAL HEALTH SERVICES ACT MAIN POINTS AND DEVELOPMENT OF THE ANNUAL UPDATE

In November 2004, California voters supported Proposition 63 and passed the Mental Health Services Act (MHSA) that imposes a 1% income tax on personal income in excess of $1 million.

- The Act provides the significant funding to expand, improve and transform public mental health systems to improve the quality of life for individuals living with a mental illness.
- Welfare and Institutions Code (WIC) Section 5847 requires county mental health programs prepare and submit a Three-Year Program and Expenditure Plan followed by Annual Plan Updates for MHSA programs and expenditures.
- The Plan provides an opportunity for Los Angeles County-Department of Mental Health (LACDMH) to
  - Review its existing MHSA programs and services to evaluate their effectiveness; and
  - Propose and incorporate any new programs through a robust stakeholder engagement process, should additional funding be available.
- It is through the Community Planning Process that LACDMH will obtain important feedback from a broad array of stakeholders.
- The MHSA Two Year Program and Expenditure Plan for Fiscal Years 2024-25 through 2025-26 was adopted by the County Board of Supervisors on May 21, 2024.

3

3

COMMUNITY PLANNING PROCESS

The goal of the Community Planning Process is to ensure community stakeholders take an active role in advising the County on service needs across all Los Angeles County communities. LACDMH takes a collaborative and inclusive approach to understanding community priorities through a community-driven partnership that engages the large, multicultural, and diverse community stakeholder group within the County.

The following meetings shared updates and collected questions/concerns. They took place both virtually and in person, with documents translated in both Spanish and Korean.

April – June 2024

Informational meetings which included:

- MHSA Foundational / Educational Video Development
- Integration of Call Center for Mental Health and Substance Use Service
- Data and Accountability 101: Introduction to Results Based Accountability (RBA)
- Data and Accountability 201

July 2024 – December 2024

MHSA Program **updates** were provided on the following:

- Full Service Partnership
- Outpatient Care Services
- Los Angeles County Population level data and service utilization
- Housing
- Linkage
- Alternative Crisis Services
- Workforce Education and Training
- Interim Housing Outreach Program (IHOP)
- Hollywood 2.0
- Innovation 7: Therapeutic Transportation
- Innovation 8: Early Psychosis Learning Network
- Prevention and Early Intervention

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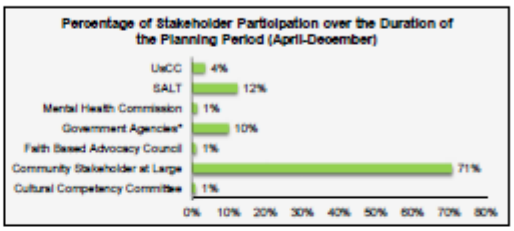
COMMUNITY PLANNING PROCESS
Stakeholder Participation

Community Planning Team
Based on recommendations from DMH stakeholders and management, the CPT includes five categories with a corresponding number of representatives:

Community Planning Team Categories	
Stakeholder Categories	**Representatives**
1.Community Leadership Team	30
2.Community Stakeholder Groups	41
3.County Departments	19
4.Education System	5
5.Government/Quasi-Government Agencies	5
Total:	**100**

Stakeholder Participation by Month

Month	Number of Attendees
April	31
May	104
June	112
July	107
August	251
September	177
October	204
November	55
December	70



*Government Agencies include: Chief Executive Office, Probation Department, Department of Health Services, Department of Public Health, Fire Department, Public Defender, Board of Supervisors, Justice Care and Opportunities and Los Angeles Homeless Services Authority (LAHSA)

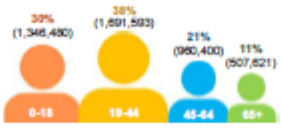
5

POPULATION ENROLLED IN MEDI-CAL

This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, and age.

Approximately 40% of the Los Angeles County population are Medi-Cal Eligibles.

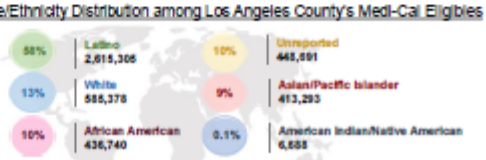
Age Group Distribution among Los Angeles County's Medi-Cal Eligibles



Top 3 Primary Languages

60%	English (2,638,861)
33%	Spanish (1,451,889)
2%	Armenian (91,924)

Race/Ethnicity Distribution among Los Angeles County's Medi-Cal Eligibles



Note: The following data is taken from the California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, Gender and Age Group. Downloaded on April, 2024.

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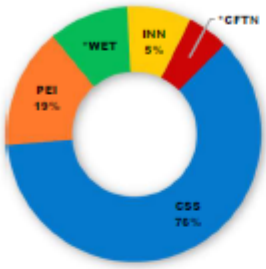
MHSA OVERVIEW BY COMPONENTS



- CSS, PEI and INN percent of total annual MHSA allocations shown below
- *WET and CFTN allocations are funded by transfers from CSS

- COMMUNITY SERVICES AND SUPPORTS (CSS)
- PREVENTION AND EARLY INTERVENTION (PEI)
- WORKFORCE EDUCATION AND TRAINING (WET)
- INNOVATION (INN)
- CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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COMMUNITY SERVICE AND SUPPORTS (CSS) – FY 2023-24
Component and Client Served

About CSS
- Largest MHSA component with 76% of the total MHSA allocation
- For clients diagnosed with a serious mental illness (SMI)

CSS Programs:
- Full Service Partnership
- Outpatient Care Services
- Alternative Services Crisis
- Housing Services
- Linkage
- Planning, Outreach and Engagement Services

Clients Served

162,836

unique clients received a direct service through CSS

Client Served by Service Area

Service Area	Number of Clients Served
SA1 – Antelope Valley	12,330
SA2 – San Fernando Valley	26,259
SA3 – San Gabriel Valley	24,457
SA4 – Metro	35,809
SA5 – West	11,017
SA6 – South	26,592
SA7 – East	15,861
SA8 – South Bay	32,567

*Clients served may have received services in more than one service area. Number of clients counted are for direct services and do not include outreach efforts.

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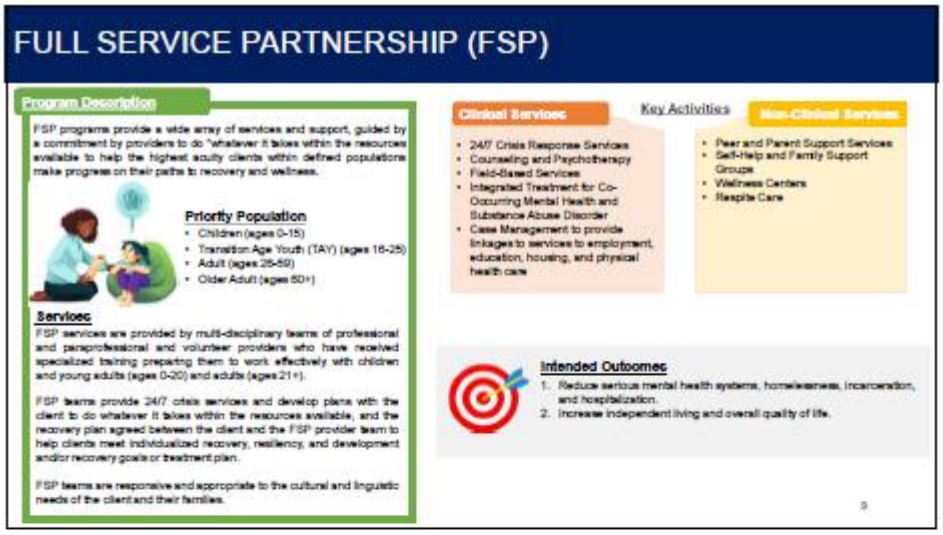
FULL SERVICE PARTNERSHIP (FSP)
Program Description
FSP programs provide a wide array of services and support, guided by a commitment by providers to do "whatever it takes within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness.
Priority Population
Children (ages 0-15)
Transition Age Youth (TAY) (ages 16-25)
Adult (ages 26-59)
Older Adult (ages 60+)
Services
FSP services are provided by multi-disciplinary teams of professional and paraprofessional and volunteer providers who have received specialized training preparing them to work effectively with children and young adults (ages 0-20) and adults (ages 21+).
FSP teams provide 24/7 crisis services and develop plans with the client to do whatever it takes within the resources available, and the recovery plan agreed between the client and the FSP provider team to help clients meet individualized recovery, resiliency, and development and/or recovery goals or treatment plan.
FSP teams are responsive and appropriate to the cultural and linguistic needs of the client and their families.
Clinical Services
Key Activities
Non-Clinical Services
24/7 Crisis Response Services
Counseling and Psychotherapy
Field-Based Services
Integrated Treatment for Co-Occurring Mental Health and Substance Abuse Disorder
Case Management to provide linkages to services to employment, education, housing, and physical health care
Peer and Parent Support Services
Self-help and Family Support Groups
Wellness Centers
Respite Care
Intended Outcomes
1. Reduce serious mental health systems, homelessness, incarceration, and hospitalization.
2. Increase independent living and overall quality of life.
9

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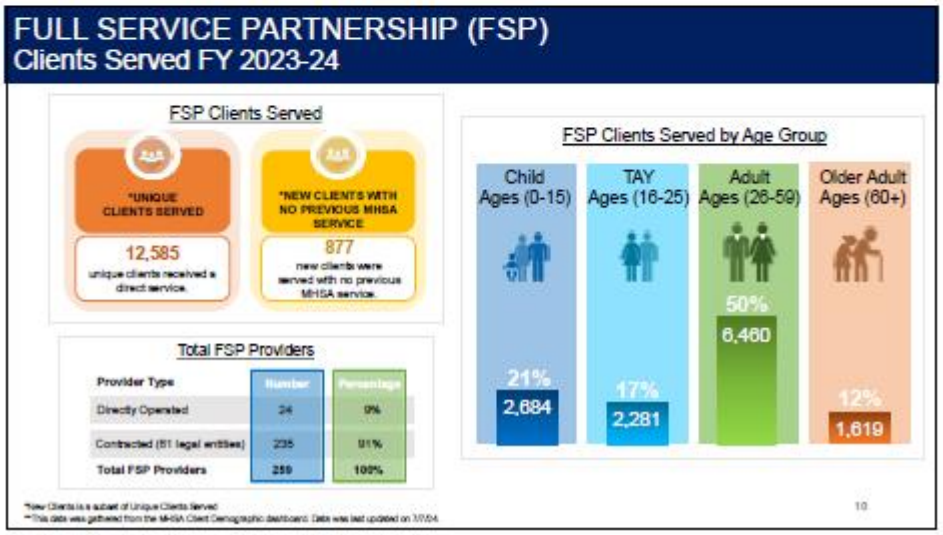
FULL SERVICE PARTNERSHIP (FSP)
Clients Served FY 2023-24
FSP Clients Served
*UNIQUE CLIENTS SERVED
12,585
unique clients received a direct service.
*NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE
877
new clients were served with no previous MHSA service.
Total FSP Providers
Provider Type
Number
Percentage
Directly Operated
24
9%
Contracted (51 legal entities)
235
91%
Total FSP Providers
259
100%
FSP Clients Served by Age Group
Child Ages (0-15)
21%
2,684
TAY Ages (16-25)
17%
2,281
Adult Ages (26-59)
50%
6,460
Older Adult Ages (60+)
12%
1,619
10

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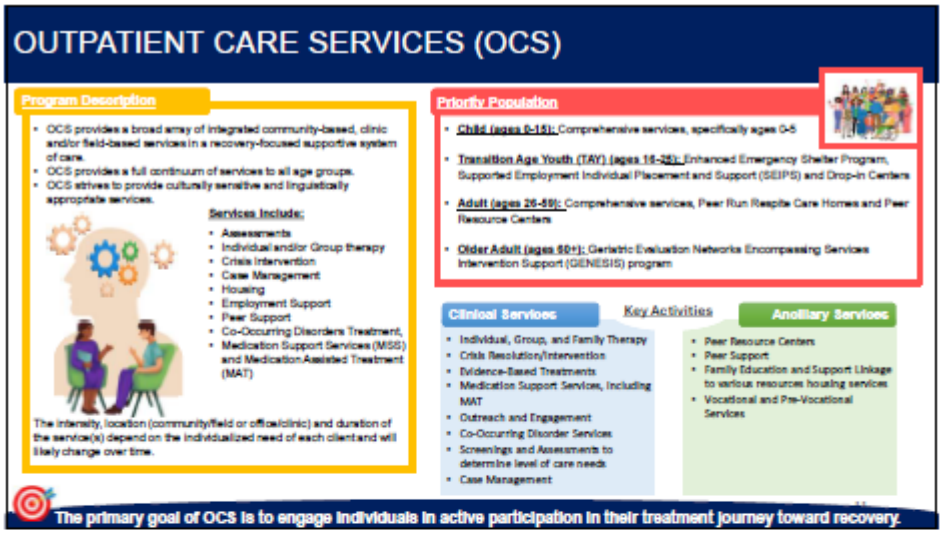
OUTPATIENT CARE SERVICES (OCS)
Program Description
OCS provides a broad array of integrated community-based, clinic and/or field-based services in a recovery-focused supportive system of care.
OCS provides a full continuum of services to all age groups.
OCS strives to provide culturally sensitive and linguistically appropriate services.
Services Include:
Assessments
Individual and/or Group therapy
Crisis Intervention
Case Management
Housing
Employment Support
Peer Support
Co-Occurring Disorders Treatment,
Medication Support Services (MSS) and Medication Assisted Treatment (MAT)
The intensity, location (community/field or office/clinic) and duration of the service(s) depend on the individualized need of each client and will likely change over time.
Priority Population
Child (ages 0-15): Comprehensive services, specifically ages 0-5
Transition Age Youth (TAY) (ages 16-25): Enhanced Emergency Shelter Program, Supported Employment Individual Placement and Support (SEIPS) and Drop-In Centers
Adult (ages 26-59): Comprehensive services, Peer Run Respite Care Homes and Peer Resource Centers
Older Adult (ages 60+): Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) program
Clinical Services
Key Activities
Ancillary Services
Individual, Group, and Family Therapy
Crisis Resolution/Intervention
Evidence-Based Treatments
Medication Support Services, including MAT
Outreach and Engagement
Co-Occurring Disorder Services
Screenings and Assessments to determine level of care needs
Case Management
Peer Resource Centers
Peer Support
Family Education and Support Linkage to various resources housing services
Vocational and Pre-Vocational Services
The primary goal of OCS is to engage individuals in active participation in their treatment journey toward recovery.

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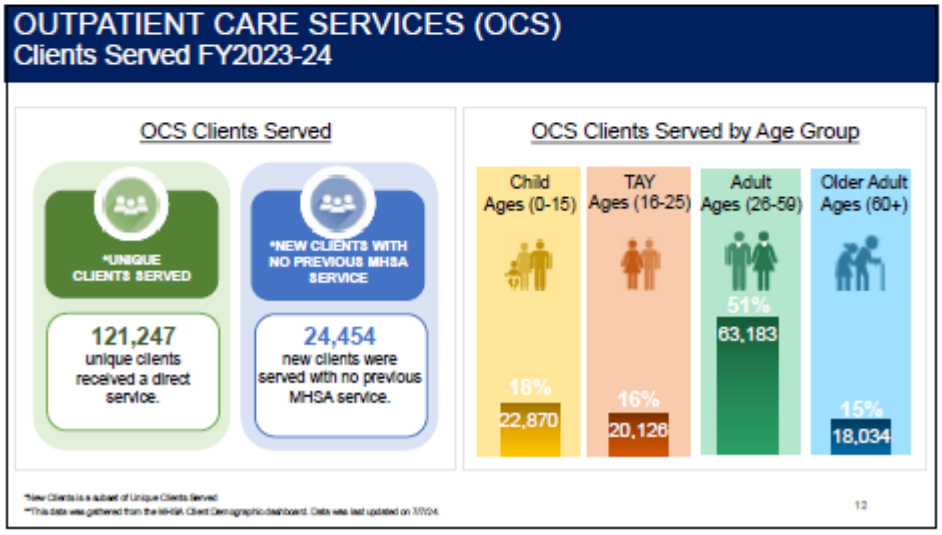
OUTPATIENT CARE SERVICES (OCS)
Clients Served FY2023-24
OCS Clients Served
*UNIQUE CLIENTS SERVED
121,247
unique clients received a direct service.
*NEW CLIENTS WITH NO PREVIOUS MHSA SERVICE
24,454
new clients were served with no previous MHSA service.
OCS Clients Served by Age Group
Child Ages (0-15)
18%
22,870
TAY Ages (16-25)
16%
20,126
Adult Ages (26-59)
51%
63,183
Older Adult Ages (60+)
15%
18,034
*New Clients is a subset of Unique Clients Served
**This data was gathered from the MHSA Client Demographic dashboard. Data was last updated on 7/1/24.
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ALTERNATIVE CRISIS SERVICES (ACS)

Program Description

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.

Services:
These programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs, e.g., FSP and Assertive Community Treatment programs, housing alternatives, and treatment for co-occurring substance abuse.

Population:
ACS serves individuals 18 years of age and older of all genders, races/ethnicities, and languages spoken.

ACS Programs:

- Psychiatric Urgent Care Centers
- Enriched Residential Services (ERS)
- Crisis Residential Treatment Programs (CRTP)
- Law Enforcement Teams (LET)
- Restorative Care Villages
- Psychiatric Mobile Response Teams (PMRT)
- 988 Crisis Call Center Services (also known as The 988 Suicide & Crisis Lifeline) – See the Suicide Prevention section for outcomes and program content.

Key Activities

- Divert clients as appropriate to mental health urgent cares
- Divert clients as appropriate to Crisis Residential Treatment Programs
- Utilize mental health clinician teams in the fields as alternatives to crisis response

Intended Outcomes:

- Reduce utilization of psychiatric emergency rooms and inpatient acute psychiatry
- Reduce incarceration of persons with severe and persistent mental illness

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HOUSING

Program Description

DMH provides a wide variety of housing resources and supportive services for individuals experiencing homelessness who have a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) including temporary housing, permanent housing, move-in assistance, eviction prevention and specialty mental health and housing case management services. DMH also administers funds that support capital development, capital improvements and operating subsidies.

Housing Programs
The following DMH programs provided clients who were experiencing homelessness or at risk of homelessness with housing resources and supportive services:

- Capital Investments Program
- Housing Supportive Services Program
- Intensive Case Management Services Program
- Federal Housing Subsidies Unit
- Housing Assistance Program
- Housing for Mental Health Program
- Diversion, Reentry and Mental Health Program
- Enriched Residential Care Program
- Interim Housing Program
- Enhanced Emergency Shelter Program for Transition Age Youth (TAY)

Key Activities

- Provide Interim and Permanent Housing
- Move-In Assistance
- Supportive Services for Housing Retention
- Preserve Licensed Residential Care Settings
- Invest in New Housing Resources

Intended Outcomes

Assist Clients to:
- Access Interim Housing
- Secure Permanent Housing
- Retain Permanent Housing through Financial Assistance and Supportive Services

Increase:
- Housing Resources such as Rental Subsidies for DMH Clients
- Number of Interim Housing Beds for DMH Clients
- Investments in the development of Permanent Supportive Housing (PSH) Units for DMH clients

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HOUSING
Outcomes FY 2023-24

Capital Investments Program

110 of the 162 Permanent Support Housing (PSH) developments finished construction, resulting in 2,706 units available for occupancy.

Individuals Housed
- 2,536 adult clients and adult family members
- 127 minor children
- 149 unknown/not report

Over half of all clients resided in Service Areas 4 and 6.

Housing for Mental Health (HFMH)

407 DMH clients were in permanent housing at some point during FY 2023-24.

- Of the 407 clients, 340 were FSP clients referred by DMH contractors and 67 were FSP clients with justice involvement referred by DHS Office of Diversion and Reentry (ODR).
- 49 individuals were newly referred to the program
- 39 individuals newly moved into housing

83% housing retention rate for the HFMH clients

Federal Housing Subsidies Unit

DMH Housing Authority contracts included 2,749 housing vouchers. These vouchers helped to provide housing to 2,498 households across all Service Areas, which was a 14% increase from the previous fiscal year.

3,606 Individuals Housed
- 2,613 adults
- 993 minor children

86.5% housing retention rate for DMH clients residing in these units. The average length of stay for clients was 5.67 years.

Enriched Residential Care Program (ERC)

In FY 2023-24, the ERC program served a total of 1,452 unique clients.

- 470 clients were referred to the program and
- 523 clients moved into an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) with ERC financial support

81% housing retention rate for the ERC program

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HOUSING
Outcomes FY 2023-24

Interim Housing Program (IHP) – Adults

The Interim Housing Program (IHP) is intended to provide shelter services for adults with Serious Mental Illness (SMI) and their minor children who are experiencing homelessness and do not have adequate income to pay for temporary housing.

Outcomes:
MHSA funds enabled DMH to contract for 783 IHP beds across 24 sites.

- 700 beds servings 1,760 individuals
- 83 family units serving 86 families
- IHP average occupancy rate was 80%

The highest number of clients served was in Service Area 4 and the lowest number of clients served was in Service Area 3.

A total of 1,081 IHP clients exited the program, of which 32% exited to permanent housing.

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HOUSING
Outcomes FY 2023-24

Enhanced Emergency Shelter Program (EESP) – TAY (18-25)

The Enhanced Emergency Shelter Program (EESP) uses MHSA and other funds to serve the urgent housing needs of the TAY population, ages 18-25. This includes TAY who are unhoused or at immediate risk of becoming unhoused with no alternative place to stay and no significant resources or income to pay for shelter and are experiencing mental health concerns and willing to accept the treatment offered.

During FY 2023-24 the EESP capacity was 110 beds, with shelters in Service Areas (SA) 2, 4, and 8.

EESP served 575 Transitional Age Youth (TAY) during the fiscal year.

Client Served by SA

SA 2	SA 4	SA 8
1 Shelter	3 Shelters	4 Shelters
90 Clients	189 Clients	296 Clients

Enhanced Emergency Shelters (EESP)

EESP Name	Supervisorial District	Service Area	Bed Total
Ella's Foundation 8th Ave	2	6	14
Good Seed 2nd Ave	2	6	32
Good Seed 5th Ave	2	6	12
Covenant House	3	4	4
Salvation Army-The Way In	3	4	14
LA LGBT Center	3	4	20
Ella's Foundation Tampa	3	2	14
		Bed Total:	110

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LINKAGE

Program Description

Linkage provides programming that works with those in the community to connect them to essential services that include treatment, housing and other mental health service programs throughout the County. Linkage programs include:

- Jail Transition and Linkage Services
- Mental Health Court Linkage
- Service Area Navigation
- Homeless Outreach and Mobile Engagement (HOME)
- Veteran & Military Family Services

Key Activities

- Assist the judicial system with individual service needs assessments of defendants, link defendants to treatment programs, and provide support and assistance to defendants and families
- Assist a multi-disciplinary team in considering candidates' eligibility and suitability for pre-trial rapid diversion and linkage to treatment services
- Develop alternate sentencing, mental health diversion and post-release plans that consider best fit treatment alternatives and Court stipulations

Intended Outcomes

- Linkage programming engages in joint planning efforts to ensure that an active locally-based support network comprised of community partners, including community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups
- Increase access to mental health services and strengthen the network of services available to clients in the mental health system
- Promote awareness of mental health issues and the commitment to recovery, wellness and self-help
- Engage with people and families to quickly identify currently available services, including supports and services tailored to a client's cultural, ethnic, age and gender identity

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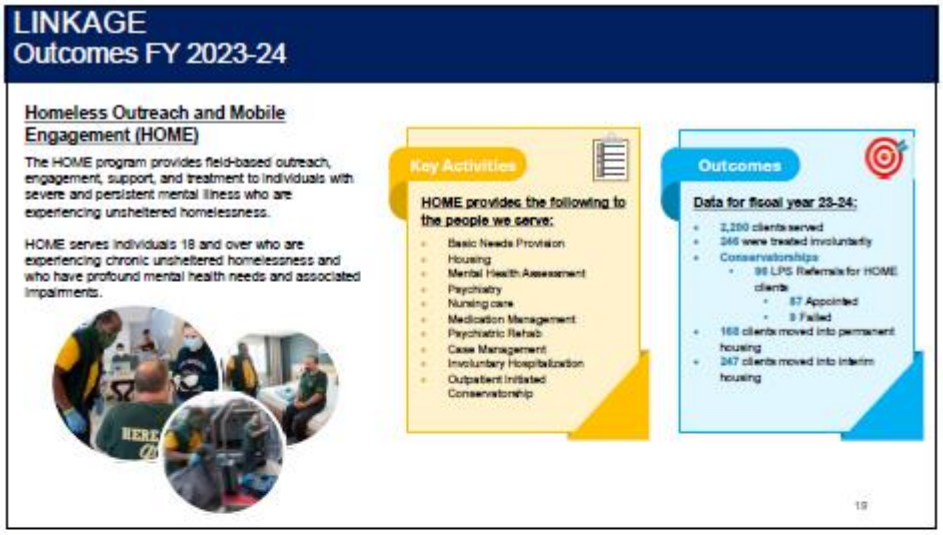
LINKAGE
Outcomes FY 2023-24
Homeless Outreach and Mobile Engagement (HOME)
The HOME program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness.
HOME serves individuals 18 and over who are experiencing chronic unsheltered homelessness and who have profound mental health needs and associated impairments.
Key Activities
HOME provides the following to the people we serve:
Basic Needs Provision
Housing
Mental Health Assessment
Psychiatry
Nursing care
Medication Management
Psychiatric Rehab
Case Management
Involuntary Hospitalization
Outpatient Initiated Conservatorship
Outcomes
Data for fiscal year 23-24:
2,200 clients served
246 were treated involuntarily
Conservatorships
98 LPS Referrals for HOME clients
87 Appointed
9 Failed
168 clients moved into permanent housing
247 clients moved into interim housing
19

19

20

21

Services Provided in 2020	Cost
Fire Department: 200 calls at $1000/call	$200,000
St. Joseph's ED: 33 visits at $6,145.76/visit	$202,810
Cedars, Tarzana, and Holy Cross EDs: 77 visits	$470,223
ED visits at other facilities: 100 $6,145.76/visit	$614,576
Limb Amputation	$121,294
One Year Total	**$1,608,903**

22

Services Provided in 2020	Cost
Fire Department: 200 calls at $1000/call	$200,000
St. Joseph's ED: 33 visits at $6,145.76/visit	$202,810
Cedars, Tarzana, and Holy Cross EDs: 77 visits	$470,223
ED visits at other facilities: 100 $6,145.76/visit	$614,576
Limb Amputation	$121,294
Services Provided in 2023	**Cost**
Psychiatric Skilled Nursing Facility: $249/day	$90,885
Current Yearly Total	**$90,885**

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PREVENTION AND EARLY INTERVENTION (PEI) Component

About PEI

- Second largest MHSA component with 19% of the total MHSA allocation
- Focus on providing preventative and early intervention strategies, education, support and outreach to those at risk of developing mental illness or experiencing early symptoms.
- PEI includes the following services:
  - Prevention
  - Early Intervention
  - Stigma and Discrimination Reduction
  - Suicide Prevention

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PREVENTION SERVICES Outcomes FY 2023-24

Prevention & Aftercare (P&A)

527 Protective Factors Surveys were administered at baseline and after completion of multi-session P&A case navigation services. There was a general increase in protective factors from baseline to end of services.

- **Parent/caregiver resilience:** score increased from 2.5 to 3.1
- **Social connections:** score increased from 2.4 to 3.0
- **Knowledge of parenting and child development:** score decreased from 2.8 to 2.7
- **Social and emotional competence of adults:** score increased from 3.6 to 3.9
- **Social and emotional competence of children:** score increased from 2.8 to 3.0

37,697 people attended P&A single events
3,088 surveys collected from events
(only one person per family completing a survey)

The following protective factors were noted:

- 85.0%Connected with others
- 79.8% Discovered something new about themselves or their family
- 87.2% Learned about community programs and resources that are useful to themselves and/or their family
- 86.3% Learned something different to do with family
- 86.1% Learned tips/tools that can strengthen themselves and/or their family's wellbeing

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PREVENTION SERVICES
Outcomes FY 2023-24

Antelope Valley Community and Family Resource Center (AV-CFRC)

19,877 individuals were served throughout FY 2023-2024. The Brief Universal Prevention Programs Survey (BUPPS) was administered at single/one-time events and at baseline/pre, update, and after/post completion of multi-sessions.

2,886 BUPPS surveys completed:

- 1,661 single event
- 268 pre
- 357 update
- 409 post

Data reflects an overall increase in protective factors including:

- Positive Coping,
- Emotional Resources,
- Increased Emotional Self-Regulation,
- Clear Expectations for Behavior & Resiliency
- Ability to Access Care, and
- Accessing concrete supports and resources.
- Reduction in risk factors including risk of homelessness and substance use.

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EARLY INTERVENTION

Program Description

Directed toward individuals and families for whom a short, relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment. Early intervention services feature the inclusion of evidence based and community defined evidence-based treatment, providing clients with access to proven, research-supported interventions.

Requirements

- Target population are individuals with less intense mental health needs who would benefit from short-term services.
- Services are short-term and time-limited (usually less than 18 months).
- Outcome measures are required to be administered for every Evidence-Based Practice (EBP) and PEI program.

Target Population

- **Children/Youth in Stressed Families**
  (Treating family members with the goal of alleviating the mental health symptoms of the child/youth, also qualify).
- **Underserved Cultural Populations**
- **Individuals Experiencing Onset of Serious Psychiatric Illness**
- **Trauma-Exposed**
- **Children/Youth at Risk for School Failure**
- **Children/Youth at Risk of or Experiencing Juvenile Justice Involvement**

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EARLY INTERVENTION SERVICE
Clients Served FY 2023-24

***CLIENTS SERVED**

35,638
unique clients received a direct service

15,606
new clients were served with no previous MHSA service

Clients Served by Race/Ethnicity and Primary Language

Ethnicity
- 55% Hispanic
- 21% Unreported
- 9% White
- 8% African American
- 3% Multiple Races
- 2% Asian/Pacific Islander
- 1% Native Hawaiian
- 0.25% Native American

Primary Language
- 76% English
- 21% Spanish

CLIENT DATA BY SERVICE AREA

Service Area	Number of Clients Served	Number of New Clients
SA1 – Antelope Valley	2,012	752
SA2 – San Fernando Valley	5,900	2,780
SA3 – San Gabriel Valley	6,034	2,348
SA4 – Metro	5,482	2,355
SA5 – West	1,048	492
SA6 – South	4,211	2,253
SA7 – East	6,602	2,820
SA8 – South Bay	5,219	2,239

*New Clients is a subset of Unique Clients Served

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SUICIDE PREVENTION/POSTVENTION- Suicide Postvention, Access, Community Engagement (SPACE)

Program Description
The Suicide Prevention/Postvention Programing provides services through multiple strategies by strengthening the capacity of existing community resources and creating new collaboratives and comprehensive efforts at the individual, family, and community level.

These services include:

- **Community outreach, engagement** and **education** in the identification of the suicide risks and protective factors.
- **Linking direct services** and **improving the quality of care** to individuals contemplating, threatening, or attempting suicide.
- **Access** to evidence-based interventions trained suicide prevention hotlines.
- **Building the infrastructure** to further develop and enhance suicide prevention/postvention programs throughout the county across all age groups and cultures.

Some of the key elements to suicide prevention are:

1. Focus on fostering prevention/postvention and well-being
2. Promote early help seeking behaviors
3. Ensure a safe, compassionate, and thorough response for community members
4. Implement a short- and long-term support system

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SUICIDE PREVENTION (SP)
Outcomes FY 2023-24

FISCAL YEAR 2023-24 SUICIDE PREVENTION DATA AND OUTCOMES:

Suicide Prevention Programs

688 surveys received for suicide prevention trainings

- 98% of participants agreed or strongly agreed the SP programs were quite successful in meeting their program goals.
- 98% of participants agreed or strongly agreed with the statement: *"as a direct result of this program I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide."*
- 99% of participants agreed or strongly agreed with the statement: *"The presenters demonstrated knowledge of the subject matter."*

School Threat Assessment Response Team (START)

84 presentations were conducted

850 referrals were served

- **90%** received early screenings and/or threat assessments
- **10%** received consultations
- Primary focus of **interventions** centered on:
  - **39%** Initial Screening/Threat Assessment
  - **23%** Crisis Intervention
  - **11%** Linkage

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WORKFORCE EDUCATION AND TRAINING (WET)
Component

About WET

The Los Angeles County MHSA - Workforce Education and Training (WET) Plan seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven and promotes the transformation of mental health services to a strength-based approach that is inclusive of recovery, resilience and wellness. Such tenets are cornerstones of MHSA.

The Plan provides opportunities to recruit, train and re-train public mental health staff to meet those mandates.

The County will transfer funds from its CSS account into the WET account to fund the following WET categories:

1. Training and Technical Assistance
2. Residency and Internship
3. Financial Incentives
4. Mental Health Career Pathways

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INNOVATION (INN) Component

About INN

The innovation programs are designed to do **one** of the following:

- Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention (PEI).
- Make a change to an existing practice in the field of mental health, including but not limited to, application to a different population.
- Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

Innovation programs should result in **one (or more)** of the following:

- Increase access to mental health services to underserved groups.
- Increase the quality of mental health services, including measurable outcomes.
- Promote interagency and community collaboration related to mental health services or supports or outcomes.
- Increase access to mental health services.

Five percent (5%) of total funding for each county mental health program for Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) is reserved for Innovation.

- Innovation programs are short-term.
- At the end of the project a County must decide whether funding should continue using a different source (like CSS or PEI).
- Evaluation data is used to support decision-making.

Programs for FY 2023-24	Programs Continuing/Starting in FY 2025-26
Innovation 8: Early Psychosis Learning Healthcare Network	Hollywood 2.0
Hollywood 2.0	Interim Housing Multidisciplinary Assessment & Treatment Teams
Interim Housing Multidisciplinary Assessment & Treatment Teams	Children's Community Care Village

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INNOVATION: NEW PROJECT – FY 2025-26

BHSA Transformation Project: DMH is seeking support to join an already approved statewide INN project to provide consultation, technical assistance and support for DMH and its providers as they transition from MHSA to BHSA. We are focused on supporting transformation of Prevention, Full Service Partnership, and Client Run Centers.

P.A.T.H.W.A.Y.S. Providing Access to Treatment, Health, Wellness, and Youth Support

DMH proposes targeted one-time funding and technical assistance (TA) to strengthen programs with proven outcomes. This initiative aims to enhance organizational capacity, achieve Medi-Cal certification, and ensure the long-term sustainability of these programs by claiming Medi-Cal. Thus, the Prevention Division is proposing a pathway ending in new CBOs contracting with the Department to deliver claimable services, through a contract that is not the traditional SD M/C contract.

Transformation from Peer Resource Centers to Clubhouses

This Innovation project proposes to redesign the system in preparation for the county's transition to Behavioral Health Services Act (BHSA) and Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) initiative. The purpose of this INN Project is to transform the existing Peer Resource Centers into the Clubhouse model, assuring alignment with BHSA and BH Connect.

Full Service Partnership (FSP)

The FSP program provides a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help the highest acuity clients within defined populations make progress on their paths to recovery and wellness. This project will allow for technical assistance and support for outpatient providers transitioning to become Full Service Partnership providers and will support any newly contracted Full Service Partnership providers.

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CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) Component

About CFTN

Capital Facilities and Technological Needs means projects for the acquisition and development of land and the construction or renovation of buildings or the development, maintenance or improvement of information technology for the provision of Mental Health Services Act administration, services, and supports. Capital Facilities and Technological Needs does not include housing projects.

The County transferred funds from its CSS account into the CFTN account to fund projects.

Projects – Fiscal Year 2023-24

During FY 2023-24, the following facilities have incurred either design fees, project management fees, construction fees and/or plan checks using either Capital Project – Tenant Improvement/New Facilities or Pool dollars/Unanticipated projects funds:

- Jacqueline Avant Children and Family Center
- Olive View Children's Crisis Stabilization Unit
- LA General Urgent Care Center

Upcoming Projects – Fiscal Year 2025-26

- Tenant Improvement/New Facilities
- LA General Mental Health Rehabilitation Centers
- Children's Community Care Village High Desert
- Jacqueline Avant Transition Age Youth (TAY) Center
- Modern Call Center
- Integrated Behavioral Health System
- Technological Improvements

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FY 2024-25 MHSA PLAN UPDATE - REVISION Summary by Component

MHSA Component	Two Year Plan Update FY 2024-25	Revised Plan Update FY 2024-25	Changes
Community Services and Supports	$701,400,000	$502,057,001	($199,342,999)
Prevention and Early Intervention	$271,499,999	$203,442,301	($68,057,698)
Innovation	$50,963,914	$55,525,130	$4,561,216
Workforce Education and Training	$45,300,000	$105,118,436	$59,818,436
Capital Facilities and Technological Needs	$107,600,000	$133,297,220	$25,697,220
Total	**$1,176,763,914**	**$999,440,089**	**($177,323,825)**

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FY 2025-26 RECOMMENDED BUDGET
Revenues & Funding $ 4,153.6 Million

Primary Funding Sources

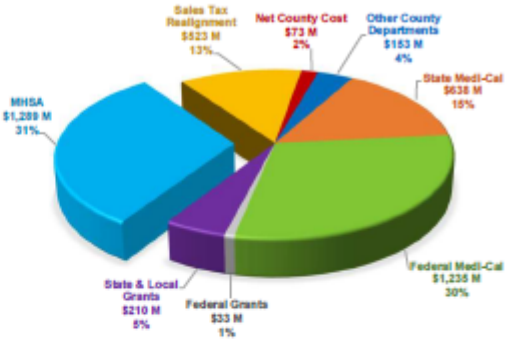
45% State and Federal Medi-Cal ($1,873 Million)
Mandated mental health services for eligible clients who meet medical necessity criteria for Medi-Cal

31% MHSA ($1,288 Million)
Outpatient; recovery and wellness-oriented services; outreach and engagement; prevention and early intervention services; workforce education and training; housing; capital; technology; and innovative projects

13% Sales Tax Realignment ($523 Million)
Treatment services in institutional settings, including Probation halls and camps, STRTPs and CTFs for youth and locked mental health treatment beds for adults

10% Grants and Other Revenues ($386 Million)

2% NCC ($73 Million)



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FY 2025-26 BUDGET PROJECTION CHANGES
Summary by Component

MHSA Component	Two Year Plan Update FY 2025-26 MHSA Fund	Estimated CSS Funds Needed FY 2025-26	Changes
Community Services and Supports	$767,400,000	$672,679,944	($94,720,056)
Prevention and Early Intervention	$207,700,000	$203,322,385	($4,377,615)
Innovation	$60,353,688	$132,355,339	$72,001,651
Workforce Education and Training	$20,300,000	$28,491,571	$8,191,571
Capital Facilities and Technological Needs	$41,599,999	$56,990,524	$15,390,525
Total	**$1,097,353,687**	**$1,093,839,763**	**($3,513,924)**

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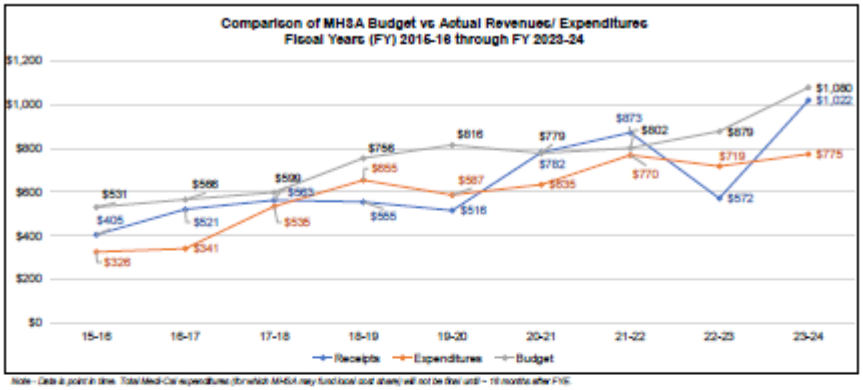
MHSA – A HISTORICAL LOOK



Note - Data is point in time. Total Medi-Cal expenditures (for which MHSA may fund local cost share) will not be final until ~ 18 months after FYE.

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MHSA 3-YEAR FORECAST

($ in millions)	2023-24	2024-25	2025-26
Carry-Over Funds	$ 1,158.2	$ 1,476.4	$ 1,284.6
Prudent Reserve	147.5	147.6	147.6
Fund Balance	**1,305.7**	**1,624.0**	**1,432.2**
Projected Allocation (includes interest)	1,099.9	928.4	688.2
Total Available Fund Balance	**2,405.6**	**2,552.4**	**2,120.4**
Projected Utilization	(781.7)	(1,120.2)	(1,084.8)
Projected Ending Fund Balance	$ 1,623.9	$ 1,432.2	$ 1,035.6

Innovation	$ 152.6
WET	$ 82.6
CFTN	$ 70.5

Estimated Fund Balance for Reallocation to BHSA Components $ 729.9
(includes $ for Prudent Reserve)

*CBHDA's Fiscal Forecasting Webinar is scheduled for mid-February 2025. FY 2025-26 projected allocation is based on CBHDA's May 2024 Forecast and is subject to change.

CONSIDERATIONS

- Significant Revenue Volatility
- Strategic transfer of CSS funds to Prudent Reserve, WET, CFTN to prolong reversion period + pay for on-going costs
- WET and CFTN will retain current 10 year-reversion period post BHSA implementation
- County – directed split of remaining CSS + PEI fund balance across BHSA categories – old money, new rules

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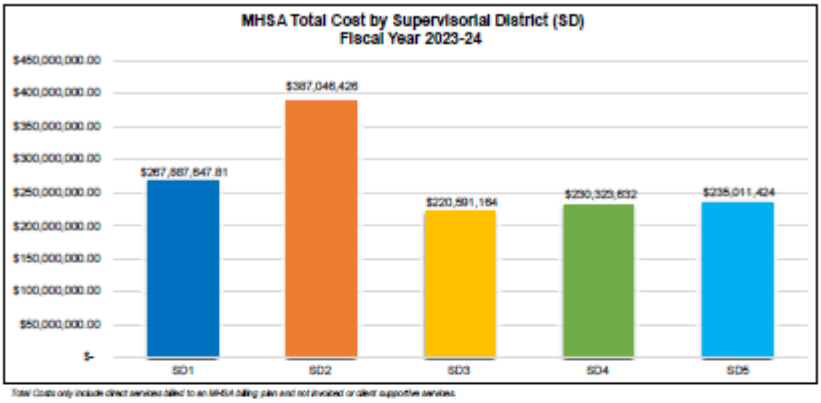
MHSA – TOTAL COST



Total Costs only include direct services billed to an MHSA billing plan and not invoiced or client supportive services.

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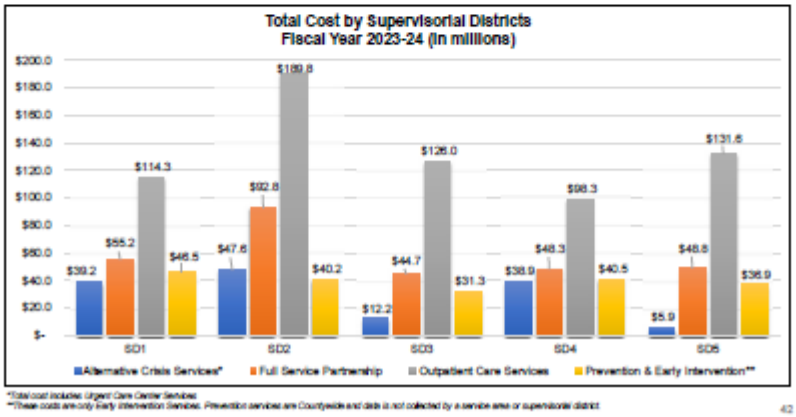
MHSA – TOTAL COST



*Total cost includes Urgent Care Center Services
**These costs are only Early Intervention Services. Prevention services are Countywide and data is not collected by a service area or supervisorial district

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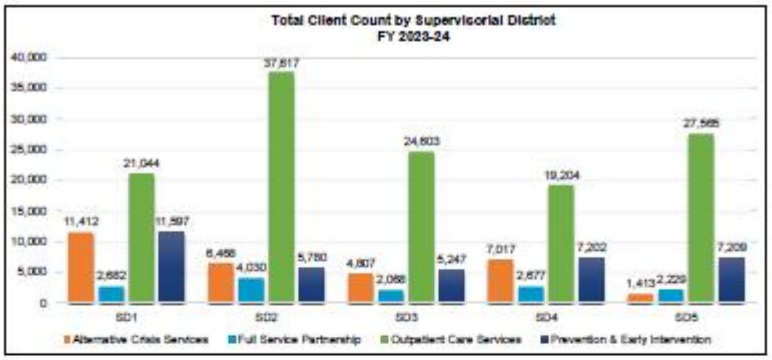
MHSA – TOTAL CLIENT COUNT BY SUPERVISORIAL DISTRICT



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Transcripts

Transcript

April 10, 2025, 5:05PM

AUDIO VIDEO MAIN 0:16
OK.
We're at 11:00 AM.
Welcome everyone.
Welcome to the LA County Behavioral Health Commission meeting.
Today's meeting is dedicated to the Mhsa updates fiscal year 20252026.
This will be the Commission's public hearing and hearing your input, your feedback on this plan updates.
I'm sorry. Apologize for that.
Let me begin with a visual.
Introduction.
Sorry about that everyone.
Let me begin with a visual introduction of myself.
I have dark brown hair, curly hair, brown skin, brown eyes.
I am wearing a Forest Green long sleeve blouse, black pants, black shoes.
Welcome all for those of you who are in the room.
Restrooms are outside.
These doors to your left and then another quick left.
There are snacks and drinks on that corner of the other room.
We also have binders that.
Have the updates.
In them. So please take a binder.
Those are for you to have.
We have also our agendas and prints on that table.
I think that's it, chair.
Thank you very much, Kenya.
Good morning.
This is Mike Molina.
I chair the Behavioral Health Commission.
Welcome everyone to our monthly meeting of the Commission.
Can you can ya?
Can you please call the roll?
Commissioner.
Commissioner Friedman.
Present Commissioner Padia Frostel, absent Commissioner, root, absent, Commissioner, Austria present, Commissioner Holmes, present.
Commissioner Stevens, present.
Commissioner dyglesh.
Ire, Roach clear Commissioner Sandoval.
Absent Commissioner Manalo.
Present.
Commissioner Molina, Chair Molina present.
Commissioner sinabria.
Absent Commissioner Shaleert here, Commissioner.
You have a quorum.
Thank you very much.
Moving on to item number three colleagues on new business, we have an update on our upcoming board election process.
Kenya.
Are we speaking about, well, the executive committee, the nominating committee?
Yes, we have a nominations committee and that has two members.
Commissioner Weisman and Commissioner Molina, and that needs to be presented to the full Commission for ratification.
So Commissioner Weisman and Commissioner Molina have volunteered to serve as the nominating committee if there are any questions to discuss, we can certainly discuss that. But we're looking for a motion and a second to move Stacy Delgle.
Thank you, Commissioner dacleish.
Do we have a 2nd 2nd?
I'll second thank you, Commissioner Stevens.
Any questions or comments about our nominating committee?
All right, seeing none. Let's have a A roll call vote, please.
Kenya, for our nominating committee.
It's not on the consent agenda, so I think we should have a roll call.
We have a discussion, yes, Commissioner Stevens.
I just want to make sure that 'cause I'm trying to envision what the current executive team looks like being that yourself.
And Commissioner Wiseman are on the nominating committee, which tells me that you won't be running for.
That position, that's correct.
So it's really important that we.

All right.
I don't know encouraging folks to.
Participate. If we don't have a slate as of yet of interested folks.
And so I am.
I'm a little.
I'm a little.
I'm a little uneasy because I don't.
I'll just say I just hope that folks are.
Can you just encourage chair all of us to?
Participate so that we are able to, you know, have a successful election.
I'll leave it there.
Premier Lips Commissioner Stevens, we completely agree, and Commissioner Weisman and I will be working diligently to make sure that we have a full slate to present to you. I believe Kenya is not true, that the next step is to pull the board, to see if people wish to.
Serve on the executive committee for next year.
It's something.
Call the board to pull the board.
We've sent the the survey already.
It's been sent out to all for anyone to self nominate or to nominate a colleague to be part of the new executive committee.
Great. Thank you.
Any other questions or comments?
All right, let's call the roll.
Please, Commissioner Friedman.
Commissioner Ostre, yes, Commissioner Holmes.
Yes, Commissioner Stevens.
Commissioner manalo.
Aye, commissioner daigleish.
Aye, the commissioner wrote.
Commissioner Molina aye.
Commissioner Charlotte.
Hi.
Commissioner Weisman.
All right. That is unanimously approved.
Thank you very much.
Kenya, please have a seat and relax for a few minutes.
There's a lot going on in the 1st 5 minutes of the meeting. Thank you.
All right, colleagues, we're going to move to our item number 4 standing items. We have two presentations before us.
The first is coming from our folks at Sapsy.
So we please ask those representatives to please come forward.
Good morning.
We'll get your microphone to work. All right, no problem.
The technician's on his way.
Great.
Substance use prevention and control.
I am the deputy director there, our Bureau director, doctor Gary Tsai, is unable to be here today, so I'll be doing a quick presentation.
I know we're very short on time, so we will introduce the concepts of around our prevention services and then if there is additional questions later on, we can always bring back content as well.
So I think we'll pull up the slides in a moment.
There we go.
So we can go to the next slide. I think you might be familiar with the Institute of Medicine Continuum from perhaps the Department of Mental Health Services. But just kind of a quick overview, the graphic here is really meant to depict, you know, the populations that are ser.
Within our prevention programming, the first being universal, those green folks that you see up there in the circle, that's for the entire population. If you look at the selective that is a subset population due to being at higher risk for substance use.
So you'll see.
You know fewer images of of people in that particular category and then indicated being individuals showing early signs of substance use.
And so we categorize the way we deliver prevention services within this particular structure to kind of define the kind of work that we do.
So you'll see some examples of our programs up there in each of the categories, the easiest being in in media campaigns would be an example of universal it. It touches everyone.
Selective would be.
Our student well-being centers that are at about 40 schools across Los Angeles County that are specifically higher risk high schools.
So those being selective and then indicated being examples of educational sessions that we would have specifically with probation youth as an example who are who are using next slide.
The way that we structure this is a very busy slide, but it's meant to just kind of very high level indicate how we go about designing our prevention programming. This example is particularly on cannabis.
Or marijuana and you know, we first start off by looking at national and state level data. We look at the prevalence, how many people have a particular condition within a community.
So you'll see, for example, individuals who are 12 to 17 who've used cannabis in the past month, as an example of prevalence.

We look at the contributing factors, things that are amendable within a community to be able to.
Change those local prevalence issues and so you see an example being perceived.
Great risk of daily cannabis use as well as perceived risk of harm to the adolescent brain as being contributing factors to substance use. We also look at access and availability, so that's how easy it is to get it from our families and friends, and how available it is.
Within our communities, for example through retail cannabis stores, retail alcohol outlets etcetera.
And often times you'll find that you know.
Regions of Los Angeles County that have higher.
Alcohol or cannabis outlets also have higher correlation with substance use as well, because it impacts the way as you see in the next area.
This way that we perceive, you know, substance used to be what we see in ads on media, in music, things like that, all influence our social norms.
And so you'll see examples of data and how that varies throughout Los Angeles County as a whole and across our service planning areas. Once we look at state and national data.
We look at kind of we do local needs assessments, so we'll do environmental scans, individual and group interviews with local community members, surveys of local community members, etc.
Designed to be a way of really getting what is the community that we're serving really look like and what are their particular needs and and not necessarily in bigger groups such as the service planning area or the county as a whole. And once we have all of that.
Data our prevention providers will then design interventions that.
Specifically, target those things that kind of rose to the top of needs within their particular assessments throughout the community.
And so that brings us to, you know, different types of programming in different areas in different focuses based on the actual needs assessment that we have in our data.
Findings next slide.
So this is an example of key strategies that we have at sapsy overall.
So our network providers would also be working in these broader categories.
So focus areas being to increase community education and awareness through positive youth development programs, mobilizing communities to develop strategies that address local concerns over substance use, enhancing data collection and also launching media related campaigns. And on the side there, you'll see some examples of the type of program.
That we have.
Just to highlight.
Say at the bottom if you have access to this, those are links to our media campaigns at the bottom so you can get a sense of what our fentanyl frontline looked like.
Our hashtag bigger choices as well as in every corner. And then just some examples of the type of programming that we do in each of those areas. Next slide.
Kind of big picture.
These are the kind of prevention programs that we fund.
So we do some directly operated work.
We, as I mentioned, we have 43 student well-being centers that are located in high schools across Los Angeles County.
Being at higher risk, we also have six connecting to opportunities to recovery and engagement centers or core centers that are located within public health centers.
And that's where any individual community member could come and get education around substance use or referrals to treatment.
We also partner with other county departments, three of which are highlighted here, the first being the Los Angeles County Office of Education, or Laco.
They manage the Friday Night Live program, which works with young people on essentially youth development efforts.
We work with county Parks and Recreation on our spot program.
Very similar doing alternative positive activities with young people and building leadership skills. And then the LA County libraries with their my brother's keeper program.
That supports individuals who within those particular.
Communities as well.
And then lastly, our biggest bucket of funding is with our community based organizations.
These are subcontractors for us and we've got 35 agencies that essentially do more education oriented work, whether that be in the schools with parents, with communities and eight community collaboration programs.
Essentially, they are coalitions that we have in each service planning area to work with. Our prevention providers, work with community members.
And to really look at what kind of policy and advocacy oriented work can be done.
In those locales, oftentimes relating around cannabis and alcohol use as well.
So overall, we spend about $60 million in our prevention programming. I think also being part of the Department of Public Health, we do emphasize our prevention portfolio as well.
And so we are federally required to spend 25% of our federal block grant on substance use prevention services.
We use about 50% of that particular allocation as well as other funding sources that we have.
Just to demonstrate, you know, kind of what we want to do at the front end of services, so that individuals hopefully don't progress to continued substance use or substance use disorder diagnosis. Next slide.
So these are just examples of, you know, more specific programming. If you want to take a look, I know that we're short on time, but this is kind of an example of our fentanyl frontline campaign, how we targeted particular community members and age populations based on the data.
That we had and what our campaign was focused on regarding.
Community awareness.
So really wanting to make sure folks understood the riskiness of fentanyl use or that being within other substances that they may be taking, really emphasizing distribution of naloxone, which is overdose prevention medication and things like that.
So the public had a bigger understanding about what they can do as individuals and for them if they if they know someone how to refer or to carry naloxone in the event that they come across someone who.
Needs to be revived from an overdose.

Next slide.
And then lastly, we have some examples of the programming that we had in the earlier slide. The three steps is an example of our drug take back.
So those are community events where community members can come in and and turn in substances that can be diverted or used. So for example, if someone has oxycodone in their home because of a surgery they had turning that into, it's not diverted to young people, we also have.
The yellow there is what we call our sticker shock campaign.
So that's going into, in this case, liquor stores or alcohol outlets, and reminding us that to not purchase sales for, for minors and things like that and having those visual cues to hopefully change people's actions around sales to minors. So these are a few examples that we.
Have on our prevention programming. You can go to the next slide.
We're happy in future sessions to be able to go over this in a little more detail if helpful and also based on prior conversations.
We've put together a bit of an outline of what we hope to discuss in future sessions, and those are listed here. Of course, if there's any questions or additional details or topics that are of interest to the Commission, please let us know.
Otherwise, our next presentation on May 8th will be value based care for treatment services. Essentially how we fund them and how we're doing.
Creative efforts to really motivate our provider network to look at outcome based care.
So thank you very much.
Thank you.
Another excellent presentation from Sappsy.
Thank you.
It was learned a lot.
Colleagues questions or comments.
I begin with Commissioner Roach.
This is a great presentation.
Thank you.
Can you talk a little bit about metrics of effectiveness, how you're gauging the success of prevention programs in specific and if you could speak a little bit to how you're distinguishing any success that you're seeing from, you know, national trends. For example, I think I think fentanyl death.
Have been decreasing nationwide for about two years now, owing to factors I I don't understand.
I was just wondering whether or not you could, you know, just be sure in your evaluation how you know it's you and not something else. Yeah, yeah.
And I think that that's always a complication with prevention. You know, when we're trying to measure something that that in many cases doesn't actually happen, it does present some challenges from an evaluation perspective. I think when we look at our broader portfolio of prevention services, our network. Prov.
I'll speak in generalities.
I don't have the specific, but we can bring back that at a future date if need be. But the broader approach that we take to evaluation from our contractor perspective, that's the 35 and eight providers that that we had shared as they're required.
To do evaluation efforts as well. So some of the same data collection you know, looking at their surveys, looking at their findings and then we have a data evaluation team at sapsy that also looks at the the service data that's submitted by our contracted agencies and and they.
Do some some evaluation work on that?
I'd have to go back and get it, get more specifics about how they go about doing that, but it is part of the prevention framework that we have to not only do the assessment piece, but also carry that through to evaluation.
And then for the fentanyl campaign, I think.
I think we would need to.
We do have some metrics that we could share at a future date on kind of how we look at where we have changes kind of in behavior. It's again a little tricky because it's who sees those particular posts that you may have on Facebook or you know things. Like that and and does that actually convert to, you know, a particular action that's a little trickier to do within the the media campaigns, but we do have some elements on doing the evaluation for those as well.
I just don't have those at my fingertips.
Today, thank you, Commissioner Friedman.
Thank you very very much.
I have two questions.
One is who is running your media campaign.
Yeah. So we have a, we subcontract that out to a community based provider.
Our particular vendor is rescue and they've been doing our media related campaigns for the last few years and we have an area within sapsi under Anton Moore, the Strategic and Network Development Branch that has a specific unit that's responsible for. Outreach as well as our media.
Oriented campaign so SAP C as well as the Department of Public Health take a very active role in shaping what those images look like, making sure that they're reflective of the community kind of designing.
And so we've got some folks that have expertise in media campaigns and and work on our staff, but we, we subcontract the actual work, the billboards that you might see the postings you might see on Facebook, etcetera are subcontracted out to the for development by a vendor with.
Our input and then they actually do all the postings and things like that.
So it's basically a social media campaign. We do a lot of social media. We do. I think you know, we do very little like television ads just due to the cost. But we've focused in areas around social media postings. If you've seen our fentanyl frontline campaign we had.
Billboards on the 5 freeway.
The 710 freeway I'd actually seen one on my way down, Vermont.
On a building that was right near Dmh, which was very exciting.

When I pass that by as well, so we do mostly those kind of things that are on buses, those little ads that you have on buses or on the metros, things like that, we've posted there as well, but really very little media related work much more in the.
Social media space or billboards and.
Like bus placements and things like that.
I'm very curious if anybody's done an evaluation to see if those billboards, which cost a lot of money, have any effect.
At whatsoever.
Yeah, I mean, I might see it, but I'm not a fentanyl user.
And I assume people who are fentanyl users.
Just goes over their head.
I mean, I can't imagine a billboard having any.
I'm wondering about the evaluation that you do.
Yeah. And I think that goes to the the earlier question as well.
So we can provide some additional detail. I would say that for our fentanyl frontline campaign, the billboards that we had on the freeway, those are not just intended for individuals who might be users but also you and I because part of it is to really kind of incre.
Understanding in the community about the benefits of naloxone and the ability for that particular medication, we can carry it around with us.
And can you know, revive an individual who might be?
Experiencing an opioid overdose so that that could be, you know, also young people, you know, who get a hold of that, unfortunately.
Getting back on right now.
Happens to the people that's on there. So it's your.
Can I speak loudly? OK.
All right. I can speak loudly if that helps for the folks in the room.
So I think that that's that's really what we've we've done around that is to really see how not only can we target individuals and we do that on different types of campaigns. You know the individual users but also how can we work with individuals who might come across.
Individuals, young people, etcetera, that might be having an opioid overdose.
And we want to make sure that we have those life saving options available.
To them, thank you, Commissioner Freeman.
Commissioner Weisman.
Thank you.
I'm wondering about the absence of meth in the literature today.
Like, is there a prevention approach there?
What is it?
How are you working to incorporate it?
Because we're deeply affected in the area I work in. Yes, absolutely.
So we have various areas that we're working on methamphetamine.
We know that that's a huge problem in Los Angeles County as well.
We have both a prevention and treatment community collaboration group that we meet with providers and other interested individuals to be able to kind of make advancements in that space.
We also, prior to the fentanyl frontline campaign, we had a targeted media campaign as well that was specifically targeting the users. And so it was very focused in placement and things like that.
But we've focused.
On ASAP C level on how do we coordinate and collaborate with providers and other stakeholders in the community?
We do that through the targeted media campaign that we have and then our prevention providers, you know, may also do marijuana related work, but often times working with youth, it tends to be focused more on.
Cannabis and alcohol and things like that.
But yeah, certainly a focus of ours as well.
Thank you, Commissioner.
Commissioner daglesh, hi.
Thank you very much for this, Ann for your work.
I'm curious about naloxone.
And the distribution I you know and the pricing of it, because I see that it's often.
Sold at my pharmacy, but it's expensive.
That, I think is a really.
Big barrier for people who might be able to use it right? OK, yeah.
So it like you mentioned, it is available for you know you and I to go and get at you know a local pharmacy over the counter that's available the way that we also distribute we distribute in various ways within the community. And so through our harm reduction, PROV.
That's a pretty predominant way that we do that.
So we've got several.
Harm reduction providers that will distribute naloxone into the community.
We also encourage our treatment providers for individuals who are enrolling and discharging in treatment services to be provided naloxone as they come in or leave the program.
We understand that folks will generally have recovery and sober goals to be abstinent upon their treatment discharge, but often times people do relapse and we want to make sure that those resources are available.
And then lastly, the Department of Health Care Services also.
Has a community based program, so community based organizations can reach out to Dhcs Department of Health care services to also get free naloxone.
So that's another way that and that's not restricted to, you know, substance use providers or anything like that.
That would be any kind of community provider that can do the application of the state in order to get a supply that they would be

able to distribute within their programs. And I also believe that it's available at.
Public county libraries as well.
So that might be another place to look at it.
I've been getting.
Kits and distributing them to like Lyft drivers and Uber drivers. I'm wondering.
If you know if you know anything about how often that particular group of professionals are able to use this because I hear that overdoses yeah, occur in those situations, I don't.
I don't have any stats on that, but I think it's a. It's a very good idea to be able to, you know, distribute it to.
Those kinds of individuals in and those in that type of employment.
So I will take that back and share that with our team. Thank you.
Thank you again, Commissioner, Austria.
I'd like to know about the education programs.
I'd like to know, you know, where they're located across, you know, the districts and the spas.
You know what's the content? You know, 'cause, I'm sure it's variable between the providers.
You know who they're targeting and you know the competency, the cultural competency of all the trainings.
Yeah, yeah.
And and that will, like you mentioned, that will vary across the county.
We we have 35 agencies that focus in the education space.
Oftentimes that is happening either in school settings or locations where.
Young people are we also have in it's the the evidence based practice is escaping me right now. But we also do require use of a particular evidence based practice for our education oriented programs in order to provide some level of consistency across our programming.
But we also very do strongly encourage providers to be to adapt curriculum and things like that to be culturally competent to the communities that they serve.
And so they're able to make adaptations and things like that to their particular curriculums. I think as they as they need to to.
But it's we do have at our website, we would have kind of where our prevention providers are located that we could share with that with you as well, OK. And they who's reviewing it from public health is there like health educators reviewing the training of these people? Yes.
Sure that is appropriate.
Yeah, we a couple ways that we do things so.
We are when we have our prevention contractor that are doing prevention education.
Within the community, we have a team at Sapsy under our prevention chief that has a team that are assigned basically to different provider agencies. So they will have some visibility on. They will develop a work plan that they do for us.
They'll often times submit curricula Flyers that they have things like that.
So we as a county have visibility on that.
We also, as I mentioned, have the core centers that are connecting to opportunities for recovery engagement which are operated outside.
Or inside the public health centers. And they do community based education.
We have developed various kind of basic curricula on various substances and things like that that we do have, and we do conduct from a county operated perspective. I'd have to check and see if they've also shared those presentations with our community based providers.
I'm just not sure, but that those are the kind of ways that we've engaged in kind of how we're doing the education, but we do not have.
Health educators, specifically on our staff, but we do the the core centers.
Are staffed with substance abuse counselors, and so they would be doing the education when it's on behalf of the county.
Thank you, Commissioner.
Commissioner Stevens, thank you very much for the presentation.
I've been trying to be quick a real question.
Is this accurate information or is this an example?
It is accurate information, so the there's a link at the bottom that's to our 2020, 2025 strategic prevention framework.
So I pulled kind of elements out of that in order to kind of create.
That, but yes, it's all it's all correct information based on.
So with this being accurate information, I'm very much interested in understanding how this ties into the coalitions that have been created the 35 and where those 35 coalition's are, per the spas, and and then. I'm also really concerned about the social norms that's listed here.
For service areas 6.
Because it tells me that we need to look at environment.
And what's missing or what?
How do we address these unmet needs that are happening as a result?
I think this is alarming, Commissioners and I think that we should look at this data, per the spas, and address that the other is around the needs assessments. So I hear about the social media and I'm glad that Commissioner Delgle was able to give you something to walk.
Away with. But I'm also interested in how the coal.
Itions are promoting if they are participating in this campaign as well.
And then in reference to the cost associated to the harm reduction tools, I mean is it necessary if we are looking at saving lives to to have a cost associated with it at A at a drug store?
And I'm sure we do. But at the same time, I'm thinking, you know, what are we, the 40% in the mortality rates?
And so I'm hoping that as.
A future item chair.
That we would be asking information around the death rate because we know that and through public health, 40% of folks who actually died on howls on the streets.

It's 40.
It's 40%.
So could you answer?
I know I said a whole lot and I'm because I want to make sure it's on the record, but in reference to the 35, you know, perhaps bringing that information back or helping us understand.
Understand how they're participating to help advance the media campaign.
Yeah. So specifically how our eight coalition's across the county are contributing to the media campaigns, is that correct?
OK.
Yeah, I would have to.
I I'd have to check and see how we're doing that now and to what extent we're really engaging them.
I think that we do do focus groups and you know kind of engagement with individuals within the Community to get a sense of.
You know, kind of is our message actually hitting the mark.
With the target community and I know that we pull from, you know, various regions of the county and things like that.
So that it's reflected, but I don't know if that's specifically being pulled from our coalition.
So I would need to check and see specifically how they're being engaged.
Thank you, Commissioner.
Following up from Commissioner, Austrian Commissioner Stevens, questions about the organizations, the 35. I'm just curious, those of us on the on the Commission, let's take a scenario.
One of us may know a great local organization.
You mentioned school faith-based location who we think.
Boy, this will be a great place within the areas that we come from.
That would be a terrific community based organization that could provide services through you.
How would that organization?
Apply do they propose?
Is it an annual RFP?
How do we encourage organizations?
Is that we know to come to you for funding to have these programs in our local areas.
What's the process?
Sure. And we can share that link with you as well.
We do contract for a multi year contract so it is not something that's typically open continuous where we add providers on good to know a kind of regular basis in the same way that we do for our treatment network because it's a medical entitlement program, but we do.
Have a link to our master agreement. It includes kind of.
All of the requirements. So we would say kind of just generally speaking to have agencies get on the master Agreement 1st and then when we do open up a new solicitation, anybody on the master agreement would be available to apply.
We've also kind of had more informal discussions with agencies as well.
They're new to our network.
We know that contracting with the government can sometimes be challenging, so we've had different kind of conversations in advance of even that process to kind of get a sense of.
The kinds of programs that are available.
Community. Is there anything that we can do in advance of kind of more formal release that we have or to provide additional support you know on how to navigate that process?
Great. But there is something on your website that people can be directed to. All right.
May I ask just one last question?
How is lived?
Experience those who have been very successful and perhaps abstinent.
How are they folded into all the work in which you are doing?
Yeah, in within the prevention space or across everything because people at lived experience would be everywhere.
Yeah. So a couple different ways. I think the, you know the probably the predominant space where we have individuals with lived experiences within our treatment component of the continuum. Substance abuse counselors are about 80% of our workforce overall.
And I would say the vast majority of them.
Come to the field because of their personal lived experience.
And so that's kind of the predominant way.
That we engaged, that we also see a lot of individuals who have lived experience, they start as a counselor, they progress through the organization.
So for example, we have executive directors that you know were once clients of organizations and things like that.
So it is something that is really the heart and soul of substance use disorder treatment is to have that we don't have because of the.
Predominance of individuals with lived experience as counselors and the service delivery.
Folks, we don't have as strong of like a peer network in the same way that that mental health programs do. But it is something that we are building, you know, as the as the state has made that a new billable category within the medical program we're providing SCH.
To individuals to kind of complete that test to be.
Up here, counselor.
And then trying to encourage our agencies to also bring on that workforce as well, in addition to kind of what they're more used to with the substance abuse.
Use counselors.
Thank you, deputy director Gibson.
It's always great to have you great presentation.
As always, we look forward to next month.
All right.
Thank you.

Appreciate it as Kayleen comes forward, colleagues, as you know, April is always dedicated to the presentation, which is now the behavioral Health Services Act.
Our upcoming year and then to provide the opportunity for members of the public to make comments relative to the proposed. Presentation.
Report that it will eventually make its way to the Board of Supervisors.
So this annual meeting not only is required by ordinance, but it is also an important moment for us each year to get a full understanding of what's to come for the bhsa and then allow them the public to provide comment. And then we colleagues will in the form.
Of a draft letter and then a final letter will send our comments to the Board of Supervisors.
Which they will use in conjunction with the report that will be received by the department.
So that's an order today.
Kayleen welcome.
We look forward to your presentation and colleagues, a reminder as our board continues to come off and on, you may want to use the the printed presentation, which is in your packet to follow along with what I'm going to assume is an excellent presentation by kayleen. Go right.
Ahead, thank you, Commissioner.
Sorry kayleen, this is gonna.
Yeah, I don't know what the T vs doing back here, but as soon as it comes up you'll have a visual.
Of it on the TV you also have the print.
Just know that everything else everyone else can see what we're doing.
It's just your TV and just verifying Kenya that despite this TV's stubbornness, virtual online folks can see everything.
Terrific. Just want to confirm that.
Thank you.
Thank you. And thank you, Commissioner Molina and and although I thought, take folks online can probably see, I will still introduce myself. I'm Kaylee Gilbert.
I'm the mental Health Services Act coordinator for the Department of Mental Health and I am a middle-aged woman with blonde hair, blue eyes.
And I am wearing a white striped shirt and black pants.
I do want to thank you all for giving us an opportunity to go through our Mhsa annual update.
This is kind of the last mhsa only conversation we're going to have next year will be a transition year as we plan.
So first I want to share that our annual update was posted.
In the comment period was from March 7th to April 7th.
It was posted in English, Spanish and Korean.
We have solicited feedback and have let folks know it is online. We've blasted out to our folks.
We have received no comments. I just want to make that clear.
We were surprised.
I think this is one of the first years at least I've seen that we've we've received no comments.
So let's go on to the first slide. I'm going to start by talking about what I'm going to go through and then I'll talk about what this plan is. You know, the the years it covers so on.
So first of all, we'll talk about the purpose of the mhsa.
In the development of the annual update, and I'm gonna cover the community planning process, the population enrolled in medica, some of our demographics needs assessments that drive our programming overview of mhsa components.
Community services and supports, which is like our outpatient services and linkage and crisis services prevention and early intervention and then workforce, education and training.
I'll talk about innovations.
We'll talk about capital facilities.
Logical needs and I'll end with some discussion on the budget.
I've brought with me some of the leadership in the areas of prevention and early intervention in the area of our our crisis services and also when it comes to linkage, so home and innovation, so that you can hear a little bit from them about the great work that.
Being done out there.
So next slide please.
And I will too.
I know we've got binders up here.
You all have your binders.
I will try as much as I get to each components. I'll reference the page number that the details reflected on. I really want to stress before I start that this is a very, very short summary. We've just picked highlights of some of our programming. The plan is over.
250 pages. There is just an enormous amount of programming and work in there that we just we would be here all day if we wanted needed to cover it.
So I want to be clear, this isn't reflective of everything we do, but I think just giving folks an understanding of what these kinds of services do and and where we think that they really shine.
So I'll start with the mental Health Services Act for folks who aren't familiar with it.
It was passed in November 2004 as Proposition 63.
This was this proposition imposed a 1% income tax on personal income in excess of $1,000,000.
And I always like to say it's supercharged.
Our system, we are a much smaller system prior to the MHSA passed in 2004, we had a huge planning process and really launched our programming 2005, 2006 MHSA is the reason we have expanded and significant peer programming.
Mhsa is the reason we have the breadth of homeless services, housing supports and full service partnerships, field based services.
This is this has been the vision of mhsa and and LA County has certainly been building this over the past.
20 or so years.
So the the but the the proposition or the? I'm sorry, the mental Health Services act. The statute requires that we hold.
A community planning process and every three years develop a three-year plan and then on the interim years we do something

called an annual update and that's what we're doing right now.
So folks know the annual update covers three time periods.
It covers the outcomes from programming.
From the year prior 2324, it covers the community planning process.
For this year and then it, or for this plan. And then it also covers the the budget and changes in the coming years.
So it does span three time periods as we start to dig into some of these programs so that you'll see maybe some different dates on some of our some of our tables. But it is through this community planning process that we obtain like of important feedback and broad.
Based stakeholders, I'm gonna. I'll point out a couple places.
In which actually stakeholder feedback has driven some of the programming and expansion and decisions.
And this particular time, it's were a little bit different.
We have a two year plan. The state has asked us to cut this one short to get us back on cycle with the rest of the state. We went off cycle during COVID.
They gave us like, an extra year on our plan.
So This Is Us getting back on track.
So next slide.
So this is their community planning process that you'll find information on that on page 21. The goal of the community planning process again is to ensure community stakeholders take a role in advising the county on service needs.
We spent the time from April to June really at 2024 with some informational sessions helping folks.
You know, just doing some orientation to mhsa and having a conversation around data and data metrics.
And that's going to be really helpful for us as we go forward.
Bhsa and we again need to talk about outcomes and metrics and how we're holding our programs accountable and services accountable.
From July to December, what we did is we spent the time to do deep dives into each area of programming, each component and so that we made sure we are our stakeholders, had a really clear idea of all the programming that we do have. One thing we learned.
From the previous year, when we asked folks what they thought the needs were.
They listed a lot of things that we knew were already in programming and we realized awareness raising was one of the things and that in order for us to talk about what our needs are, folks need to know what we have. The other reason we did things in.
That way is that we wanted to make sure that we developed this annual update piece by piece so that the end product is just right, a collection of all all of this information, so that it's been presented throughout the year.
It's not one big batch of information at the end of the year.
So all of this has been presented before with our stakeholders.
This is that combination with the additional details that's needed. Next slide.
There we go.
Our we have a look just a little bit information on the stakeholder attendance and you can see I think July, August, September is where we got a lot more participation as we were winding down on decision making.
I think we saw that drop off a bit.
We have some, you know, feedback here on who is participating.
Katie, we do have a process, but which we identify stakeholders to make sure that we're reflecting folks that are required to be represented by statute and to make sure we have a group that is reflective of the diversity of LA and is balanced.
But we it's open to the community.
We want community input and you can see here community stakeholders at large were really the largest group of folks that participated in these meetings.
Next slide.
Are some of our needs assessment information starts on page 8.
That's our population. And right now we're just going to talk about just the population enrolled in Medicare.
That is the focus for for our dmh we are the state plan.
We're responsible for serving Medicare beneficiaries with severe or mental illness. And here in Los Angeles, approximately 40% of our population are medical eligibles.
And we do.
We understand that we have a very diverse.
County here we have 13 threshold languages, but for our race ethnicity distribution, it's 58% Latino, 13% White, 10% African American.
We do have a larger than needed, unreported and that is something that our data folks are working with to make sure that that information is captured.
Our API is at 9% and American Indian Native American is at .1%.
And our top three languages are English at 60%, Spanish at 33, and then Armenian at 2%.
However, we provide services in far more than even the 13 threshold languages that are provided. We are responsible for ensuring that we can provide services to those who need it, regardless of language.
So we have access to things like language lines and we really do work on ensuring we have a diverse staff.
That's always the ideal, so I'm going to start with, did I go ahead and let's go on to the next slide.
I thought I missed something. OK, so this is just an overview of the major, the mhsa components.
So I noted this is this mhsa is a revenue source from the state.
All of those tax dollars go up to the state and then they.
Red.
Off their funds, off the top and the MSA lays out exactly how we're supposed to spend those dollars.
So you can think of these as like little separate accounts, and I'll go through what each of them are. But we have the largest one is community services and supports at 76%.
That includes, you know, outpatient crisis linkage, PEI prevention and early intervention at 19%.
Workforce education. Training. That's wet.
And cftn that is capital facilities and technological needs.

Those are components we need to have present and we need to fund, but we funded at our discretion and only out of that CSS component, we can't fund it for PEI or innovations. And then finally, innovations at 5%, we are to set aside 5% annually to.
Fund projects where we try new ideas and then once they're done, look at them to see if they've been successful and consider how we may be able to continue them.
So we're going to do a deep dive into each of these components.
Let's go into community services and supports.
As I noted, this is our largest under CSS.
We served 162,836 individuals.
It is.
It covers our full service partnership program, our most intensive field based program in in, in we've got home as well, but home is under linkage. So we'll talk about that in a little bit outpatient care services, alternative crisis services.
Housing services, all of our housing.
Not only housing services, but rental assistance and supports and even funding for new housing that comes out of that housing piece.
Linkage, planning, outreach and engagement services. So in terms of services by service area, you can see that we have, you know this is just for CSS overall for all of these different funded services.
We have our largest portion served in LA Metro at 35,000.
Second largest is in the South Bay area.
Next slide.
It's a full service partnership.
This is, I've said.
I think is probably my fifth time this is.
This is our most intensive program, but it offers. It provides services for children, transition age, youth, adults and older adults.
It's provided by both directly operated and contracted providers. The majority of our FSP providers are contracted providers, particularly with children's.
These services they provide 24/7 crisis response.
I provide counseling and psychotherapy field based services integrated treatment for Co occurring mental health and substance use disorder.
In fact are directly operated. Fsp docs are all trained in medicine, medication assisted treatment or mat and case management to provide linkages to services like employment, education, housing and physical healthcare.
The motto for this program and we launched it was whatever it takes.
And so the idea is we've got funds for services, we've got funds to help you get into housing, to start school, whatever it's going to take.
To help you towards your own recovery goals.
The goal here and the target population is, is around folks who are homeless, who have a history of incarceration or hospitalizations.
And of course, the goal is to reduce all of those things and to increase independent living and overall quality for life. For children services, we want to.
To make sure that we are helping children and youth stay out of the the child welfare system and the juvenile justice system.
Next slide.
Full service partnership in 2324.
We served 12,585 individuals, 877 of which were new to US, and as I noted, are directly operated versus contracted.
That we have 24 directly operated.
Sites and 235 contracted sites, the largest age group that is served is adults at 50%, followed by child at 21%.
And I what I.
Don't have here, but I do want to note that we do have our outcomes which are listed and reflected in this report, that show reductions in homelessness and reductions in hospitalization and reductions in.
Sorry, injustice, involvement, outpatient care services, this is probably the largest.
Service within this component.
This provides the broad array of specialty mental health services for adults and children.
This is kind of the the meat of the requirement that we have in in our our obligation to the state and our commitment to serve the local population.
So those services include assessments, individual and group therapy, crisis intervention.
Case management, housing, employment support, Peer support, Co occurring disorder treatment and medication services. This is our outpatient clinic system that you see in every service area. We have a mix of contracted and and directly operated clinics that serve both children and adults.
This also includes our client run centers, our Wellness centers.
So it's a really broad array of services which should be available and accessible in every.
Every community.
Priority populations here are again individuals who meet this specialty mental health criteria, meaning not only for adults and children that have a mental health disorder, but are also having symptoms that significantly impact.
Their ability or suspected mental health disorder, but also their symptoms are significantly impacting their functioning in their life.
What has been, it's not new anymore.
It's been with us for quite a while, but we do have a separate mild to moderate system for folks who maybe have symptoms.
Who have a diagnosis but are able to have a higher functioning level.
In next slide please.
Outpatient services we served 121,247 in 23/24/24, thousand of which are new.
Again, the largest group is adult and I think that's just because of the age span, right zero to 1516 to 25 and then we have 26 to 59.
So that is clearly the largest group that we're serving here.
So are these numbers Dmh clients only or that includes the concert?
It includes contractors.
It is everybody who is served.

Yeah, it is everyone.
And so yeah, this is it's a pretty, pretty large clinical system.
So if we go to the next slide, I'm gonna invite up. We're gonna talk about alternative crisis services.
There are a number of programs there.
Thank you.
Ajayson is joining me.
That I don't know that we talk and dive into.
Enough. And so I thought it might be good to highlight a few things.
So thank you for joining.
Thank you.
Sorry. Name again.
My name's Jay Sun and I'm one of the program managers and managed care operations.
My senior deputy director Jacqueline Balcom is unable to join this meeting, so I'm filling in for her and I'm gonna talk about alternative crisis services quickly. So alternative crisis services.
Is ACS is a comprehensive range of services and supports for manag individuals that are designed to provide alternatives to emergency room care or acute inpatient hospitalization or institutional care and reduce homelessness and prevent incarceration related to mental health.
And the services are.
Essential to crisis intervention and stabilization.
Service, integration and linkage to community based programs.
For example, FSP and assertive Community treatment programs, housing alternatives and treatment for Co occurring substance abuse.
The population is targeted at individuals over 18 years of age and older of all genders and race and ethnicities and languages spoken.
ACS programs include psychiatric urgent care centers therapy.
There are 8 urgent cares in the across the county and enriched residential services and crisis residential treatment programs, loans for law enforcement teams and restorative care villages.
And Pmrt psychiatric mobile team response teams and 9A a crisis call center services.
I'm here to feature one of the programs crisis residential treatment program.
It is a intensive and short term and structured residential program.
Average length of stay is about 30 days and maximum is up to 90 days and currently the program is for adult population and is utilized as an alternative to hospitalization for individuals experiencing psychiatric crisis or episode and who do not have medical complications requiring nursing care.
The program serves both.
Both medical and and insured clients and referrals can be made directly to providers in the community or through Dmh office.
And each provider has 16 beds or less.
It's a relatively smaller residential program.
And more than 90% of the individuals served are homeless who experience mental health crisis.
In fiscal year 2425.
And we received over 2000 referrals in 19 about 1900 individuals were admitted and served and the average length of day for those were 36 days.
And individuals are being discharged to home, go back home or boarding care, sober living or transitional housing based on their needs. And I I just want to talk to you about a success story.
This person is in early 30.
And he started hearing voices in his 20s, severe paranoia and suicidality.
And he was in and out of the hospitals and in and out of homelessness and hopelessness. And at one point he considered suicide by cop.
But he was referred to one of the CRTP programs, and he was quickly stabilized and went back to.
The community, however, because of his symptoms and substance abuse, he was arrested and refer back to the one of the CRTP programs, and in this second time around he was able to quickly get stabilized and he was determined to get better.
And now he's discharged to a residential program long term residential program, and he's aiming to become.
A substance abuse.
Counselor. So this is one of the clients that was served.
And he was able to go back and was able to function in the community.
So these are the residential services that we provide for individuals for experiencing crisis in the Community and we're helping them to go back and get better.
Thank you.
Do you want to wait till the end or do we want to?
OK.
Yeah, come on up.
3.
Drtp some of the Crtps are part of restorative care villages in the in the restorative care villages there are urgent cares and sepsis programs and you know, and also CRT pieces.
So it's a one stop shop at Olive View campus as well as LA GMC and Rancho Los Amigos.
So those so crtp is a part of the programs and we also have.
Other standalone crtps in the community.
So not only we have crisis residential programs on those campuses, we have other crtp programs in the Community providing services. And thank you, Kaylee, can you continue please?
And so for and more on on ACS, that is actually on page 60, folks wanted do a little bit more of a dive there.
We can move on to the next slide.
So Doctor Maria Funk is over housing.

She wasn't able to be here with us today, but she left me with a few notes to once I get through some of these slides that I'll share on what's coming and what's new.
Our.
Housing program under CSS covers a wide variety of resources and services.
It is intended again for individuals who are experiencing homelessness or have a serious mental illness and or serious emotional disturbance, including and it provides we provide temporary housing, permanent housing, move in assistance, eviction prevention prevention.
And especially mental health and housing case management services. You know, I think when we looked at the funding, you know, we spent at least with mhsa more than than 40 million in just mhsa in these kinds of housing services.
But it's not our only source of funding that funds housing services.
So some examples of the programs that we have under this though are capital investment programs, the housing Supportive services program. And I think that's the program that attaches some of the new housing projects that are coming online.
Where we're putting folks on site, the Federal Housing subsidies unit that manages the Section 8 Housing Assistance Program, Housing for Mental Health Program diversion, reentry Mental health Program that is the ODR.
We have our office of Diversion Reventry where we're working collaboratively with DH DHS, taking folks who are coming out of incarcerated sites and providing services.
We're pairing them with FSP and housing and interim housing and Tay.
So again, goal is really providing permanent and interim and permanent housing.
The ultimate goal is always, always, always permanent supportive housing, or at least I think helping to house folks at the at the level at which they need the most move in assistance, supportive services for housing retention, preserve licensed residential care settings which I know is something that doctor.
Fok is a champion of.
And investing in new housing resources.
The goal, of course, is to access housing, secure housing and retain housing.
And let's on page 78, but let's go into the next page.
Look at just a couple of couple of stats around here for the capital investment Programs, 110 of our 162 permanent supportive housing developments have finished construction resulting in 2706 units for occupancy. And so in 2320.
Four, we were able to House 2500.
36 adult clients and family members, 127 minor children and 149 where we don't have the age report, but over half of them reside in service areas four and six where we know there's a concentration of need the Federal Housing.
Subsidies unit. It's the dmh Housing Authority contracts with seven or 2749 housing vouchers which were provided.
To 2498, households across service areas and there was a four.
This was a 14% increase.
Increase from the previous year together with individuals and families. 3606 folks were housed housing for mental health.
This is a specialty program where FSP clients are referred.
Oh, actually sorry of the 407 clients that were referred to. This program is award permanent supportive housing at some point during 2324. Of the 407, three, forty were FSP clients referred by contractors.
67 were FSP clients with justice involved.
And referred by the Office of Diversion and re entry, there's a 93% retention rate for folks who participate in this program, yeah.
It's worth it, yeah.
Yeah, absolutely.
Enriched residential care services, too. This is.
Providing additional supports for folks who are in housing settings.
Let's go on to the next slide, interim housing.
This is most often kind of our.
Program we fund shelter freds across LA County.
And so we were able to contract for 763 inter own housing beds across 24 sites.
And that those 700 beds served 1750 individuals.
The occupancy rate stays at about 90%, the highest number served, unsurprisingly, is in service Area 4 where again we know we have a concentrated need the the lowest number there is in service area 3.
And of the 1081 folks who exited the program, 32% exited to permanent housing.
So for these and we'll talk a little bit too about the supplemental service. IHOP, we've got a representative here to talk about the interim housing outpatient program. When we get to innovations which I think is also an exciting support for this program. Next slide.
Emily, we have the enhanced.
Emergency Shelter program for teens also uses MHSA funds.
Includes take who are unhoused or at immediate risk of becoming.
Fiscally, the capacity was 110 beds, but we serve 575.
There's one shelter in service area 2-3 in service area four and four shelters in service Area 6 and on the right we have the providers who deliver those services.
Along with their bed totals.
In addition to these, you know one of the things that we wanted to share is that.
We there. Maria has worked with folks to do a.
Bed rate study and there is a plan to or right now an RFA is going out to increase our housing availability significantly.
There are new bed rates that are again we've we've established new bed rates with our partners.
All sites will provide housing navigation, the current and new interim housing sites are going to add the opportunity to apply to and add an LVN or mental health clinic.
On site this is going to more than double our current interim housing bed.
So we're adding more beds and more services connected to these beds and this is in just in, in.
As part of the stakeholder process.
That in led the housing group and got a lot of feedback from folks, so there's a lot of focus on specialty communities, particularly teh older adults. Just as involved folks and also working with some housing vendors who are able to specialize in serving LGBTQ.

And veterans?
Finally, through permanent housing through home Key plus, we're gonna be expanding permanent supportive housing beds.
And that solicitation was done.
Applications are being reviewed now, so we have some significant expansions on the horizon and we also have done a lot of work to make sure we're meeting the needs of some vulnerable populations.
What?
I am.
It's good timing.
Gonna go ahead and turn this over.
I'm gonna invite Aubrey up at waiters timing here. Sorry, Aubrey.
Aubrey is our chief over home and a variety of services, but she's going to speak to linkage. We have a variety of programs under linkage, including jail transition services, veteran and military families.
But we really wanted to highlight some of the work that was done across the good programs with home.
Good afternoon, everybody.
I'm Aubrey Lovelace. As Kaylee mentioned, if we could go to the next slide.
Some here, one more.
Sorry about that. OK.
There we go.
Yep, OK.
So I'm here to talk about home.
So our homeless outreach mobile engagement team, which has been around for a few years but wanted to give some outcomes for fiscal year 2324.
But home is created to serve the unsheltered population and as Kaylee mentioned earlier, we have our FSP program at home is what we would consider a higher level of care to FSP.
So we're really serving the individuals who are refusing all services and all care, mental health care, physical health care and then.
Obviously shelter.
So we are county wide.
We have teams with 18 teams across the county.
I think we're at 223 staff.
And the services we provide are basic needs.
So, you know, going out with.
Food, water, tents, blankets, things like that.
We provide any kind of housing support. Individuals are ready to go into, including motels, utilize interim housing that kayleen just mentioned.
We have staffing with clinicians.
Psychiatrists, nurses, counselors, peers and caseworkers to provide the full scope of psychiatry and mental health services in the field.
And we do as needed.
And the stats will show we do initiate our own inventory holds for hospitalizations. We are able to initiate conservatorship from the streets as the only designated program within DMH to do this in the county, I guess.
So really proud of what we do so.
The data for 2324.
We served 2200 clients, 246 we.
Were 51 fifties initiated by the teams in the community we referred 96 for conservatorship Lp's conservatorship. 87 of those were granted through the court, and nine of them didn't make it through.
We housed 168 individuals in permanent housing and moved 247 into interim housing, which?
Doesn't include.
Include individuals who we may have moved into motels on a temporary basis with through put.
And I don't know if we have the. Yeah, there is. OK. And then if the next slide, we just wanted to show a success story of ours. This is not in the packets, but these are just the photos, so show.
So this is an individual. That home is very proud of.
He was being nobody could serve him.
He was somebody that was being touched by all of our city accounted entities.
Law enforcement fire in and out of every hospital.
He was paralyzed from a gunshot wound.
And so this is somebody that home took on as one of actually one of our first cases.
Lots of contact with him and we ended up being able to conserve this individual and.
He went into a locked placement for a period of time into a skilled nursing facility, locked placement and is now in an open setting also.
So tradition from being conserved by the Public Guardians office to his family, who are his guardians now?
So he's reconnected with everybody.
So I think next slide.
That's him now. So he's doing great and he obviously authorized for us to be able to share his story with everybody.
Next slide.
So this is just just kind of a numbers game for you guys to share?
So this individual in one year.
Costs the county and city from what we had access to over a million and a half dollars.
In and no actual treatment done, he was just cycling through everywhere.
Once conserved, I think next slide if if I may interrupt.
This is Kenya.
I know you're looking for the prints. This was after we had printed, so it's not included in your packet, but we will make sure that.

That we share it.
Yeah. I apologize for that.
So the pictures in this slide is not included, but I'll make sure that you get the final version of it if that is on me.
Next slide.
OK.
So then post conservatorship, when we were able to place him into a nursing facility?
His yearly cost was under $100,000, so not only was he obviously now cared for and safe and healthy, it was a, you know, substantial number and impact to the county. Not only you know cost but the amount of time he took up from our law.
Partners and our fire departments and things like that was pretty dramatic.
So just a success from home, one of many, many so thank you.
What's your name again, Aubrey?
So Abby's gonna be back.
Yeah, she'll be back.
She's got a couple other programs to talk about, but next I'm gonna step away. 'cause, I'm inviting 20. Actually. No, I'll start with planning outreach and engagement planning. Outreach and engagement is.

Juan Mata 1:13:50
Hello.

AUDIO VIDEO MAIN 1:13:56
One of the one of the components that we have under CSS. This is really what funds our planning process. It's what funds our salts. It's what funds our USCC.
So this is really all about engaging the community and trying to bring the community.
Into our planning process and raising awareness around Dmh and Dmh services. And so where we've really been focusing most of our efforts for a very long time now has been on supporting the underserved cultural communities whereby we have several groups.
We have a group dedicated to the lat.
Community the.
African American community to LGBTQ plus include, and we also have.
Of Disabilities API and Middle Eastern communities, so making sure that they play a role of not only advising.
Us on on, on programming and providing those kinds of recommendations, but they also use these funds to do projects out in the Community to engage their communities and in the long past I've seen everything from, you know, getting onto a local radio programs or local newspapers or just.
Trying to find ways, particularly when we're working.
With communities who speak other languages to make sure that they have a connection to our services.
So right now what I'm gonna do now, I'm gonna invite up my prevention and early intervention team.
They're gonna go through the next few slides. Preventionally inventions. I noticed. That is our second largest component at 19%.
And I'm gonna invite up Conchi Tate and drive Carri Passanti.
And I'll step away.
So they both have something.
To the report.
A couple of weeks ago.
Good afternoon.
Did you hear me?
No.
OK.
That better. OK, good afternoon.
I'm conchita.
I'm one of the managers with our prevention services division.
Hi, good afternoon.
I'm doctor Carey prasanti.
I'm a prevention manager with our prevention services and I oversee early intervention and suicide prevention.
So today I'm Kerry and I are going to present to you some of the programs under prevention and early intervention.
I oversee prevention services.
And so I'm going to cover two programs that we that has been with us since fiscal year.
18191 program is we partnered with another county entity to expand the program and another program we started from ground up.
Engaging stakeholders.
So next slide please.
OK, so prevention aftercare.
This is the program that DCFS launched back in 2008 and in fiscal year 1819, we had the opportunity to partner with them as they were doing a lot of the prevention work. But with our partnership, their capacity to address well-being mental health issues.
Was kind of like our our target and what we did was.
We worked with them closely to address protective factors and risk factors.
Protective factors includes social connections, knowledge of like, you know, just development. When it comes to children and families and ensuring that they're connected to the concrete supports. So the families that receive these services are from the general community and but they are more.
Lined with like selective prevention.
Because they are at risk of going into the DCFS system.
And there are 8 agencies that provide services across the county and two county wide programs that really target the API population and the American Indian population.

And the services include outreach case management.
They do a variety of events for families like family night.
They do.
Do a lot of financial literacy supports as well as Wellness activities and supporting and linking to concrete supports. So this slide.
Outlines a little bit about the outcomes that we saw during fiscal year 2324.
This program is, as you heard from before, from the public health.
Team member we we really used that public health model.
This program has universal prevention where they go out into the community and do big Community events, and they also have a very selective and tertiary service delivery.
So that's the top number that you see. That is the case.
Navigation supports.
So these are families that have a lot of need. So there's 527 families that were served and you will see some of the impact that was made based on.
The protective factors surveyed that was administered just highlighting some of them social connections. We saw an increase of .6%.
So from 2.4 to 3.0 as well as an increase in social and emotional competence for adults and children.
And with the large events, we were able to reach about 37,000.
1000 individuals and able to collect.
About 3000 surveys.
That's a definitely an area we do need to improve. It gets challenging when we have large events to get folks to kind of stop and complete a survey.
So that is some of the things that we are working out with the agencies and DCFS, the DCFS team we work with.
We can go to the next slide.
The other program, this is a program that we build from bottom up.
We started in the in service area, one in the Antelope Valley area and this was after the tragic deaths of two children and we did a lot of stakeholder engagement to see what are the needs, what are we missing out there? And based on what we were hearing.
There was a model that was created.
The Community Family Resource Center.
So it's a one stop shop.
Where families can come and receive a variety of different services from case management to like workshops around parenting.
As well as like even just health service services.
And housing supports. And if a family is not enrolled in medical, they support.
In that process as well.
And so this slide.
Outlines a little bit about the impact that we were able to make during fiscal year 2324.
We were able to collect about 2500 surveys, so we do do the bulk survey, which is the brief universal prevention Screener, and we were able to collect about 1000 single event surveys and.
Able to make some impact I would say with regards to we were seeing individuals reporting that they're able to cope better. They're able to understand when they're triggered and support their regulation.
As well as they were getting a lot of linkage and access to care supports.
And with that, I'm going to turn it over to Kerry for early in Ridge.
Thank you everyone.
So this is me.
Talk. Next slide please.
So early intervention services in LA County have been implemented from around 2009, 2010 and these primarily focus on early onset and mental health symptomology.
So these are clients that are, you know, qualified for specialty mental health services and they and with our programming we implement evidence based treatments, community defined treatments and promising practices.
And so our target population is and these are typically low intense clients.
These are maybe treatment sessions, like once a week. If you're working with children that might be twice a week where you're integrating a session with a client and then also with their caregiver or their parents or their family members.
The target populations, as it highlighted in that slide, is definitely lower intense.
So these are not clients that need that are needing extensive services.
There might still be some targeted case management and some supports that are also needed to get them connected to resources.
Services are typically less than 18 months and on average our clients, especially majority of these services are with children and youth and you know Tay.
Typically we're staying around four to six months of treatment, but there are cases that they can get services up to 18 months.
This applies to all of our early intervention practices, except for first break for first break clients, they can be seen up to approximately 2 years, and sometimes it may be a little longer depending on the individual needs of the clients. So.
So our target population, specifically children and youth of stressed families, underserved cultural populations, trauma, exposed individuals experiencing early onset children and youth at risk for school failure and children and at risk for experiencing juvenile justice involvement.
Next slide please.
So and we look at the number of clients that we were able to serve last fiscal year, there were 35,638 clients served within our legal entity and are directly operated programming out of those unique clients, we had 15,600.
And six clients that had not received mental health services before in our system.
So that means that they've not had any like any types of treatment prior.
To coming into those PEI services.
We have an ethnicity breakdown of last fiscal year. If you want to take a look at that slide where it talks about the primary services are delivered to our Hispanic population at 55%.
Unreported at 21 percent, 9% white, 8% African American, 3% multiracial, 2% our API population 1%, Native Hawaiian and .25%

Native American.
Primary our services are delivered in English at 76% with secondary Spanish at 21%. I think to kind of take a look at a little bit of our breakdown.
That we noticed last fiscal year is that the San Gabriel Valley and.
East.
La County had the highest number of clients served last fiscal year, with the number the newest clients that the highest number of new clients coming in actually were in our San Fernando Valley.
As well as east LA County.
So we are serving quite a few children, youth and TE adults and older adults.
And just some of these practices, I I would want to add for all of you you know, they range from birth to older adults.
So we have programming that rages the the lifespan. We also have programming that also supports especially working with children and families as having parents and caregivers be the change agents, right? So giving them skills to help their child and their youth and and being healthy. Thank you. Next.
Slide.
Our side, we should OK suicide prevention.
So I'm going to pivot a little bit and talk about our suicide prevention work that we've been doing here in LA County and.
Really this has been a year of concentration of really upping and increasing our trainings. The work that we do with our clinical staff and ensuring that they have the skills to work with clients that are presenting with suicide ideation intent planner means and really broadening that that work.
Work so over this past year we focused quite a bit on prevention and also post fention and this in the suicide prevention. We kind of have a new a new perspective of really the focusing on suicide postvention access and community engagement.
We call it space within our team to really make sure we're educating and addressing information and sharing information not only with our community providers and our directly operated clinics, but also our general.
So our teams do training with different departments, we do training in the Community, we work with schools.
We'll do training.
We get requests all over the county. We've gotten requests from different workforces, different industries that really want to address suicide prevention and how to ask questions, how to be aware and how to find and refer and link individuals to resources.
So some of the work we want to really build on.
Existing community resources and we really have been intentional about building collaborations and comprehensive efforts.
So these services include really focusing on community outreach, engagement, education, linking direct services and improving of quality care to individuals contemplating and threatening or attempting suicide, as well as access to evidence based interventions, not only through our trained staff on the suicide prevention hotlines, but also as I.
Mentioned earlier.
We've really invested in training our clinicians in both our directly operated and our legal entity providers on working with clients with active suicide ideation.
We've also been implementing loss and grief group trainings so that clients can at times groups both in our directly operated programs and our LE programs. If they've lost some of a loved one by suicide.
So another focus really is building an infrastructure to further develop and enhance suicide prevention efforts across all age groups and really focus on cultural appropriateness and cultural communities.
We are navigating.
You know, there's still quite a bit of stigma, and so we really are being very intentional on how we roll out programming, how we conduct our trainings, what languages we're offering our trainings in, partnering with different cultural community groups, faith-based organizations to make sure that we can.
Get that training out and that that we're really increasing that anyone in our community can go to different places and and be able to.
You know, find resources and get linked to services.
Next slide please.
So just as a you know, during our suicide prevention trainings, so we offer these trainings, QPR gatekeeper trainings throughout the county, we were able to collect 688 surveys last year and some of the feedback that we've received on these trainings and these.
Two, our providers is it 95%?
Participants agreed.
Strongly agreed that the suicide prevention programs were quite successful meeting their program goals.
That 98% of participants agreed or strongly agreed as a direct result of this program, I'm more knowledgeable about professional and peer resources and 99% agreed that there was a depth of demonstrated knowledge and subject matter.
So we really have invested in in training and knowledge and expertise in our departments and we have also spent quite a bit of time.
Collaborating with public health, we collaborate with Laco DCFS probation. Any any requests we get Parks and Recreation and the public libraries, so.
On the other side, there's another part of the slide that does talk a little bit about and the salts. Yes, and the salts and the usccs.
Thank you, Reba.
I also want to just add that there is some data from our smart our START team.
That's our school threat assessment team. I know Marianne Brown was not able to be here today, but there is some statistics there.
About 84 presentations were conducted in schools.
850 referrals were served 90% early screening or threat assessments were conducted.
10% of you know the youth that were involved.
Received.
Consultations and the primary focus of interventions were centered on screening.
At 39 percent, 23% crisis intervention and 11% to linkage.
Thank you.
Thank you very much.
Thank you, colleagues and members of the public just for information were slated to conclude the presentation around 12:45, which we will then follow up with public comment both in in the room as well as virtually and then followed by questions and comments by the Commission. Thank.

You kaylene continue please.
It it is really hard to understate just how much.
For sure, I think as you start to look at the budget too, it's like.
We're doing a lot.
So next slide and I will go quick through some of these.
I really if if I could choose where I wanted to spend some of my time, I would definitely want a little bit of time to make sure we talk about some of the innovations, programs, amazing work that they are doing and I will make sure to spend some.
Time talking about the budget, so I'll gloss over some of these. Our workforce, education and training component.
This is funds that are used to support not only the training of our workforce, but more importantly incentives and training outside to bring people.
We all know that we have a huge crisis when it comes to staffing and in specifically here in LA County, making sure that we have staff that are culturally competent can provide the care that people need in their communities.
So this has been really essential funding for that next slide and I'm going to invite Aubrey back up.
She's going to talk very briefly, but she will talk about Hollywood. Not not too, too brief, but but briefly about Hollywood, 2.0 and IHOP.
I'm back.
Thanks guys.
Aubrey Lovelace again.
So two of our big innovations projects that we're really proud of and excited to see what comes in the next few years is our Hollywood 2.0 project and our now known as IHOP Project.
So Hollywood 2.0 has established our field based care teams in variety of levels of care and is in collaboration with our clinic based support and that's called our Hollywood Mental Health Cooperative.
So we're currently partnering with special services for groups at our Mark Twain site and our Hollywood Walk of Fame interim housing sites to provide temporary shelter for adults.
We have 100 beds.
There and they are always full and ready to go.
We also have a new dawn, which is a 94 bed board and care facility in East Hollywood that we partner with.
We are partnering with the Fountain House to add a clubhouse.
They've added a clubhouse.
These are things that have been done in the last fiscal year.
We've established a hyperlocal media campaign to raise awareness for Hollywood 2.0 we've.
They engage in regular.
Community meetings and stakeholder meetings.
With Hollywood forward and for Hollywood 2.0 to make sure we're getting the community input for the needs there and have established a contract with Rand Corporation to evaluate our program implementation and impact and things to come.
Our finalizing a contract with Pacific clinics for supportive employment services.
A move hopefully coming this summer for to bring both the field based and the clinic based teams into a new site in Hollywood.
And we're working on two potential providers to establish a UCC and a peer respite, hopefully to come at the end of the year.
So that's a very brief overview of Hollywood.
Located in Hollywood, yes.
The second program, which has changed some names but is currently known as IHOP. Our interim housing outreach program is our collaborative team working with DHSDMH and DPH to provide treatment for people with severe mental illness and substance abuse disorders. In our interim housing.
Sites. So as Kayleen mentioned, we have.
We're anticipating a huge.
You know, bringing in a huge number of new sites that are going to need need support.
For dmh and we're providing support at all interim housing sites.
So loss of funding DHS funded, funded by COHI, things like that.
So currently for those teams, they've been an active recruitment and are in our building.
They will be county wide as well, with teams across all service areas up and running.
Is the teams in Spas 2 four and six?
Spa 8 should be up and running by the end of this month.
Spas 35 and seven should be up and running by next month and then spell 1 should be up and running in June.
So that's 170 staff.
So since the last update, 114 of those staff have been on board.
We have 34 in queue with start dates and are actively recruiting the rest.
We have over 800 active IHOP clients and are in the process of finalizing contract with UCLA and the California Policy Lab for evaluation of the program.
Thank you.
OK.
I think folks have been here maybe for quite some time.
I think it was back in 20/16/2017 when we talked about that Trieste program.
So making sure folks can make that connection, our Hollywood 2.0 is the newer version and the implementation now of that vision from some long ago. We're excited to see it move forward.
And drive the way it has.
So I'm gonna go on to the next slide.
This is just a quick, brief slide on another new proposed innovation project to try to tap into any unspent funding we might have.
Would be able to utilize it for consultation and support for the programs that are going to have to transition as part of BHSA with main focus on prevention providers that we are able to determine can provide direct services and become early intervention providers that their services fall under.
That category with bhsa.

So it's part of that analysis and support and and and bringing them up so that.
'S but also FSP, making sure we have everything we need and to develop more club houses.
Which is going to be part of BH Connect next slide.
So there's oh, sorry cftn. I should have said next slide one more.
OCFTM.
I did just go through that one.
I skipped ahead with the oh, sorry, cftn. OK, cftn.
Sorry about that cftn.
Capital facilities and technological needs.
This is funding that we're able to set aside for housing.
Projects during fiscal year 2324 included the Jackman Avant Children and Family Center.
All of you children's crisis stabilization unit and LA general Urgent care center.
Coming up, we have the tenant, we have some funding of course set aside for 10 improvements.
New facilities. This is just kind of our ongoing making sure what we have is is in good shape.
La General Mental health rehab centers, children's community care village in the high desert.
The Jacqueline Avant Transition Age Youth Center, modern, the modernizing our call center and the integrated behavioral health system.
And that's our electronic healthcare system that we need to maintain in order to continue to provide services and claim for services.
And it keeps our our records as well.
And then also used for technological improvements and that can be anything from you know, improving telehealth services, making sure we have data resources and things like that.
So there's just a variety of needs there that actually is only going to increase with with bhsa that's coming.
So next slide, OK.
So 2425, I'm just this slide and I think the next couple of ones, the main point that I want to make here, this is about changes.
So it is revising the 2425 budget that was in the three-year plan last time and there is also a revision to the budget going forward. I had shared in this group previously that these are not reductions in services.
This is right sizing to what we're actually delivering.
So I want to repeat that there are no reductions to services here, even though you're seeing a reduction in budget. I think This Is Us looking at how much we're spending and trying to adjust the budget to actually be more reflective of that. We get very ambitious, but.
Staffing.
Being shortages and a number of other things really have have challenged us to grow some of our programming.
And so this is our effort to to clear that up and especially I think in preparation for some of the changes ahead.
Next slide.
This is our recommended budget.
This is I usually like to include this just to show folks that you know mhsa is just one source of funding.
It is 31% of funding this year.
It usually is really more in the range of 2527%.
They're millionaires, did really well, and one of the things you'll see in a slide coming up is this is a really volatile source of funding.
It's been volatile in a in a good way in that you know, we've seen a lot more funding coming in, but what makes?
That challenging is we have to plan.
Three years in advance and we don't know how much we're getting really until the year of and so we have to make sure and there's a three-year time limit on the funds. So it has created a lot of challenges and being able to make sure that we.
Are able to spend on those funds, but we.
Have certain I think we know with vhsa we know we have from some very specific needs coming up.
So we're grateful for for what we have now the next slide.
Budget projection changes.
This is similar to the last slide that I noted.
This Is Us now.
Right sizing the budget going forward.
So it's it's a similar thing where you'll see reductions and again, this is according to what we're spending. If we need to spend more, if we need to add more to the budget, of course there's a county process to do that, but we can do so next slide.
Then this is this is I I like. This is our our volatility chart. So the blue line there is called receipts.
That's the revenues that we've received from the state.
The Orange Line is expenditures, which you see have been rising pretty steadily. Like COVID, we took a little hit and then came back up. And then with our budget, you can see our budget trying to keep up with the increased receipts here.
So and you'll see, sometimes things do change, such as you see in 2223.
We actually were told we were getting much more than that, like twice that amount. Well, not twice.
Not quite twice, but almost almost a billion. And we got a 572.
So sometimes things like disasters, other things change.
We we're not sure, for example, how the fires are going to impact, especially if there are delayed receipts.
So it's just something to consider as we develop our budgets. The three-year forecast in the next slide.
I'm I'm 2 minutes three-year forecast in the next slide.
I think this was the ask for unspent funds.
So you have our carryover funds and and projected allocation in the coming year. Projected utilization for 2526. And then we want to make note that innovations wet and cftn are all ongoing sources of funding.
So innovation could be spent over five years.
So those funds are encumbered and planned for.
Wet and cftn are also encumbered and planned for.
The funding we just requested to move over into CFT not CFTN but into wet is actually intended to maintain us at least five years into into bhsa.

Because it will be, we will be able to maintain that category of funding, but it will be much, much, much more difficult to fund given the other priorities and the shifts that have been made.
So that that means that we have a balance of about 720.9 and right now.
Now it really is about as we start to shift over, this is the funding that's going to help us maintain that outpatient system while we right size and shift the rest of our system to be in line with with bhsa.
Total cost.
Next slide.
This was an ask A thank you very much khusha.
Austria actually for like I didn't know we had this, this this chart available to us.
This is a dashboard that we do have available, so if there's an ask we can produce this pretty quickly, but this is mhsa costs by soup district.
You'll see the greatest amounts being spent in soup District 2.
And then total cost by soup districts from our last meeting I believe were asked for a breakout.
And so next slide, you'll see a breakout by by different services, alternative crisis services, full service partnership, outpatient.
Care and prevention and early intervention.
Pretty consistently outpatient in fspr are our priciest services.
Next slide and here are the total client counts that should correspond also with the expenditures.
And I just as I'm finishing, just want to acknowledge, I think some of the work of the team, first Robin and her team, who particularly put that report together, that is in front of you.
Over the year and also has prepared all of these wonderful presentations for me that I think a wonderful job and I want to acknowledge also doctor Darleish Horn, who could be with us today, but she is actually the one who spent the last two years really rebuilding.
Our community planning process and has just done, I think, a fantastic job.
We're in a great, great space now with that.
So I just want to acknowledge those folks.
Great. Thank you, kayleen.
Lots of information.
Thank you also to other dmhshs dmh staff who joined us today.
And added to this annual presentation to to the Commission.
Appreciate all the work and as you said at the very end, kudos to all the staff who work so hard to make this presentation and the information in the binder.
So thorough, colleagues, I know we're all dying to ask questions, but we're not because we're going to go to public comment next.
I think it's important for us to listen to public comment because that may inform and educate the questions that we ask.
So we're going to move directly to public comment.
Anticipating a number of folks interested in public comment by the number of people virtually right now, we're going to limit public comments to two minutes per person.
So Kenya, would you like to take the microphone to people or would you like to take the the microphone?
This is Kenya.
It's up to you.
Whatever you feel, it would be more orderly.
It may be just taking it to each person, yes, and we just go in order of.
We'll start from that end of the room and just come back around.
So for those people in the room, Kenya will bring the microphone to you.
We tried this last Friday at our town hall meeting for care port and it worked very, very well.
So let's go ahead and do it this time as well.
Kenya, if you would like to provide public comment, please raise your hand or just indicate so. So Kenya knows that you are interested or Daniel will bring the microphone to you.
After we take public comment for folks in the room, we will go virtually and take comment from people who have joined us online.
So at this point.
Thank you, Sir.
I could have everyone's attention and we will begin 2 minutes please 2 minutes.
Good afternoon.
Good afternoon.
This is Andrea McPherson from service Area 5.
I may sound a bit restricted.
I had dental work this morning. Two crowns put in, so excuse me. Sorry about that.
But you talked about the statistics and data. According to population of LA County.
And is this data based on the severity of that population because of the the numbers?
'Cause if the numbers are based on according to general population of LA County alone, that means, for example, I'll give you an example of what I'm talking about. .1% of the programs would adhere to the necessity of the Native American population.
But if the Native American population community is 10% of the mental health population of LA County, suffering from mental illness, according to.
Either PTSD.
Or poverty.
Or genetics. Then how would that program?
How would all these programs be linked to the Community resources according to their mental health chronic illness? Population?
I wanted to know topics like PTSD, domestic violence, suicide prevention.
How available are they?
According to of course the.
Of communities and populations as well.
Oh, goodness gracious. But suicide rate is 35% Latino and 31 percent African American.

But there's only 10% African American.
So are there more programs according to that particular community?
Because people are more open to.
Peer on peer type of population in order to give their personal information and in order to adhere to their necessity.
Sometimes it has to be more open with programs that have that eye to eye contact.
So.
Next speaker please.
Good morning, everybody. OK.
I am from South 7.
My name is Yvonne Sandoval and I'm here to report some of the good things.
With our area so.
Evelyn, who is our peer support.
Person and our chief Manny Rojas is actually right now in New York visiting.
A.
The New York clubhouse.
So that they may see what is going on there to bring here to our area 7. Now when we say salt seven, what it really means because I'm sure there there's gotta be new people on the line.
So what it means?
What does that mean?
It used to be called SPA, but it has, you know, changed to salt, right?
So salt stands for service area leadership team and so I welcome you anytime.
To come on to continue visiting us here at the Commission, meeting, online or in person, and definitely you can come out and visit us at South 7.
Right now we're having a virt.
From a center in Whittier.
OK.
So there's that and.
With our Jaime Gomez, who is our liaison and our our tech guru and has done so well with our assault 7 on on Instagram and you know.
Social media.
He's he is getting ready to shoot a podcast, hopefully in in April also, but in May and what I was told he will be doing a podcast with, I don't know what Commissioner, but with a Commission.
A Commissioner and a surprise star.
So now before I turn the mic over to our next.
Salt 7. Sidney. Get out your notepads and pen because she will be announcing dates and events that will be happening from here on.
Thank you.
Next week, please. Thank you.
Good afternoon.
I'm Sydney from Area 7. What we have every Tuesday and the next one is actually.
On April 16th, every 3rd to Thursday.
Is at least Los.
Tacos in East LA and the event is called aliento.
And on April 26, we have a Spring jubilee at Walnut Park and.
The next one would be on the April 27th, which is butter via the Del Nino and that will also be at is Los Tacos.
Another event we have is on the 30th of April is the clergy lunch, which will be at Artesia Library.
Emmett, thank you very much.
Appreciate it.
Next speaker please.
Good afternoon.
Good afternoon.
My name is Lee Mole with Sauce 6 culture.
At this moment, we don't have any as great as they want on, but we're working on take action at this moment.
Question what part of the what program was that that she was talking about?
That's the next solid area 6.
She was speaking to all of the MHSA funded programs in Salt Erie 6.
Thank you, Sir. Next speaker please.
Good afternoon.
Just so everybody knows, there's a handout going out for now that covers the topics that we'll be discussing.
There's also a QR code if you'd like a PDF copy.
Good afternoon, everyone.
Thank you so much for allowing this space for all of us to come together and have this discussion.
My name is Doctor Israd Allah Mohammed psychologist, affiliated with Los Angeles County Department of Mental Health.
I'm currently on involuntary medical leave while awaiting ADA accommodations, and I speak today not on personal grounds.
But I speak today in defense of public safety systems, accountability and the future of care for our county.
I also speak as a family advocate, navigating the care court process.
I've developed a model of transfer a model of transformation.
Designed not only to diagnose institutional harm, but to prevent it, it's called the Bureau. Care to custody to cemetery pipeline.
The framework maps how fragmented care, oversight failures and trauma neglect displace individuals and families from services into homelessness, incarceration, and irreversible harm.
It is not theoretical.

It is preventable and it is happening now.
Despite multiple warnings submitted between 2019 and 2023, a child died by suicide January 2024. Within weeks, a county health services employee took her own life on county grounds, and already this year, more families have been displaced without coordinated care following the wildfires.
This is not a failure of intention. It is a failure of infrastructure.
What we are facing is not a crisis, it is a crisis.
A collapse of care that turns public space into open air.
Asylums, prisons and containment sites for untreated trauma, especially in communities long excluded from equitable investment.
Over the years I've contributed to improvements across prevention, early intervention, quality assurance, workforce education and training, contract monitoring and management division.
Clinical liability and risk management and arise work now reflected in departmental strategies, but a deeper issue persists when those closest to the crisis are excluded from the systems they help shape.
The result is symbolism, not safety.
One example, the transformation of Arty to what is now called arise anti racism, inclusion, solidarity and empowerment.
My 2023 recommendations shaped its 2024 direction, yet I was excluded from authorship and implementation.
Could you please wrap up, Sir?
A publicly funded initiative was built using my input, but applied without fidelity, without infrastructure, and without those closest to the crisis at the table.
This is not equity, it's exploitation.
Thank you very much.
Clear next speaker, please.
Thank you.
Would you like to make a comment?
Hi no public comment, but Bruce Boardman, Commissioner, from the drug and Alcohol Commission, thank you for having us out here today.
I represent supervisor Holly Mitchell.
Great. Great to have you with us, Commissioner.
Thank you for your presence. Next speaker please.
Chair Merlina and members of the Behavioral Health Commission.
My name is Ricardo Kim, stakeholder and service area four. I would like to address 2 items regarding LA County mental health, community health workers in the Mhsa annual update for fiscal year 2526.
First item on page 232 under subheading interim housing multidisciplinary assessment teams.
IHOP subsections expectations for fiscal year 2526 first bullet point states recruitment and hiring of remaining IHOP staff.
Including DPH clinicians for inpatient STD treatment.
How many positions will tmh make available for LA County mental health community health workers? Questions in the second bullet point, same subsection? How many?
How will Dmh ensure a full time role for our peers in equal standing with other members of the IHOP team?
When Will Dmh implement new training curriculums for LA County mental health community health workers? In addition to those listed on pages 2:47 to 2:49?
Sub heading, mental health, career pathways, subsection 4A.
CDEFG to better support their role and responsibilities on the IHOP team and their future career advancement and promotion opportunities.
Second item on page 246 under subheading mental health career pathway, subsection #1 intensive mental health recovery specialist training program.
The last sentence states Dmh will not continue this program after this fiscal year.
Why is this program being discontinued?
Will the intensive mental health recovery specialist training program be funded through another source, and if so, for how many years?
What is Dmhs strategic plan to engage and recruit future cohort cohorts?
Our peers does dmh have an intensive mental health recovery specialist training program for LA County Community mental health community health workers who are interested in the psychosocial rehabilitation field and case management level career opportunities.
If no, what are the reasons for discontinuation and if?
Yes. Does the ENV envision the intensive mental health recovery specialist training as a pathway for promotion for LA County mental health community health workers who are employed at peer resource centers that will become eventually become clubhouses?
Page 210 under innovations. Thank you, Sir.
Moreover, what page was the last one you talked about?
246 Thank you very much.
May may I just say one last thing. One sentence.
20 seconds here. Thank you.
Moreover, will this training.
Meet the criteria for LA County mental health community health workers.
To receive the recovery practices for leadership, for leaders training on the subsection 4B, page 248. Thank you.
Thank you, chair. Next speaker please.
Hi, John.
Associatedwithjw.org.
And this Saturday.
Better this Saturday, April the 12th.
7:00 PM the event held at jw.org give the support for the community that people may be able to come and not suffer isolation, which is the spurnestone of struggle of more mental health.

Also, resuscitation of dignity and worth is supportive community encourages.
Well, thinking.
Light, light, stress.
And got the meals to help us to avoid the stress of the times that we live in.
Even though some have lost their houses.
This community is able to help them to find the houses and get over the trauma of loss of the fires that we have had.
I've seen it in person ate it also in the suicide prevention.
So this Saturday is a celebration of the memorial.
Christ, that this community of Jehovah witness supplies for everyone to come to.
And it would do well for the environment and mental health Commissioners.
To encourage this, for the sake that it enhances the whole person care, addressing not just mine but the heart and spirit.
He carries that kind of hope that overcomes.
Despair and trauma.
Please and that zoom zoom number.
Got your pencils out?
Zoom number 8217.
2701.
513.
And the passcode is memorial.
The word memorial.
MEMORIAL everybody's invited and this is worldwide invited.
Don't wanna exclude nobody.
It's all inclusion.
Thank you, Sir.
Thank you very much.
Next speaker please.
Anyone else on this side of the room wishing to be heard?
Wanna make sure?
All right.
Anyone on this side wishing to be heard that are not dmhf staff?
All right, let's move then to our virtual participants.
Please Kenya, if you can instruct the AT&T operator.
AT&T, can you provide instructions how to unmute to be put through?

+12*****86** 2:03:12
Yes, if you would like to make a public comment and you are on the phone, please press 1 then zero at this time.
You may remove yourself from queue at any time by pressing the 10 again and if you are using a speaker phone, please pick up the handset before pressing the numbers.
Once again, if you have a public comment at this time, it is one then 01 moment please.
And we'll go to line #7.
Hello, this is Charles from Area 6 service Area 6 and I just want to thank you all for having this meeting.

AUDIO VIDEO MAIN 2:03:51
Thank you, Charles. Thank you very much.
Att operator. Next speaker, please.

+12*****86** 2:03:58
Once again, if you have a public comment at it at this time, it is ones and 0.
And Sir, we have no lines in queue.

AUDIO VIDEO MAIN 2:04:13
Thank you very much and once again, anyone else wishing to be heard at this time.
Seeing none, we're going to move to Commissioner comments and questions.
Kayleen, if you can come back to the table, I'm going to begin with Commissioner Schallert since I rudely interrupted him about an hour and a half ago.
So he's going to finish his question and then we'll go down the table at that point.
Commissioner Dagley, if you have a question or clarification, no, I have a question.
OK, great.
You're starting with Commissioner shower.
That's fine.
Thanks, Commissioner. Perfect Commissioner schauder.
Your question, So what if I have 10 questions, they go one at a time, then choose your top two Commissioners, top two. All right.
Ah man, that's a hard one.
I might just have to buttonhole you guys afterwards or something.
Just maybe just.
I mean, that's a very good point. If I can interrupt one more time for a point of clarification Commission, our staff is available to you at any time during this deliberation time. If a question comes up as you go through the binder and you find other questions or.

Comments. I know kayleen and staff are ready.
And willing to take our questions by phone, by e-mail, etc.
To assist you in the next month or so, as we dive through this phase mound of paperwork, that's very good point that you make, Commissioner.
Thank you.
Go ahead.
This is really hard, but let me I'll just may finish with the other questions about restorative care versus. You know, we have a lot of questions about how to get into those.
Just recently I've had several questions about how do we.
Identify referral criteria and referral protocols for the restoration care and the.
Crisis Pro crisis housing programs, and it's just not clear, and I'd I'd like some clarification about that.
We don't necessarily have to do it now, but if we could get something really clear, does it have to go through a through a navigator? Does it have to go? Can. Can anybody refer? It's been a lot of questions in my area about how do we get into these really cool programs.
At all of you that nobody knows how to get into.
So that's just maybe you can do it later.
The other question and among many is I don't see any. I can't see anything about the tree program, and I can't even remember what the tree stands for, but it's like, but what I remember about it is you're going to get zero to five mental health consultation out.
Of that program, it's like a school.
It's kind of a preschool based zero to five.
Mental health consultation, which in my experience is many years of experience.
That's one of the most powerful prevention programs there is, and I haven't seen anything about that.
And I tried to find it in here and I didn't see it, but doesn't mean it's not there just because this was pretty thick.
So we'll just start with those two.
I think we have our experts here, Jason, on the 1st question and Kanshi can speak to prevention.
Thank you.
Look for services referral to.
Providers or facilities that.
Restorative care villages.
Currently, urgent care Centers for under Dmh urgent care centers. There is no referral process.
You could just step in.
I understand that you understand to get to the neck because the urgent care on all of you is is right there next to the right next to the new dmh directly operated. And I know if I'm an urgent care, you can go across the alleyway to get in.
But just somebody that's not in urgent care.
So if someone is not in urgent care.
And in order to utilize services at crisis residential, for example.
You because of community licensing, there are certain things that's required like chest X-ray or you know skin test for TB that's required. But that's something that can be arranged at urgent care centers.
But OK.
Other than that, if somebody already has like TB test result, they could refer themselves directly to crisis residential.
We have two ways to do that.
You could go through our office or you could directly refer them.
I mean, refer someone to crisis residential.
OK.
All right.
Maybe we get something in writing on that, plus the referral criteria.
That would be great.
And do we have somebody who can talk about zero to five?
Yeah. So the tree program is the program that we did with LAUSD, where we focused in on the early Ed centers and we worked with them very closely to Co locate LAUSD psychiatric social workers at the sites to provide supports to the caretakers and to work with famil.
And that program has now fully been transitioned to LAUSD.
And they're implementing it on their own, using their own funding.
Oh, that's that's that's good for LAUSD, but no other districts, because that's a really powerful program.
And from a Commission point, I'm not talking four other Commissioners, but for myself and my experience, zero to five mental health consultation is one of the most powerful.
Prevention programs there is.
Anywhere. Then there's lots of research around that from the Georgetown model, and so I would.
I don't if we have any influence to make to try to make that a program county wide, but that would be my recommendation.
Thank you, Commissioner, Commissioner Roche.
I'm going through my notes and I can't find them, but I do remember seeing abnormally large number when it came to unspent funds in the last years. About a billion dollars or something that effect. If you could speak to why that might be the case in your present.
You alluded to.
Maybe it being a tricky business to sort of anticipate, you know, two or three years down the line, but like to sort of know if you have greater insight into that number, you know why secondly?
One thing that sort of isn't addressed and and specifically I was looking forward in the innovation piece is this idea of our partners being able to access funds in a timely manner, being reimbursed in a timely manner or.
Sometimes being hamstrung by just bureaucracy, signatures and paperwork in general, I just want to know whether or not that's something that's under the microscope and as part of the innovation and work that the organization's doing things.
Yeah, I'm sorry.
Can you elaborate a little bit on the second question please?

Yeah, sure. I can give you a couple of different examples.
So last week I visited the people concerned over the course of an hour or two conversation.
Two things came up. The first was, you know, we do work.
We have a partnership with the MH and it takes months to get.
The basically the money that we're owed for some of the work that we're doing. The second thing that they brought up is the fact that, you know, they'll have clients that come in and these these folks desperately need.
Psychiatric care.
Sometimes they're losing, you know, 1015, sometimes 20% of clients that come in the door solely due to the fact that these folks can't stand to fill out the amount of paperwork that they're required to in order for the organization itself to seek reimbursement, which is start.
To me, to the point where people concern is now just using their general fund to pay for their own psychiatrist, so that that person.
Who needs the care? Can just get it right away. They're having to bypass a bureaucracy that's sort of been imposed on them.
When we have a system in place now that's impeding care for the people that we're aiming to serve, that becomes problematic.
I wish I had more specifics for you. I'm sure we can call them.
I'd love to have them here and so to speak.
Maybe that's something for down the line, but those are the things that are here more or less commonly in some of the site visits that I'm seeing could be wrong.
Interested to hear.
Hear your feedback on that.
I can speak to your second question.
Could you reintroduce yourself please?
Yes, sure.
My name is ramihuntal.
I'm the chief deputy director of the department, so sometimes we receive invoices that need a little more information, or maybe if there's a line not filled out, it's not to add more to the bureaucracy, it's just the paperwork that we are also required to submit and we are.
Also required to have on on hand and as far as the medical paperwork and the documentation.
That's a statewide requirement in order for them to get the receive the payment.
So that's not a dmh rule. Most of the time when they in order for medical, it is a lot of paperwork. It is.
It's a lot, but it I I may I acknowledge that. But it's not a dmh rule for that.
I think I know that I can.
I can speak to our quality assurance division that has been actually working really hard to try to minimize the burden on staff when it comes to things like assessment and some of the paperwork that is required.
So recognizing it's challenging, I think there's a focus on trying to make at least what we have to do as as easy as possible.
That doesn't mean that it's easy. At the end of the day it it is a lot.
I also want to just comment that.
Oftentimes there's a balance between.
Kind of that work and that bureaucracy.
And then the need for accountability and transparency and data collection and all the things that that we are being asked to do and some of the things we should be able to report on, to show how we're doing our services. So some of these things are always gonna.
Be necessary if we want a transparent and accountable system trying to find the best way to do that and the least amount of burden is always gonna be the challenge.
But it's we don't stop trying.
Caitlin, can you address the unspent fund question?
Unspent funds.
So we'll start with there.
I wish there was a single answer that I can get for that.
It is a large amount of funds.
I would say that I'll start with.
I will start with the volatility and the planning and the need.
To plan many years in advance.
So then we try to build up the project.
I think we find ourselves.
I will admit we find ourselves becoming really conservative because we hear we're not going to be getting so much dollars and then it's going to go down next year. It's going to go down next year and it does it. And when when you have a three-year Tim.
On that, our Co does not like one time ongoing program.
So then you have to find.
Really big things to spend your dollars on in a very short period of time and that is hard on the community as well.
So, but there are a lot of other things.
Bureaucracy. You've already spoken to. That is certainly one of them too.
And what it takes within the county to get funds out the door is it's a challenge, and I personally always want to be so much more optimistic like we can do this like, I know what the steps are.
It'll be pretty easy to move forward, but we find that there are so many steps and it does come back to transparency, accountability.
The county's responsible, too, to be transparent about our budget and the contracting process. And so that's what starts to grind.
Some of those gears down and makes it hard to get those dollars out of the door.
I can speak to more, but I we want to acknowledge it's there. It it shouldn't be there.
One of the pieces of advocacy that we've had around Bhsa is we wanted a longer timeline. We think, you know a five year timeline, for example, would allow us to give us the time to.
To to keep those funds would allow us a little bit more flexibility.
To ensure that we could keep a program ongoing because it takes, it can take up to a year to get something launched.

But thank you, Rami, if you want to.
Yeah, that's the thing. We can't.
Sorry we can't start programming based on the unspent funds, as Kaylene said, because then it's not fair to the community when we stop it because the funding is now gone because it's only a it's become a one time fund because we may or may not get it next. Year.
And again, it depends on the taxpayers.
Some certain years we do better in certain years. We don't do so good.
And it's same for the millionaires. And so it's based on that formula.
Sometimes we will have some more money than we could spend.
It would show up in the unspent money. Thank you.
Thank you, Commissioner.
Commissioner Holmes, please.
Oh, go ahead, Caitlin.
I can just.
I I think prevention and early intervention has been one of the more challenging ones that we've really turned around on because of the restrictions and because of the population that it's focused on.
So the expansion and prevention has has been a a really, really big deal for us.
But but now it's I I don't.
It's certainly not a good thing. We would have rather certainly seen these dollars go out into the community over these past few years, but this is going to help us with the bhsa transition because when we hit July 1st, 2026, those dollars are component neutral in.
Other words, they don't stay CSS and prevention.
And we can apply them where we need them. And this is what's going to help support our outpatient system.
Again, while we are while we need to trend down and shift over to some of these new components and the 30% housing piece, we are keeping that money is not going back to the city.
We've never reverted.
Actually, we have always managed to spend those dollars down.
We're kind of like a year now.
We just have like a year in advance funds, but but we've not reverted to date.
We're going down the table, Commissioner Steve is Commissioner Holmes.
Yes, OK I have.
Two questions.
The well I have a whole lot, but I've narrowed it down to two.
The first is in looking at the FSP right and I was looking at the number of of of participants that were served and you might not have this information, but I was wondering giving that it's almost three times as many adults served as Tate.
I was wondering if you all can disaggregate data and say how many of those adults are were actually TE or DCFS involved. Do you know that?
I think age wise we can do that.
I think DCFS involvement.
I'm looking at my data person.
OK.
Yeah. So that's something it might take us a a minute.
We'll see if we're able to gather that information, but we can break out by age.
Yeah, and and and and just my reason for asking that is because if we're talking about prevention and early intervention and we know the difficulty that those that children who are involved in the system early that they have.
It just stands to reason that a lot of those adults could have been caught early.
So that was the first question that I had. And then the second, you're requesting that report back.
Yes, I'm requesting that report back, please.
Thank you.
And then the second question that I have, believe me, I know that you know you all are like driving the Titanic and I applaud you for all the work that you do on the programs that you oversee in the the communities that you serve.
So, but one question that I that I have that I often see is missing.
Is.
A.
A focus.
On supports like family supports for people who for, for families who are dealing with adults with mental illness and the the example of the the the success story that was shown about the young man who was in the wheelchair and then he had, you know, was a million.
Dollars of services. And then once you got him conserved and then it was 90,000 and then now he's conserved back to his family and I interact with a lot of folks who are dealing with adults who have mental illness, adult children.
And it is so difficult for them to a get information about how to help their children and B how to get support for themselves to know how to deal with, you know, and to handle and how to navigate the system.
And I'm just wondering, are there like truly any robust programs that parents who have, you know, adult children or family members who are dealing with adults?
How they can get support to help their loved one?
So do you want to go?
You can take it.
So when I talk about NAMI, what we do, that's what we're starting.
Yeah. I would start with partnership and support for for NAMI.
They are the largest organization we have really robust NAMI organizations here that provide that support for parents can can I?
I'm sorry. Can I just say one thing?

Sure. I just want to say one thing because you brought up NAMI and then I'm hush.
But like for example yesterday I was doing some research for a family and NAMI has online support groups for caregivers.
And none that are in LA they're virtual ones in Texas and Virginia.
And I was like, how are there none?
That are occurring within the next six months, they were not in that, but they went from.
March until June and there were none in California at all, even virtually.
And so when I went on and clicked on Texas, it was like you have to put in your ZIP code because they show what counties they serve.
So the families that I have here couldn't even be in a support group Anami in Texas, but there are none here.
So I'm very familiar with NAMI, and so that's a problem.
There should and then there are.
There are in person meetings, so I think that's something I I don't know about their full network for online, but it's something to we can ask our partners, we're not.
We're listed and there were none.
Yeah, online or in person?
Yeah, and we're not.
That's what NAMI specializes in is to help family members navigate through these systems.
It may be registered or listed under another name rather than just this.
It could be that we can look into it and we work with NAMI very closely.
And we'll certainly share the feedback and and ask them if they have something listed differently.
And that within the department we have roles in each service area that we call service area navigators and their role is to identify to know their community and their community needs and their providers in the Community and to help individuals and family members navigate and find services.
There should be.
There should be a number of doorways in but, but thank you for the the comments as something that we can take back.
Thank you, Commissioner, Commissioner Friedman.
I have a two-part question that's very very quick.
I'm wondering if you're satisfied with the number of stakeholders that participated.
Your program is wonderful.
It is complicated.
It is beyond complicated any other department in the county, and I realize all the hard work that you're doing, but I am wondering if you are satisfied with the number of stakeholders and secondly, when you find out that you do have this money.
Leftover. Isn't that a perfect time to get out there and say to the community, hey, we have this, if you have ideas, we want to hear from you.
I mean, figure it out a certain way.
It's more manageable than that, but do something to let because there are every person that I talk to. I talk to a lot of people. They never even heard of Mhsa. They don't even know what it is.
They haven't a clue. They've never.
Even heard of being a stakeholder and they would like to be.
Thank you for that. For that comment and I'll I'll start by saying two years ago within our stakeholder process that's actually almost exactly what we did.
What are the needs?
We have these dollars.
We have these unspent dollars.
What ideas do you have? And we had a variety of recommendations that came forward, many of which were implemented and and that's something that we can report back on and talk about, particularly in the areas of prevention.
Some the larger ones take longer.
So we've had a year.
Some of them are set to go out, forbid like expansion of the family community resource centers is a really good example of a large expansion that came out of that stakeholder process. And we said, hey, we have unspent dollars.
And I think if are we satisfied with, I will say we will always want to see increased participation from the Community.
And so I love seeing some of the numbers we're seeing now with Bhsa is generating a lot more interest.
We're doing things both in person and online to really expand accessibility, and Dr. Horn has started a program over the last year that she's called beyond the walls and she and her team members are going out to community settings like libraries and things like that just to find.
To reach Community members, we don't usually reach and talk about mental health and talk about the stakeholder process and invite people in.
So the team is really trying to find.
Other ways to engage and bring people in, and we're gonna continue to do that and advertise our process.
It's hard to reach folks across LA County.
We have, I think some of our our stakeholder or take action events that are coming.
Those are also opportunities for us to tell people what we're doing and invite them in because those are community based events.
So I I would say this is something we're passionate about.
Yes, certainly.
We're very passionate about this and we also talked about.
Having meetings at different times of the day, so individuals that work at this time who cannot make it here.
Can come to evening meetings and we also talked about taking the show on the road, not just libraries, other community centers and things like that to expand our reach to stakeholders because we do want to hear from them. And also we'd like to request you to also help.
Us with that, please help us spread the word when there's a stakeholder meeting so we can get more participation. We exist because of this participation because of the stakeholders and we want to continue to engage.

And have more numbers. More people come to these meetings.
Thank you, Commissioner Weisman.
Thank you, rimi.
While you're up here, I have a question or more of a request for a presentation and follow up because I do understand that the unspent dollars are rather humongous this time around.
But, but it's not really uncommon for dmh to carry such an A balance of unspent year to year.
So it's not just this year that it happens to be the case.
So my request is as we look to bhsa, if we could work with the finance team to understand the rationale in the plan for tightening up controls on budget to actuals.
Because it's not just startup that delays the payments and the spend down.
It's really like over those longer term contracts budget to actuals and managing that more tightly will give us better perspective on how much is unspent much earlier in the case then when we come to the end of a year and we would love to understand that more th.
Thank you and thank you for that. We we agree.
I think this is the first time we have come with a an adjustment to those budget to actuals, to try to do exactly.
Exactly that. Let's make it a report back at a future meeting then.
So we have a better understanding how that works.
The question comes up every year, so let's figure it out.
We'll invite them mid year to come into a presentation as to where we are, what the projections were, what the actuals and where we will end up in the next six months. Certainly. Thank you. And maybe like even looking back for the like a rolling average like the.
Last five years of mhsa what it looked like, and then how we're looking to beat that for the next five years prospectively for bhsa.
There's just so much that more that can be done. If we had earlier advanced notice about ideas, spend down planning all of that.
Thank you.
And then the other question goes to conchi.
Sorry, I have a question for you on the early intervention spreadsheet with like the percent of completion for the EBPS.
I just was so curious.
Some of these ebps have not been completed up to 50% and I was wondering if someone if folks don't complete the EBP.
Fewer than 50% of people complete the EBP.
How useful is the EBP?
You know I'm on 1/31/31.
And I was just wondering if going forward, I know this is really wonky and technical. You don't even have to address it right now, but it just seems to me that the point of an EVP is 100% completion and we're maintaining programs with less than a.
50% completion rate and I just wondered if that was to our collective benefit.
I don't, OK.
I'm sorry. It's in our big workbook.
Sorry.
And forgive me because I'm not a clinician, so it may be the case that it's it's very practical. And I think there's different practices and there's different reasons for.
Non completion. So depending on the practice so I'll kinda give you an overarching and if there's like a specific practice you'd wanna know more about. Yeah. Like peer. Like what happened there?
There was such a big push in the department.
It's done at the bottom.
It's an alpha order. Yeah, I see.
It was 17%.
Reported completing the EBP OK.
So, and I know doctor. So Doctor Carratukuchi is our outcomes guru in our department. But I can definitely give you a little overarching idea that when clinicians determine completion.
So sometimes clients will end treatment on their own.
And.
That may be considered a dropout rate because it wasn't like a technical completion of the curriculum, right?
So the 17% may not just be reflective of benefit of treatment, but technically what it means is that in the documentation in ouroma system that they met, they went through the entire course of treatment.
So that's part of what that number can stand for.
So it's it looks very low I think for peer specifically.
We have a psychologist that overseas the program and the implementation and 1st break work.
I know that the county's also working now with the state on as we're moving in through bhsa.
Really implementing.
Some changes to our first bike programming that I think would probably be working to address some of that.
How do we do?
A lot of engagement, and specifically with first break clients, there's a ton of engagement with their families, their caregivers.
It's not just a client.
Individually, so I can kinda give you that framework, but we could probably get more information back to you.
That's very helpful.
I'd say I'm not coming from a clinical perspective, but rather like an investment. If we're spending staff time and investing in these programs and so few completions, is that really worthwhile? But it sounds like more of a conversation for later.
Thank you so much. Thank you.
Thank you, Commissioner, Commissioner Manolo.
Thank you, Mr. Chairman.
I I just had one question for Aubrey. If I if I could ask her about the the the home.
Program and congratulations.
Sorry. Congratulations on the on increasing the numbers.

Of home teams, right?
Is that is that enough to cover LA County? It just seems like it's a it.
I mean, it's great to have that number, but is this is the intent. And I saw that there was also some challenges for.
In terms of hiring staff and things like that, so but is there is the intent to raise a number of home teams?
Over it in the future.
I don't believe so.
So I think sort of our vision and the way we work within the so home works within the whole outreach system.
So we partner with Lhasa and the Mdt's and housing for health is that clients.
Kind of get elevated to us and we serve this very small, very sick population and our hope is that.
The other teams within the department, FSP teams, those that'll transition to act and things like that can serve.
The bigger chunk of those people.
So right now home is almost fully staffed, so home doesn't have any hiring issues.
Thankfully, we're very happy with that.
I think the challenge is to kind of throughput sometimes for some of the people, I think we hold onto people for quite a while.
Because.
As we build things out, there's challenges around placements around appropriate places and things of that.
Most of our clients can't go into a traditional interim housing site, so the department is working really diligently to get people.
Into and bring online single room occupancy sites that manage our clients better, more robust services at the sites, more hospital beds.
So I think some of it is as we're continuing to build out the resources, we will be able to move more clients through, but I don't think we need more boots on the ground. The teams carry good caseloads, nobody's carrying, nobody has they call wait list per.
Southeast.
So I think as we expanded.
We doubled.
I think I think what we manage is good.
I think if we get bigger, we lose the ability to.
Do the things we do in the way that we do them.
Where do the referrals come from that that go to the home team?
Is it just just from other county departments or we get referrals from everybody, community members?
Other outreach teams, law enforcement partners.
Board offices.
Kind of anybody. Anybody can send a referral our way.
We don't take referrals from hospitals.
We don't take referrals from the jail.
Because those aren't people that we we need to be able to know where the person is.
So if they're being discharged out of a hospital with no sense of where they're going to go, but we take referrals from everybody.
OK.
Great. Thank you.
Sure. Appreciate that. And I think the other.
The other question I had was in relation to the the stakeholders as mentioned by.
By Commissioner earlier that.
I when I looked at the the government agencies that are involved as stakeholders, they're mostly.
County agencies correct and and my perspective my I had I come from a a very specific perspective here because I was a Council member in one of the 88 cities in Los Angeles County.
County and the cities are struggling specifically with homelessness.
And it's it's not because and and it's really it's a little complicated, but a lot of it has to do with now people are recognizing people living in their cities are recognizing now that there are unhoused people living in their neighborhoods or in the parks or, you know.
Wherever they're going and they're not, they may call the Sheriff's Department, for example, but they're going to call City Hall first.
So now cities are getting pressure about doing something and then it's.
So for for me to sit here and and hear about all the great work that's being done and that I know my colleagues, former colleagues in cities throughout LA are just up to here because they're getting pressure from their constituents about why isn't anyone doing anything about the.
Unhoused people in our neighborhoods.
So I'm I'm suggesting and I would love to help as as the chairman suggested to to connect some some City Council folks with you.
You know there are. There are councils of governments, you know, throughout Los Angeles County where in Artesia, we're part of the Gateway cities and they're very, very concerned about homelessness. And but I don't see them being connected at all with the work that you're doing. They're trying to.
Get connected with.
With the prop.
A money and and all this stuff is coming down and and and so they're trying to kind of navigate. But I I would love to be able to see that they get engaged as a stakeholder in this.
Certainly that's a great idea.
I do work with Gilbert Gilbert Saldate from the Gateway cities. He's in charge of the homelessness initiative and will definitely be inviting him more often to come to our meetings. But others as well. Please let us know and we would love to invite them. Thank you, Commissioner 0.
So I'm wondering and don't need to answer do the second part, but why are the unspent ones so high?
And then it appears that.
Service participants overall to me appear low overall for MHS. Say there's a lot of really good quality programs out there.
You know, it seems like there's great staff, great programs and low participation as a whole.
Not, you know, by program, but as a whole like FSP. To me that's a low for the amount of people who live in the county.
Why is FSP so low?

So and I'm wondering if that's correlated.
You know, we're not spending enough funds.
And there's an accessibility, and perhaps a knowledge problem of the programs.
Why?
Why are? Why aren't we having more participation in our programs?
Well, the FSB slots are.
And not just that one, but this is an overall question that was an example.
Yeah, I I was gonna ask fspi don't know.
Overall, we will look into this.
Yes, 12,000 out of, you know 10 million.
Mm hmm. Yeah, that's me, right?
That I think that was the number in there, something like that.
But when I went through, as we go through and I look through here and here, it just seems to me.
That out of 10 million residents in the you know, LA, there's a lot more.
Need then we're touching.
And we need to identify that, I mean, we have outreach engagement.
People are working hard.
I just can't fathom why.
And here's a hearing we had 0 written public comment that should not be.
Why is there a little comment in the room?
I'm just very concerned about that and also, you know in the past, because you do have so much information to provide to the community and to us, you know, we should be doing this as really a whole day, weren't we used to do it as a whole day.
Or at least 4.
Or five hours, you know, and do a much, I guess, better job at outreach than we've done. And and I will take some responsibility on my part, although I send it out.
You know, but.
Help, sure.
We will look into that.
Thank you for that.
Thank you, Commissioner, Commissioner Stevens.
Yes, thank you very much for this presentation today.
I'm gonna work really hard not to be.
Too critical?
Because I really do appreciate the information in which you've shared, but there's so many ways in which I believe that for for not only myself, but for the public to really be able to narrow down where you're going and what you're what you're.
Talking about, so I want to start with some of the dmh staff that identified our unhoused neighbors as homeless and the homeless.
And I really think that we should start looking at language and how we are identifying people. Right now, the county of Los Angeles has this huge crisis and I think that we could do better by identifying folks who are unhoused as unhoused individuals.
That's one.
The other is around the community.
Planning process and so this is a lot of good information and I attend those meetings and I'm still questioning the.
Ability to get folks to actually participate heavily.
You would think that there should be an interest.
I remember a time, years ago when there really was an interest and we had a lot of people that showed up.
I think that we can improve in that area.
But I believe that people are hurting and right now we have this crisis and there is no reason.
To have unspent dollars.
At any rate, there's the county of Los Angeles right now is looking under rocks for money.
And we are sitting siloing and having all these unspent dollars when there is a great need in our community, but around the Capitol facilities, one of the questions that I have is are legal entities eligible to, you know, apply for funding for capital facilities and technology.
It's supposed to be for county buildings only.
County buildings only so that that right there. I think we we have to start looking at. I'm looking through a different lens. And so we rely upon who provides the majority of the services that are being provided. They happen to be from the people that you are cont.
With and so I believe that that's a barrier and it's it's an unfair process.
It seems to me that doesn't seem very equitable.
The other is around and I mentioned the change of language.
Early intervention, you know, there is so much housing that is needed right now. And so I believe there was one slide where you were mainly talking about Altadena, not Altadena, Antelope Valley and the work that's going on there.
But what?
I didn't hear. Was all the wonderful services that you're providing?
I have to believe that there are people there that are also knocking on those doors or entering those spaces that are in need of housing, and so I would like to know how you're how are.
Providing that service.
The other is when when providing the data and the numbers, it would be very helpful to use the general population numbers first, which actually allows us to see when you're talking about these percentages that we begin to see because black people are 7.6% of general.
General population.
And so if we're 10% and then Latinas are 10%, then there is there's a distance.
It's not balancing right.
So I think to be very clear to.

Public and so that we remember to remember that there's a disproportionate.
In the House, services are being rendered when looking at.
The survey.
So I was excited about hearing about the surveys, but the numbers of surveys that were actually administered, that's just really, that's terrible. When you look at how large the county is and what the needs are, the unmet needs are we don't do enough around. Collecting that data around unmet needs and then the last thing that I would say is around our stakeholder groups, the DMHUSCC's service area groups, one of the requirements and this came from your office.
Kaylene the.
I don't know bylaws or something like that for the stakeholder groups to and the requirement is to come to this Commission meeting. And and present to us and give update. And so we're not there's a disconnect there which makes me have a it challenges me to believe that any of the data that you're writing in reference to stakeholders particularly like with the CPT because it's not actually working the way.
In which it's written.
So where is the accountability?
The last last thing chair, I promise.
I always expect a yes last.
That's the real.
It's around recommendations for those unspent dollars, you know, and I think that we should be also thinking about our county Board of Supervisors and their agendas that we either divide those dollars by 5.
I would prefer the 1st.
My recommendation would be that we are funding maybe a one time spending fund to our legal entities or fees for services.
I'm curious about how.
Cal AIM is working and whether that is a part of the reason.
That's why those dollars aren't spent.
And then the last thing is that not really understanding where these dollars are coming from?
What dollars are unspent?
And so I think that we need to be really clear about that.
And then I want to remind us that as we're talking about a stakeholder process that even in our service area groups, you make it too difficult for people to spend those Community dollars.
So when we have a we have 60 and spa 6 there's over $60,000 that's going to go back to you and it's unfair to the community when you're saying that, you know, we want to get the word out. And then when you think about the low.
Numbers of those surveys.
But I can go on and on.
I have a whole lot of things in which I could say, but I think that we should be considering funding our Community. Cbo's with this unspent dollars.
Thank you, Commissioner.
Thank you very much. Tyler, any questions?
I gave my time to Reba.
Hi everybody.
My name is Tyler Cash.
I am the new representative here on the the Commission Supervisor Barger's office, so it's good to meet a lot of you. See faces. Prior to this work coming into the role of the health deputy, I was doing actually homeless stuff, though for the Supervisors office. I was homeless services, so I understand that system and that sector very well. And of course the strong correlation to Jason C to to mental health.
Caitlin, I appreciate the presentation today, especially the parts about prevention. I know there's going to be probably a lot more conversations at the county level.
Between the prevention programs that you guys have and the prevention programs, La Casa.
The housing agency's gonna put together and then the county with our our new homelessness department.
I don't really have any additional questions.
I just will reiterate what Commissioner Victor said. You think he made a great point about engaging the cities. Some of the work that I did, what I was working on homeless services with a supervisor, was making sure that all of our cities were engaged to stakeholders. It's by.
Far and at least in my experience, the number one issue that you see wherever you go around the county, that communities and councils bring up.
So it would be, you know, very prudent to have them be part of these conversations and aware and educated on what's going on here.
And on that note, I will make a recommendation.
Supervisor is chair of the Accra.
That's the executive Committee of Regional Homelessness Alignment, which is a body about, you know, governance within the homeless service system.
It does include the membership from a bunch of the cities, and I know that they have brought up comments before regarding.
Say in wanting to better understand the mental health service system.
So I think it would be a wonderful opportunity for you guys to connect with them and I'll. I'll reach out to from the supervisors end to facilitate that because they're right now going to be they had to get through the measure, a stuff pass all, yeah, pass all.
That now that that timeline is is moved on, they're working on developing the standardization of care. And of course, we want to make sure that, you know, mental health components are baked into that.
So that's all that I'll say.
But thank you very much.
Thank you, Tyler. And once again, welcome aboard.
It's great to have you on this Commission.
All right, colleagues.

Where do we go from here?
As you know, we have complied with and concluded the required public hearing and discussion relative to this bhsa. Our next job is to draft a letter that accompanies this document to the Board of Supervisors particularly.
Describing some of the questions and concerns that has been articulated.
Very well this afternoon I wrote down a number of things that that had been had come up, particularly those that came up repeatedly, particularly the unspent balance. I think it would make sense and I would recommend encourage you and urge you, colleagues, that if there is.
Or are issues or concerns that you would like addressed in this letter that you send to Kenya within the next week?
An e-mail not to all of us, but to Kenya within the next week.
Here are the issues I want to see in the letter and describe that issue so that we can compile that list and executive committee gets a chance to take a look at it at its April 20th.

Stacy Dalgleish 2:49:10
SD
Wow, what do you think?
When is it freon or what's the what do you think the deal is?

AUDIO VIDEO MAIN 2:49:16
AM
I'm sorry someone has their mic on and you're coming through our meeting.
This is Kenya.
I think it's one of maybe one of our interpers.

Stacy Dalgleish 2:49:21
SD
OK.

AUDIO VIDEO MAIN 2:49:25
AM
All right, so.
I think it's Commissioner Tagleish. So Commissioners, if you don't mind.
If there is an issue or there are issues that you would like to see in the letter that we send to the Board of Supervisors.
That that companions this document.
Please send that information by e-mail to Kenya in the next.
Week we will compile it and start working on the draft letter that will be forwarded to all of you for review before we meet again in May.
So that's our homework, Commissioners, if that's all right, I don't see any objections.
So we'll move forward with that.
You talking to me?
Oh, Commissioner Dagley, she has something to say we don't want.
To lose the opportunity for you to make comments, I'm sorry.
All right, it's come.
Oh, wonderful. She submitted comments in writing to Kaylene directly.
Terrific. All right.
So with that being the order, asking all Commissioners to please send your comments to Kenya within the next week, we will officially close the the annual report and the public comments and that takes care of the items on the agenda.
Just two quick announcements, Commissioners.
I first want to thank.
All the.
All those who participated in last.
Friday's care court town hall that was that was conducted by this Commission.
Folks, the meeting's still going on.
Meeting still going on.
Please like to thank all those people who participated in the care court town hall last Friday evening. We had over 70 people participate.
In particular, Commissioner Weisman, who joined me in person Commissioner Manalo, and others who joined us virtually, it was a in many ways an eye opening, meeting a very difficult meeting, a lot of.
Reflection and responses given that evening, we were putting together.
A report that will be sent to the Board of Supervisors on the findings and the recommendations made at that meeting. So thanks to all, particularly thanks to Kenya and Crystal and Millican staff who did a terrific job putting together an evening meeting.
We saw a whole group of faces in the evening, so that was really, really good.
Secondly, I know that we have talked about reuniting in August for an annual retreat.
Of course, that would be under the new chair and the new Executive Committee, but we wanted to.
Look at.
A date and a date has been identified.
Kenya, can you remind us of that date again?
It will be August 13th.
That's the Wednesday at the endowment.
I know that Commissioner Friedman has already shared her concern with that date in particular.
So Kenya, can I ask you please to go ahead and formally poll the Commission to see if August 13th is a good date for everyone?
I think we went ahead and chose a date without asking the the Commission.

If all we did ask.
I will send a survey out.
Alright, great.
Thank you very much.
Alright. Is there a good Commissioner Freeman that we can find out that way?
All right, all right.
Seeing can I ask for one thing?
Commissioner Weisman and Commissioner Stevens, just to let you know that the executive committee had considered the unspent balance in our town hall line item for the Behavioral Health Commission budget and are working to create a town hall from the town hall line item on Bhsa.
With Sapsy and Mhsa, staff from the departments, so that will happen between now and the end of June. And Kenya is our point person for logistics, trying to make that happen.
The point of that would be to raise awareness and engagement for the future bhsa process.
Terrific. Thank you, Commissioner, Commissioner Stevens.
Yeah. I just want to remind us that while we move meeting.
To the second week that it is still a barrier for our S for service Area 2 and I just got to give a shout out.
Got out to Barbara Wilson, who's one of the best advocates that I know who's unable to attend this meeting. As a result of how it changed.
In addition to that, I think that we should really look at the calendar and find a space that is empty and then work to fill it in.
Thank you, Commissioner Freeman.
I would like to 2nd that because this meeting having it the 2nd Thursday in the month is makes it impossible for me because I also serve on a state board and that's exactly when their meetings are.
So as a Commissioner, I have to mishap the meetings 'cause I can't be at two places at the same time.
Thank you very much.
Any other announcements?
Seeing none, we will adjourn at 1:54. Thank you.
Thank you to all our services.
We appreciate your patience.
We'll see you in a couple of weeks.

+12*****86** 2:54:35
We're sorry your conference is ending now. Please hang up.

Kenia Fuentes stopped transcription

Appendix C – Acronyms

Acronym	Meaning	Acronym	Meaning
ACS:	Alternative Crisis Services	EBP(s)	Evidence Based Practice(s)
ACT:	Assertive Community Treatment	ECBI:	Eyeberg Child Behavioral Inventory
ADLS:	Assisted Daily Living Skills	EESP:	Emergency Shelter Program
AF-CBT	Alternatives for Families – Cognitive Behavioral Therapy	EPSDT:	Early Periodic Screening, Diagnosis and Treatment
AI:	Aging Initiative	ER:	Emergency Room
AILSP:	American Indian Life Skills Program	FFP:	Federal Financial Participation
APF:	American Psychiatric Foundation	FFT:	Functional Family Therapy
ARF:	Adult Residential Facility	FOCUS:	Families Overcoming Under Stress
ART:	Aggression Replacement Training	FSP(s):	Full Service Partnership(s)
ASD:	Anti-Stigma and Discrimination	FSS:	Family Support Services
ASIST:	Applied Suicide Intervention Skills Training	FY:	Fiscal Year
ASL:	American Sign Language	Group CBT:	Group Cognitive Behavioral Therapy
BSFT:	Brief Strategic Family Therapy	GROW:	General Relief Opportunities for Work
CalSWEC:	CA Social Work Education Center	GVRI:	Gang Violence Reduction Initiative
CAPPS:	Center for the Assessment and Prevention of Prodromal States	HIPAA:	Health Insurance Portability and Accountability Act
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools	HOME:	Homeless Outreach and Mobile Engagement
CBO:	Community-Based Organizations	HSRC:	Harder-Company Community Research
CBT:	Cognitive Behavioral Therapy	HWLA:	Healthy Way Los Angeles
CDE:	Community Defined Evidence	IBHIS:	Integrated Behavioral Health System
CDOL:	Center for Distance and Online Learning	ICC:	Intensive Care Coordination
CEO:	Chief Executive Office	ICM:	Integrated Clinic Model
CF:	Capital Facilities	IEP(s):	Individualized Education Program
CFOF:	Caring for our Families	IFCCS:	Intensive Field Capable Clinical Services
CiMH:	California Institute for Behavioral Health	IHBS:	Intensive Home Base Services
CMHDA:	California Mental Health Directors' Association	ILP:	Independent Living Program
CORS:	Crisis Oriented Recovery Services	IMD:	Institution for Mental Disease
COTS:	Commercial-Off-The-Shelf	Ind CBT:	Individual Cognitive Behavioral Therapy
CPP:	Child Parent Psychotherapy	IMHT:	Integrated Mobile Health Team
CSS:	Community Services & Supports	IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
C-SSRS:	Columbia-Suicide Severity Rating Scale	IMR:	Illness Management Recovery
CTF:	Community Treatment Facility	INN:	Innovation
CW:	Countywide	IPT:	Interpersonal Psychotherapy for Depression
DBT:	Dialectical Behavioral Therapy	IS:	Integrated System
DCES:	Diabetes Camping and Educational Services	ISM:	Integrated Service Management model
DCFS:	Department of Children and Family Services	ITP:	Interpreter Training Program
DHS:	Department of Health Services	IY:	Incredible Years
DPH:	Department of Public Health	KEC:	Key Event Change
DTQI:	Depression Treatment Quality Improvement	LGBTQ:	Lesbian/Gay/Bisexual/Transgender/Questioning

Acronym	Meaning	Acronym	Meaning
LIFE:	Loving Intervention Family Enrichment	PE-PTSD:	Prolonged Exposure therapy for Post-Traumatic Stress Disorder
LIHP:	Low Income Health Plan	PMHS:	Public Mental Health System
LPP:	Licensure Preparation Program	PMRT:	Psychiatric Mobile Response Team
MAP:	Managing and Adapting Practice	PRISM:	Peer-Run Integrated Services Management
MAST:	Mosaic for Assessment of Student Threats	PRRCH:	Peer-Run Respite Care Homes
MDFT:	Multidimensional Family Therapy	PSH:	Permanent Supportive Housing
MDT:	Multidisciplinary Team	PSP:	Partners in Suicide Prevention
MFT:	Masters in Family and Therapy	PST:	Problem Solving Therapy
MH:	Mental Health	PTSD:	Post-Traumatic Stress Disorder
MHC:	Mental Health Commission	PTSD-RI:	Post-Traumatic Stress Disorder – Reaction Index
MHCLP:	Mental Health Court Linkage Program	QPR:	Question, Persuade and Refer
MHFA:	Mental Health First Aide	RFS:	Request For Services
MHIP:	Mental Health Integration Program	RFSQ:	Request for Statement of Qualifications
MHRC:	Mental Health Rehabilitation Center	ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
MHSA:	Mental Health Services Act	RPP:	Reflective Parenting Program
MHSOAC:	Mental Health Services Oversight and Accountability Commission	RRSR:	Recognizing and Responding to Suicide Risk
MMSE:	Mini-Mental State Examination	SA:	Service Area
MORS:	Milestones of Recovery Scale	SAAC:	Service Area Advisory Committee
MOU:	Memorandum of Understanding	SAPC:	Substance Abuse Prevention and Control
MP:	Mindful Parenting	SED:	Severely Emotionally Disturbed
MPAP:	Make Parenting a Pleasure	SF:	Strengthening Families Program
MPG:	Mindful Parenting Groups	SH:	State Hospital
MST:	Multisystemic Therapy	SLT:	System Leadership Team
NACo:	National Association of Counties	SNF:	Skilled Nursing Facility
NFP:	Nurse Family Partnerships	SPC:	Suicide Prevention Center
OA:	Older Adult	SPMI:	Severe and Persistently Mentally Ill
OACT:	Older Adult Care Teams	SS:	Seeking Safety
OASCOC:	Older Adult System of Care	START:	School Threat Assessment and Response Team
OBPP:	Olweus Bullying Prevention Program	TAY:	Transitional Age Youth
OEF:	Operation Enduring Freedom	TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
OEP:	Outreach and Education Pilot	TN:	Technological Needs
OMA:	Outcome Measures Application	Triple P:	Triple P Positive Parenting Program
OND:	Operation New Dawn	TSV:	Targeted School Violence
OQ:	Outcome Questionnaire	UC:	Usual Care
PATHS:	Providing Alternative Thinking Strategies	UCC(s):	Urgent Care Center(s)
PCIT:	Parent-Child Interaction Therapy	UCLA:	University of California, Los Angeles
PDAT:	Public Defender Advocacy Team	UCLA TTM:	UCLA Ties Transition Model
PE:	Prolonged Exposure	VALOR:	Veterans' and Loved Ones Recovery
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors	VPAN:	Veteran’s Peer Network
PEI:	Prevention and Early Intervention	WCRSEC:	Women's Community Reintegration Service and Education Centers

Acronym	Meaning	Acronym	Meaning
WET:	Workforce Education and Training	YOQ:	Youth Outcome Questionnaire
YOQ-SR:	Youth Outcome Questionnaire – Status Report	YTD:	Year to Date

Adult Age Group: Age range is 26 to 59 years old.
Child Age Group: Age range is 0 to 15 years old.
Older Adult Age Group: Age range is 60+.
Transitional Age Youth Age Group: Age range is 16 to 25 years old.
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.
Unique client means a single client claimed in the Integrated Behavioral Health Information System.
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.