Los Angeles County - Department of Mental Health

WELLNESS • RECOVERY • RESILIENCE

Mental Health Services Act

Three Year Program & Expenditure Plan
Fiscal Years 2017-18 through 2019-20

Los Angeles County Board of Supervisors
Adopted May 30, 2017

Jonathan E. Sherin, M.D.,Ph.D.
Director

Table of Contents

Introduction

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

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

MHSA Component	Dates Approved by the State
Community Services and Support (CSS) Plan	Feb. 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	Sept. 27, 2009
Innovation (INN) Plan	Feb. 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
INN 2	May 28, 2015

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

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

Any questions or comments should be directed to:

Debbie Innes-Gomberg, Ph.D.
Deputy Director, Adult System of Care Bureau
Los Angeles County Department of Mental Health
(213) 738-2756 or DIGomberg@dmh.lacounty.gov

Executive Summary

Three Year Program & Expenditure Plan
Fiscal Years 2017-18 through 2019-20

The Los Angeles County Department of Mental Health's MHSA 3 Year Program and Expenditure Plan represents a review of the public mental health system after 10 years of MHSA program implementation. The plan seeks to build upon the systems of care for each age group that have developed over the last 10 years to create more of a continuum of services through the consolidation of work plans and programs associated with the Community Services and Supports Plan and Prevention and Early Intervention. Consequently, the 3 Year Plan is organized by structural changes to be made to LA County's MHSA services beginning July 1, 2017 as well as a comprehensive review of services provided during Fiscal Year 2015-16.

Community Services and Supports Plan Work Plan Consolidation

The original CSS plan was organized according to age group and over the course of the last 10 years has grown to 6 work plans for adults, 5 for children, 5 for Transition Age Youth (TAY), 5 for older adults and 3 cross-age group plans. Each of those 24 work plans represents a financial category for purposes of budgeting and claiming. The Department's consolidation of these 24 work plans into 6 represents an administrative simplification of the CSS Plan as well as creating greater service continuity without modifying program expectations, intentions or service capacity.

POE	FSP	Alternative Crisis Services	Recovery, Resilience & Reintegration Services (Non-FSP)	Linkage	Housing
• POE Teams	• FSP • FCCS (part of) • Family Support Services (C) • Family Crisis/Respite Care (C) • Housing FSP	• Residential & Bridging • Urgent Care Centers • IMD Step Down/Enriched Residential Services (A) • Countywide Resource Management • Mental Health-Law Enforcement Partnerships (MHSA funded)	• FCCS (part of) • Wellness/Client Run Centers (A) • TAY Drop In Centers • Probation Camp Services (T) • TAY Supported Employment • Family Wellness Resource Centers (C) • Integrated Care Programs • Crisis Resolution Services • Service Extenders (OA)	• Jail Linkage & Transition (A) • Service Area Navigation	• Housing for TAY and Adult • Housing specialists • MHSA Housing Program/Special Needs Housing Program • Housing Trust Fund • Housing support team for No Place Like Home

(A) - Adults **(C) - Children** **(T) - Transition Age Youth** **(OA) - Older Adult**

FSP capacity will increase significantly through the CSS Work Plan consolidation via the expansion of FSP criteria as well as through a one-time allocation received from the State, spread over 3 Fiscal Years.

Total slot increase all age groups: 4,808

Program	*Plan Consolidation*	*One-time MHSA Allocation*
Child	*1,460*	*----*
TAY	*230*	*2,571**
Adult	*265*	
Older Adult	*16*	*266*
Total	***1,971***	***2,837***

Prevention and Early Intervention (PEI) Program Consolidation

The original PEI plan identified 13 programs with overlapping evidence-based, promising and community-defined evidence practices associated with each of the 13 programs. This consolidation of 13 programs into 7 represents a one-to-one correspondence between practices and the programs that counties are required to report on, increasing reporting accuracy.

Existing PEI Programs (13)	Consolidated Projects (7)
ES-1 Suicide Prevention	
1. Latina Youth Program	PEI-01 Suicide Prevention
2. 24/7 Crisis Hotline	PEI-01 Suicide Prevention
3.Partners in Suicide (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults	PEI-01 Suicide Prevention
ES-2 Early Start-School Mental Health Initiative	
START	PEI-06 At-Risk Youth
ES-3 Early Start-Anti-Stigma Discrimination	
1.Family-focused Strategies to Reduce Mental Health Stigma and Discrimination	PEI-02 Stigma and Discrimination Reduction
2.Children's Stigma and Discrimination Reduction Project	PEI-02 Stigma and Discrimination Reduction
3.Older Adults Mental Wellness	PEI-02 Stigma and Discrimination Reduction
PEI-1 School Based Services	
1. Aggression Replacement Training	PEI-06 At-Risk Youth
2. Cognitive Behavioral Intervention for Trauma in School	PEI-04 Trauma Recovery Services
3. Multidimensional Family Therapy	PEI-06 At-Risk Youth
4. Promoting Alternative Thinking Strategies	PEI-05 Individuals and Families Under Stress
5. Strengthening Families	PEI-06 At-Risk Youth
PEI-2 Family Education & Support Services	
1. Caring for Our Families	PEI-03 Strengthening Family Functioning
2. Incredible Years	PEI-03 Strengthening Family Functioning
3. Managing and Adapting Practice*	PEI-5 Individuals and Families Under Stress
4. Mindful Parenting*	PEI-03 Strengthening Family Functioning
5. Promoting Alternative Thinking Strategies*	PEI-05 Individuals and Families Under Stress
6. Nurse-Family Partnership	PEI-05 Individuals and Families Under Stress
7. Nurturing Parenting Program	
8. Triple P Positive Parenting Program	PEI-03 Strengthening Family Functioning

Existing PEI Programs (13)	Consolidated Projects (7)
PEI-3 At Risk Family Services:	
1. Brief Strategic Family Therapy	PEI-03 Strengthening Family Functioning
2. Child-Parent Psychotherapy	PEI-04 Trauma Recovery Services
3. Families Over Coming Under Stress (FOCUS)*	PEI-05 Individuals and Families Under Stress
4. Group Cognitive Behavioral Therapy for Major Depression	PEI-05 Individuals and Families Under Stress
5. Incredible Years	PEI-03 Strengthening Family Functioning
6. Make Parenting a Pleasure	PEI-03 Strengthening Family Functioning
7. Mindful Parenting*	PEI-03 Strengthening Family Functioning
8. Parent-Child Interaction Therapy	PEI-03 Strengthening Family Functioning
9. Reflective Parenting Program	PEI-03 Strengthening Family Functioning
10. Triple P Positive Parenting Program	PEI-03 Strengthening Family Functioning
11. UCLA Ties Transition Model	PEI-03 Strengthening Family Functioning
PEI-4 Trauma Recovery Services	
1. Child-Parent Psychotherapy	PEI-04 Trauma Recovery Services
2. Crisis Oriented Recovery Services	PEI-05 Individuals and Families Under Stress
3. Dialectal Behavioral Therapy*	PEI-05 Individuals and Families Under Stress
4. Depression Treatment Quality	PEI-05 Individuals and Families Under Stress
5. Group Cognitive Behavioral Therapy for Major Depression	PEI-05 Individuals and Families Under Stress
6. Individual Cognitive Behavioral Therapy*	PEI-05 Individuals and Families Under Stress
7. Parent-Child Interaction Therapy	PEI-03 Strengthening Family Functioning
8. Prolonged Exposure Therapy for Posttraumatic Stress Disorder	PEI-04 Trauma Recovery Services
9. Seeking Safety	PEI-04 Trauma Recovery Services
10. System Navigators for Veterans	
11. Trauma Focused Cognitive Behavioral	PEI-04 Trauma Recovery Services
PEI-5 Primary Care & Behavioral Health	
1. Alternatives for Families – Cognitive	PEI-03 Strengthening Family Functioning
2. Incredible Years	PEI-03 Strengthening Family Functioning
3. Mental Health Integration Program (formerly IMPACT)	PEI-05 Individuals and Families Under Stress
4. Triple P Positive Parenting Program	PEI-03 Strengthening Family Functioning
PEI-6 Early Care & Support for Transition Age Youth	
1. Aggression Replacement Training	PEI-06 At-Risk Youth
2. Center for the Assessment and Prevention of Prodromal States	PEI-06 At-Risk Youth
3. Group Cognitive Behavioral Therapy for Major Depression	PEI-05 Individuals and Families Under Stress
4. Interpersonal Psychotherapy for Depression	PEI-05 Individuals and Families Under Stress
5. Multidimensional Family Therapy	PEI-06 At-Risk Youth
PEI-7 Juvenile Justice Services	
1. Aggression Replacement Training	PEI-06 At-Risk Youth
2. Cognitive Behavioral Intervention for Trauma in School	PEI-04 Trauma Recovery Services
3. Functional Family Therapy	PEI-06 At-Risk Youth
4. Group Cognitive Behavioral Therapy for Major Depression	PEI-05 Individuals and Families Under Stress
5. Loving Intervention for Family Enrichment	PEI-03 Strengthening Family Functioning
6. Multidimensional Family Therapy	PEI-06 At-Risk Youth
7. Multisystemic Therapy	PEI-06 At-Risk Youth
8. Trauma Focused Cognitive Behavioral	PEI-04 Trauma Recovery Services
PEI-8 Early Care & Support for Older Adults	
1. Crisis Oriented Recovery Services	PEI-05 Individuals and Families Under Stress
2. Interpersonal Psychotherapy for Depression	PEI-05 Individuals and Families Under Stress
3. Program to Encourage Active Rewarding Lives for Seniors(PEARLS)	PEI-05 Individuals and Families Under Stress
4. Problem Solving Therapy*	PEI-05 Individuals and Families Under Stress
PEI-9 Improving Access for Underserved Populations	
1. Group Cognitive Behavioral Therapy for Major Depression	PEI-05 Individuals and Families Under Stress
2. Nurse-Family Partnership	PEI-05 Individuals and Families Under Stress
3. Prolonged Exposure Therapy for Posttraumatic Stress Disorder	PEI-04 Trauma Recovery Services
4. Trauma Focused Cognitive Behavioral	PEI-04 Trauma Recovery Services
PEI-10 American Indian Project	
American Indian Life Skills	PEI-06 At-Risk Youth

An overview of the PEI Plan is presented below. See pages 148-164 for more extensive descriptions of the PEI 3-year Plan.

(* Indicates programs are new additions to the PEI Plan)

PEI - 01 Suicide Prevention	PEI - 02 Stigma and Discrimination Reduction	PEI - 03 Strengthening Family Functioning	PEI - 04 Trauma Recovery Services
1. 24/7 Crisis Hotline 2. ASIST Training 3. AMSR Training 4. Latina Youth Program 5. Partners in Suicide (PSP)Team for Children, TAY, Adults, and Older Adults 6. QPR Training 7. RRSR Training	1. Children's Stigma and Discrimination Reduction Project 2. Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination 3. Mental Health First Aid (MHFA) 4. Mental Health Promoters/Promotores Program 5. Older Adults Mental Health Wellness Project 6. Profiles of Hope Project	1. AAFEN 2. AF-CBT 3. BSFT 4. CFOF 5. FC 6. IY 7. LIFE 8. MPAP 9. MP 10. PCIT 11. RPP* 12. Triple P (Prevention and Early Intervention Services)* 13. Second Step* 14. UCLA Ties Transition Model	1. CPP 2. CBITS 3. PE-PTSD 4. SS 5. TF-CBT 6. TF-CBT - Honoring Children, Mending the Circle (American Indians)

PEI – 05 Individuals and Families Under Stress	PEI – 06 At-Risk Youth	PEI - 07 Vulnerable Communities
1. CORS 2. DTQI 3. DBT 4. FOCUS 5. Group CBT 6. Group IPT (Maternal Depression)* 7. Heathy IDEAS* 8. Ind. CBT 9. IPT 10. MAP 11. MHIP 12. Mindful Schools* 13. NFP 14. PST 15. PEARLS 16. PATHS 17. SCALE 18. Senior Reach* 19. The Mothers and Babies, Mamas y Bebes*	1. ART 2. American Indian Life Skills (AILS) 3. Boys and Girls Club Project: LEARN* 4. CAPPS 5. Coordinated Specialty Care Model for Early Psychosis (CSC-EP)* 6. Early Identification and Prevention of Psychosis Outreach (PIER Model)* 7. FFT 8. MDFT 9. MST 10. OBPP 11. Positive Action* 12. Safe School Ambassadors* 13. START* 14. SFP 15. TAY Drop-In Center Targeted Outreach & Engagement Strategies 16. Why Try? Program*	1. Commercial Sexual Exploitation of Children and Youth (CSECY) Training 2. Domestic Violence and Intimate Partner Violence Services* 3. Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and 2-Spirit (LGBTQI2-S) TAY Prevention Services* 4. PEI Supportive Housing Services* 5. Veterans Community Colleges Outreach and Case Management Services* 6. Veterans Mental Health Services (peer support, female veterans, suicide prevention)* 9. Veterans Service Navigators

In addition, this 3 Year Program and Expenditure Plan seeks to address the essential services and supports for the No Place Like Home and Measure HHH housing initiatives as well as other locally identified priorities, such as LA County's Whole Person Care initiatives that focus on intensive service recipients and re-entry of mentally ill adults into the local mental health system.

Information contained in this 3 Year Program and Expenditure Plan focuses on services and the corresponding projected budgets for Fiscal Years 2017-18, 2018-19 and 2019-20, and reports on MHSA services provided in the last full Fiscal Year prior to the drafting of the report. Consequently, the service and outcome information contained in this report is for services provided during Fiscal Year 2015-16.

Fiscal Year 2015-16- at a Glance

- 119,277 unique clients served in the Community Services and Supports Plan, a 17% increase over the previous Fiscal Year.
    - While most Service Areas experienced some level of increase in clients served through the Community Services and Supports Plan, Service Area 6 experienced a 33% increase in clients served from Fiscal Year 2013-14 to Fiscal Year 2015-16.
- 11,583 clients were served in Full Service Partnership programs
    - Children enrolled in FSP programs experienced a 29% reduction in days hospitalized, compared with the year prior to enrollment.
    - FSP services resulted in a 38% and 45% reduction in children and Transition Age Youth psychiatrically hospitalized, respectively.
    - Transition age youth enrolled in FSP programs experienced a 38% increase in the number of days living independently and a 41% reduction in days homeless.
    - Adults enrolled in FSP programs experienced a 69% reduction in days homeless, a 65% reduction in days psychiatrically hospitalized, a 56% reduction in days incarcerated and a 46% increase in the number of days living independently.
    - Transition Age Youth enrolled in FSP programs have experienced increases in days employed, including a 490% increase in an evidence-based Supported Employment.
    - Older adult FSP clients experienced a 58% reduction in days homeless, 27% reduction in days psychiatrically hospitalized and a 41% reduction in days spent incarcerated.
- Over 34,000 clients were served in Mental Health Urgent Care Centers
    - 8% of the clients seen at the Eastside UCC, Westside UCC and the MLK UCC received an assessment at a psychiatric emergency room within 30 days of a UCC assessment for FY 2015-16.
- 45,288 unique clients were served in Early Intervention programs, 47% of whom had not received prior mental health services.
    - Early intervention services resulted in symptom improvement in excess of 40% for the treatment of trauma, behavioral disorders, anxiety, and depression and in parenting difficulties.

The Department's stakeholder process meets Welfare and Institutions Code 5848 on composition of the System Leadership Team (SLT) and meaningful involvement of stakeholders related to mental health planning, policy, implementation, monitoring, quality improvement, and evaluation and budget allocations. The composition of the System Leadership Team meets the California Code of Regulations Section 3300 on stakeholder diversity.

To create meaningful stakeholder involvement, the Department engages 3 levels of stakeholder involvement in ongoing mental health service delivery planning:

- The 58 member System Leadership Team (SLT) is the Department's stakeholder workgroup to inform the implementation and monitoring of MHSA programs. The composition of the expanded SLT is as follows:
  - *LA County Chief Executive Office*
  - *Service Area Advisory Committee (SAAC) leadership*
  - *Consumer and family member representation, including NAMI, self-help and the LA County Client Coalition*
  - *Department of Public Social Services*
  - *Health Care, including the Hospital Association and LA County Department of Public Health, LA County Department of Health Services*
  - *LA Police Department*
  - *Probation*
  - *Housing development*
  - *Older Adult service providers and LA County Community and Senior Services*
  - *Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino*
  - *Clergy*
  - *City of Long Beach*
  - *Veterans*
  - *LA County Mental Health Commission*
  - *Unions*
  - *Co-Occurring Joint Action Council*
  - *Education, including the LA Unified School District, universities and charter schools*
  - *Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)*
  - *LA Department of Children and Family Services*
  - *LA County Commission on Children and Families*
  - *Junior blind*
  - *Statewide perspective*

- The efforts of the SLT are guided by ad hoc committees and work groups, including a budget work group. Committees and work groups are comprised of volunteers from the SLT, any interested individuals, including clients and family members, provider staff, Service Area Advisory Committee members, Mental Health Commissioners and Department managers with responsibility for planning, implementing and managing MHSA programs. Work groups and committees represented diverse perspectives and are considered a microcosm of the larger SLT. Work groups were formed

at the September 21, 2016 SLT meeting by age group of service recipient to inform CSS and PEI services. These work groups were open and met regularly through November, 2016. Work groups will continue to meet to advise on implementation details of the CSS work plan consolidation outlined in this MHSA 3 Year Plan. (See work group meeting dates below. Work group sign-in sheets are available upon request.)

- The Service Area Advisory Committees (SAAC) continued their planning, aided by service utilization and outcome information for MHSA funded services in their Service Areas.

The Department provides training to new System Leadership Team members on the MHSA, the roles and responsibilities of SLT members and DMH services. The most recent orientation was conducted on June 23, 2016.

The SLT heard a summary of data and information from the Annual Update on December 21, 2016 and endorsed the Department to move forward with plan development and posting of the plan in mid-January, 2017. The plan was publically posted on the Department's website on January 23, 2017 and remains publically posted.

The Public Hearing was convened by the Mental Health Commission on February 23, 2017. At its next regularly scheduled meeting on March 23, 2017, the Commission approved the Department's 3 year plan. The Commission's subsequent discussion served as a framework of sorts for the implementation of the 3 year plan. The key themes related to increasing service continuity as a client ages, by reducing age group differentiation that leads to silo'd approaches to care. The commission also stressed the need to review disparities in FSP outcomes across Service Areas. Finally, reducing ethnic disparities remains a concern for the Commission, as it does for DMH. The Department agreed to present on different components of the MHSA every other month at Commission meetings, beginning with Full Service Partnership program models and outcomes in April, 2017.

Work groups met the following dates and times:

September			
Monday	Tuesday	Wednesday	Thursday
26 **TAY-CSS** 9:00- 10:30 **TAY-PEI** 10:30-12:00 **Older Adult-CSS & PEI** 2:00	27	28	29 **Children-PEI** 9:30-11:00 **Countywide-PEI** 1:00-2:30

CHILDREN TAY ADULT OLDER ADULT COUNTYWIDE - PEI HOUSING

October			
Monday	Tuesday	Wednesday	Thursday
3 **TAY-PEI** 1:00-2:30 **TAY-CSS** 2:30-4:00 **Older Adult-CSS & PEI** 9:30-12:30	4 **Adult-CSS** 9:00-11:00 **Adult-PEI** 11:30-1:30	5 **Children-CSS** 10:00-12:00	6 **Children-PEI** 9:30-11:00 **Countywide-PEI** 1:00-2:30
10	11 **TAY-CSS** 2:00-3:00 **TAY-PEI** 3:00-4:30	12 **Children-CSS** 10:00-12:00 **Adult-CSS** 8:30-10:30 **Adult-PEI** 10:30-12:30	13 **Children-PEI** 9:30-11:00 **Countywide-PEI** 1:00-2:30
17	18 **Children-PEI** 9:30-11:00 **TAY-PEI** 1:00-2:30	19 SLT MEETING **Children-CSS** 1:00-3:00 **Adult-CSS** 1:30-2:30 **Adult-PEI** 2:30-3:30	20 **Countywide-PEI** 1:00-2:30 **Older Adult-CSS & PEI** 10:30-12:30
24 **TAY-PEI** 9:00-10:30 **TAY-CSS** 10:30-12:00	25 **Adult-PEI** 11:00-12:30 **Adult-CSS** 1:00-2:30	26 **Children-CSS** 10:00-12:00	27 **Children-PEI** 9:30-11:00 **Countywide-PEI** 1:00-2:30

CHILDREN TAY ADULT OLDER ADULT COUNTYWIDE - PEI HOUSING

November			
Monday	Tuesday	Wednesday	Thursday
Oct 31 **TAY-PEI** 9:00-10:30 **TAY-CSS** 10:30-12:00	1 **Housing** 1:30-3:30	2 **Children - CSS** 10:00-12:00	3 **Countywide-PEI** 1:00-2:30 **Children-PEI** 9:30-11:00 **Adult-CSS** 1:00-3:00 **Adult-PEI** 3:00-5:00
7 **TAY-PEI** 2:30-4:00	8	9 **Adult-CSS** 8:30-10:00 **Adult-PEI** 10:00-11:30	10
14 **Adult-CSS** 10:30-12:30 **TAY-PEI** 10:30-12:00 **Adult-PEI** 1:00-3:00	15	16 SLT MEETING	17

CHILDREN | TAY | ADULT | OLDER ADULT | COUNTYWIDE - PEI | HOUSING

AGN. NO.____

MOTION BY SUPERVISOR JANICE HAHN February 21, 2017

One of the great strengths of Los Angeles County is our highly diverse multi-cultural community – a community that is continuously evolving. Given our constantly changing demographics, County Departments must strive to ensure that disparities in service provision are regularly identified and addressed. The Asian Pacific Islander (API) community is one of the most rapidly growing within Los Angeles County. However, despite the fact that API residents account for 15 percent of the County's population, API consumers represent only 5.38 percent of consumers served in Mental Health Services Act funded Community Services and Support (CSS) programs and 2.64 percent of the consumers served in Prevention and early Intervention programs. Overall, API consumers represent approximately 4.7 percent of the Department of Mental Health clients served annually.

Since the passage of the Mental Health Service Act (MHSA) in November, 2004, the Los Angeles County Department of Mental Health (DMH) has partnered with stakeholders in an effort to address disparities. Successful efforts have included the Integrated Services Model, one component of the Department's Innovations Program. Through this approach, culturally adapted outreach and engagement efforts ensured

-MORE-

SOLIS _____

KUEHL _____

HAHN _____

BARGER _____

RIDLEY-THOMAS _____

that members of the API community received appropriate integrated mental health and either physical health care or substance use services, including non-traditional services and supports sensitive to the specific preferences of those being served. The Department of Mental Health has also funded numerous and continues to fund other API initiatives that focus on outreaching and reducing mental health stigma in these communities. Over the past several months, DMH has met with its providers, including contracted and directly operated agencies that serve the API communities, to implement activities to increase services not only to the API communities but to other underserved ethnic and cultural communities. These activities would allow the expansion of the services available to the API communities by adding new community based organizations to provide prevention services and appropriately allocated funding to provide school-based and school-linked services, serving the uninsured, etc.

The efforts described above, along with the following recommendations, will demonstrate the County's commitment to reducing disparities for one of its most vulnerable populations.

I, THEREFORE, MOVE that the Board of Supervisors:

1) Direct the Director of Mental Health to include in the Mental Health Services Act Three Year Plan, which is currently in development, recommendations on outreach strategies to address the needs of the API community for mental health services commensurate with the mental health services to the County-wide population over the next five years. A recommendation should address appropriate allocations for CSS funding for individuals with serious mental illness and MHSA Prevention and Early Intervention funding in all age groups; and

2) Require the Department of Mental Health to conduct an evaluation to determine the specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population and;
3) Require the Director of Mental Health or his staff to collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population including the option of expanding the service delivery network; and
4) Report back to this Board in ninety days regarding these efforts.

# # #

JH:jh

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

May 30, 2017

TO: Supervisor Mark Ridley-Thomas, Chairman
Supervisor Hilda L. Solis
Supervisor Sheila Kuehl
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Jonathan E. Sherin, M.D., Ph.D.
Director

SUBJECT: **STRATEGIES TO REDUCE DISPARITIES TO MENTAL HEALTH SERVICES IN UNDERREPRESENTED ETHNIC AND CULTURAL COMMUNITIES (ITEM NO. 8, AGENDA OF FEBRUARY 21, 2017)**

INTRODUCTION

On February 21, 2017, your Board unanimously approved a motion by Supervisor Hahn that directed the Director of Mental Health, subsequently amended by Supervisors Ridley-Thomas and Barger, to develop strategies to reduce disparities in the delivery of mental health services to underrepresented ethnic and cultural communities, focusing on the Asian Pacific Islander (API) community (see Attachment I). More specifically, your Board instructed the Director of Mental Health to do the following:

1. Include in the Mental Health Services Act (MHSA) Three-Year Plan recommendations on outreach strategies to address the needs of the API community for mental health services commensurate with the mental health services to the countywide population over the next five years, including a recommendation to address appropriate allocations for Community Services and Supports (CSS) funding for individuals with serious mental illness and MHSA Prevention and Early Intervention (PEI) funding in all age groups;

2. Conduct an evaluation to determine the specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population;

550 S. VERMONT AVE., LOS ANGELES, CA 90020 | HTTP://DMH.LACOUNTY.GOV

3. Collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population, including the option of expanding the service delivery network; and

4. Conduct a gap analysis on disparities and areas that are underrepresented, how to address those issues, and disparities in funding throughout the County.

The specific recommendations and actions taken or planned to address them are detailed in separate sections below.

1. **Recommendations on outreach strategies to the API community were included in the MHSA Three-Year Plan.** The Department of Mental Health (DMH) presented a set of recommendations for API outreach strategies and funding intended to address disparities for API clients of all ages in the MHSA Three-Year Program and Expenditure Plan (see Attachment II). These recommendations were based on input provided by several API stakeholder groups prior to the Motion as well as from reports and studies on API mental health disparities and are incorporated into a fuller set of recommendations developed as a result of this Board Motion.

   As required by MHSA regulations (California Welfare and Institutions Code Sections 5847 and 5848), DMH presented these recommendations to the System Leadership Team (DMH's MHSA Stakeholder body) on February 15, 2017, and at the required public hearing convened by the Mental Health Commission on February 23, 2017. The MHSA Three-Year Program and Expenditure Plan, including the API recommendations, were approved by the Mental Health Commission on March 23, 2017, and to be heard by your Board on May 30, 2017.

2. **Conduct an evaluation to determine the specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population**. DMH conducted an evaluation to identify specific geographic, programmatic, and population disparities that impact the API communities. This evaluation included reviews of past and recent publications on API mental health disparities (with assistance from subject matter experts at UCLA, USC as well as Rand corporation) and analyzing data on service utilization, funding allocations and expenditures, workforce capacity, estimated prevalence of mental illness and service penetration rates for API, and the other major ethnic groups by geographic Service Areas. Recommendations based on this evaluation and targeted outreach strategies that have already started are described in Attachment III.

3. **Collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population, including the option of expanding the service delivery network.** DMH has a lengthy history working with A3PCON and its current network of API agencies. DMH management has met regularly with API mental health stakeholders and a representative from the Mental Health Commission, and the outcome of these meetings resulted in many of the action items that were included in the DMH recommendations in the MHSA Three-Year Plan (see Attachment II). These recommendations are incorporated into those developed with API stakeholders, including A3PCON, as the result of this Board Motion (see Attachment III). In addition, Attachment IV contains statements from A3PCON and consumer and provider stories and input. There are several initiatives that were already in progress prior to this Board Motion. For example, current DMH contractors with MHSA PEI funding were strongly encouraged and authorized to use their current allocations to expand their outreach and prevention efforts or collaborate and subcontract with culturally specific community-based organizations that do not have a DMH Legal Entity contract. DMH has also initiated other efforts to expand the service delivery system for API and other underserved communities including strategies that will increase community capacity such as peer support and self-help services, media outreach, community practitioners, health promoters (Promotores), school-based and faith-based services, non-traditional and culturally relevant care, interagency collaborations, career pipeline, and recruitment efforts. Presently, DMH is funding several staff from community-based organizations to be trained as trainers or trained in Mental Health First Aid, an anti-stigma and mental health awareness program and Question Persuade Refer (QPR), a suicide prevention course.

   DMH plans to utilize established Underserved Cultural Communities Sub-Committees (UsCC) as oversight and advisory groups for each of the major ethnic and cultural populations. These Sub-Committees consist of a broad range of stakeholders, e.g., consumers, family members, clergy, providers, and community advocates. For this API initiative, DMH plans to work with its API UsCC Sub-Committee that has representation from API stakeholders, including A3PCON.

4. **DMH will establish a gap analysis method and process to analyze mental health disparities that impact other underrepresented cultural communities.** The gap analyses will be collaborations involving DMH, its current advisory committees, community members including persons with lived or shared experiences with mental illnesses, providers, and researchers from academic institutions.

DMH will report on the progress of its efforts to reduce disparity among its most vulnerable ethnic and cultural communities in its Annual Quality Improvement Work Plans and Evaluations, Annual MHSA Updates, Cultural Competency Plan, and generate a quarterly scorecard to be published on the DMH Website.

If you need additional information, please contact me, or your staff may contact Dennis Murata, M.S.W., Deputy Director, Program Support Bureau, at (213) 738-4978 or DMurata@dmh.lacounty.gov.

JES:RK:DM:cm

Attachments

c: Executive Office, Board of Supervisors
Chief Executive Office
Robin Kay, Ph.D.
Dennis Murata, M.S.W.
Lawrence Lue, Mental Health Commissioner
A3PCON Mental Health Committee

Attachment I

Board of Supervisors Statement Of Proceedings February 21, 2017

8. Recommendation as submitted by Supervisor Hahn: Instruct the Director of Mental Health to include in the Mental Health Services Act Three Year Plan, which is currently in development, recommendations on outreach strategies to address the needs of the Asian Pacific Islander (API) community for mental health services commensurate with the mental health services to the Countywide population over the next five years, including a recommendation to address appropriate allocations for Community Services and Support funding for individuals with serious mental illness and Mental Health Service Act Prevention and Early Intervention funding in all age groups; and conduct an evaluation to determine the specific areas of geographic and programmatic disparities in order to develop a targeted outreach strategy for addressing the needs of the API population, and collaborate with groups that provide mental health services to the API population to enhance existing successful outreach approaches and identify new strategies for decreasing disparities in mental health care among this population, including the option of expanding the service delivery network, and report back to the Board in 90 days regarding these efforts. (17-0947)

Herb Hatanaka, Mariko Kahn, Mark Masaoka, Jane Kim, Margaret Shimada and Patricia Mulcahey addressed the Board.

Supervisor Ridley-Thomas made a friendly amendment to Supervisor Hahn's motion to instruct the Director of Mental Health to include in the report back to the Board a gap analysis on disparities and areas that are underrepresented, and how to address those issues. Supervisor Hahn accepted Supervisor Ridley-Thomas' amendment.

Supervisor Barger made a motion to amend Supervisor Hahn's motion to instruct the Director of Mental Health to also review for disparities in funding throughout the County.

After discussion, on motion of Supervisor Hahn, seconded by Supervisor Barger, this item was approved as amended; and the Director of Mental Health was instructed to include in the report back to the Board a gap analysis on disparities and areas that are underrepresented, how to address those issues, and disparities in funding throughout the County.

Ayes: 5 - Supervisor Solis, Supervisor Kuehl, Supervisor Hahn, Supervisor Barger and Supervisor Ridley-Thomas

Attachment II

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

Addressing Cultural and Ethnic Disparities through the MHSA 3-Year Plan

A central focus of the Department's Mental Health Services Act (MHSA) 3-Year Plan for Fiscal Years 2017-18, 2018-19 and 2019-20 is addressing disparities in access to care for mentally ill individuals who are homeless, who are incarcerated, and who have high use of psychiatric hospitals. This focus, in addition to child welfare, is also consistent with our County priorities. In Los Angeles County, while the majority of individuals in those focal populations are ethnic minorities, Asian and Pacific Islanders (API) are not included in significant numbers. Therefore, addressing disparities for those focal populations will not reduce disparities for the API communities.

Addressing ethnic and cultural disparities requires more than allocating funds. It requires the incorporation of culturally relevant traditional and non-traditional approaches to mental health care. It requires community-based strategies that focus on prevention, outreach, engagement, integrated care and stigma reduction efforts that involve consumers, parents, family members, community leaders, faith and community-based organizations and service providers.

At the February 15, 2017, System Leadership Team (SLT) meeting, its members recommended a number of strategies to reduce the ethnic and cultural disparities in mental health care. While disparities in mental health care remain for several ethnic and cultural groups, the API and Native American populations have been particularly underserved.

The Department will work with its API Underserved Cultural Communities workgroup, A3PCON, and other API stakeholders to review, refine, and implement the following recommendations:

- Review and scale up the successful outreach, engagement, and service strategies, e.g., the MHSA Innovation 1 Integrated Services Management model, including:
    - Using culturally specific non-traditional activities.
    - Framing mental health services in ways that minimize feelings of shame, such as using the word "healing" and "emotional well-being" over "mental illness."
    - Embedding services within cultural values and activities, such as blessing ceremonies.
    - Using education as a way to connect.
    - Providing assistance with basic needs as a way to engage individuals.

- Consider Countywide rather than geographic-based approaches to serve dispersed API communities and expand the API service provider network and increase their capacity to outreach and engage communities.
- Review and/or develop stigma and discrimination reduction strategies relevant to the API population.
- Engage, include and educate family members to break down historic and cultural resistance to seeking mental health care within households.
- Involve API cultural brokers, such as a clergy, in efforts to raise awareness of the signs and symptoms of mental illness and where to seek help.
- Increase presence at schools and colleges.
- Utilize health promoters, peers, parent partners, and family members in all aspects of care.
- Align wellness activities to the needs and interests of the API population.
- Utilize holistic service approaches involving the mind and body.
- Collaborate with A3PCON and SHARE!, the Department's advocacy contractor, to foster a culture of care seeking, peer inclusion and development of peer support and self-help services for the API communities.
- Collaborate with API agencies and National Alliance on Mental Illness (NAMI) to expand family groups to the API communities.
- Declare May 10th as API Mental Health Day, taking the lead from other key markets including San Francisco and Austin, Texas, and leveraging anti-stigma slogans and messaging.
- Promote research and evaluation efforts to study help-seeking behaviors, access to care barriers, and effective service models to develop programs that will reduce disparities.

The Department will review with relevant stakeholders the demographic trends and conduct a gap analysis, reviewing service utilization patterns of API clients, including excess capacity in current Full Service Partnership programs dedicated countywide to the API community. The Department will also consider re-allocating unspent funds as well as consider expanding services in County-Operated mental health clinics in Long Beach and Gardena that target Asian clients and families.

This effort to reduce disparities for the API, and other underserved ethnic communities, will be a major focus of the SLT as it reviews the implementation progress of the MHSA 3-Year Plan.

Attachment III

County of Los Angeles Department of Mental Health
Summary of Gaps and Recommendations to Reduce Mental Health Disparities Among API Communities

	Identified Gaps/ Barriers/Problem Areas	Facts	Recommended Solutions/Priority Service Area/Pop
		System Level Strategies	
1	Under-utilization of public mental health services by Asian Pacific Islander (API).	1. API, as a group, do not utilize public mental health services in proportion to either their relative percentage of the County's population or estimated mental health prevalence rate. 2. Low API utilization of public mental health service is historical and not unique to Los Angeles County. It is seen throughout the state and nationally. 3. API mental health penetration rates, i.e., percent of persons estimated with a Severe Mental Illness who receive services, vary among the API sub-groups and by Service Area (SA). For example, among the SAs with the largest API populations, SA 3 is 8.2%, SA 4 is 22.8%, and SA 8 is 11.4%. 4. There has been a 20% increase of API consumers served over the past nine years, but the API percentage of the total DMH client population has remained the same, approximately 5%. 5. Under-utilization of services by API consumers results in API specialty agencies having to serve non-API clients and/or not maximizing their contract allocations. This is especially evident with PEI funded programs and filling Full Service Partnership (FSP) slots in certain age groups.	1. Expand and enhance the current API Mental Health Network of public and private providers. 2. Develop, fund and implement strategies that address the unique cultural and linguistic needs of the diverse API sub-populations. 3. Expand current innovative, non-traditional services to meet the needs of the API sub-populations 4. Reduce stigma and discrimination and increase awareness of mental illness through culturally relevant and sensitive prevention and outreach activities by partnerships and collaborations with established community networks serving API communities, foundations and media. 5. Explore strategies that will maximize the flexible use of funding to better serve API consumers. For example, increase community-based rather than clinic bound services, hiring of peers and use of non-traditional services and serving mild to moderate API consumers. 6. Overall goal is to increase the number of API consumers served and community contacts each year by 20%. 7. Establish mental health penetration goals for each SA and API sub-populations.
2	API sub-populations are unique, culturally diverse and are separated by language and their own cultural beliefs, norms and practices.	1. The API communities in Los Angeles County consist of more than 45 ethnic groups speaking 28 languages. 2. Social determinants of mental health vary among the API sub-populations. 3. Levels of poverty, immigration and generational issues, domestic violence, substance abuse vary significantly among the API sub-population. 4. The API sub-populations are dispersed throughout the County with large concentrations living within their own ethnic communities. SAs 3, 4 and 8 have the largest numbers of API residents living under 200% Federal Poverty Level.	1. Strategies for addressing API mental health disparities must be developed at the sub-population level, not as a single, aggregated API group. 2. Collaboration with academic and research institution to analyze social determinants specific to each API sub-population. 3. Develop, fund and implement strategies to address the needs of the sub-populations involving community stakeholders, County Departments, relevant social and human service agencies, faith based.
		Program Level Strategies	
1	Publicly funded mental health services have historically not focused on prevention but providing direct services to	1. The focus has been on serving persons who meet the Medi-Cal medical necessity criteria, therefore mostly providing services that are claimable to Medi-Cal Specialty Mental Health Services. Approximately 75% of the API clients served in FY 2015-16 were Medi-Cal beneficiaries. 2. Funding allocations make it necessary to maximize federal revenue in order to develop	1. Increase API relevant mental health prevention and educational services in the communities through sub-contracting, work orders, direct contracting with new or existing legal entities. 2. Explore using MHSA PEI funds to serve mild to moderate consumers. 3. Training ethnic specific community organizations and members on

1 5/30/2017

Attachment III

County of Los Angeles Department of Mental Health
Summary of Gaps and Recommendations to Reduce Mental Health Disparities Among API Communities

	Identified Gaps/ Barriers/Problem Areas	Facts	Recommended Solutions/Priority Service Area/Pop
	persons with moderate to severe mentally illness who meet Medi-Cal medical necessity criteria.	sustainable programs. Therefore, outreach, engagement, preventative and non-traditional culturally appropriate services not claimable to Medi-Cal are not widely available.	prevention and promotional practices, e.g., MHFA, QPR, e-CPR, CDEs and Promotores models.
2	Lack of ethnic specific community-based organizations, including primary health care providers and health plans are difficult to form due to contracting and other bureaucratic barriers.	1. Cultural and linguistic services are not adequately available and accessible to API communities throughout the County. 2. The current API network of providers consists of both contracted and directly operated API specific mental health providers that provide specialty mental health services for the majority of API clients served.	1. Expand the API network of providers including community organizations and Faith-Based Organizations (FBO) and services beyond clinic based and bound services. 2. Develop community capacity in areas where there are dense populations of an API sub-population. 3. Reinstitute sub-contracting for services and agency incubation programs to build community capacity.
3	Current API bilingual workforce is dispersed throughout the County in areas or in positions where their language skills are not utilized.	1. There are 1,510 API active rendering providers in our DMH directly operated and contracted programs. 2. Of the 1,510 rendering providers, 834 (55.3%) speak at least one API language. The most frequent API language spoken is Cantonese/Mandarin, followed by Korean, Tagalog and then Vietnamese. 3. Approximately 75% of the rendering providers are social workers, MFTs, psychologists, physicians or nurses. Only nine listed peer advocate as their discipline.	1. Further analysis is needed to look at assigned location of bilingual staff, languages spoken by discipline and staff to client ratio by specific API sub-populations. 2. Pipeline programs to encourage API to seek careers in mental health and to allow current API workers to obtain professional degrees in mental health. 3. Training and hiring of peers, family and community members
4	Low utilization of intensive services, e.g., Psychiatric Mobile Response Team (PMRT), Outreach, SB82, Law Enforcement Team (LET) by API communities.	1. API contacted by countywide outreach teams varies by SA, funded program and by API sub-population. For example, PMRT/LET visits occur more frequently for Chinese, Korean and Vietnamese than other API sub-populations. 2. One program where the penetration rate is higher than the overall API rate is for Assisted Outpatient Treatment (AOT).	1. Review the reasons why the disparities exist among the various outreach, engagement and triage efforts by studying the services that serve higher numbers of API compared to others.
5	FSP slots are at or close to capacity for most of the API age groups.	Based on DMH FSP Tracking Reports as of March 2017, status of API slots by Age Group and by SA were as follows: • Child: Most API providers are projected to meet their target enrollments. • TAY: At or over capacity in SAs 2 and 4. Not expected to meet target for API in other SAs. • Adult: All API providers were either projected to meet or exceed their target enrollments. The API slots allocated to the API Alliance were already at 98% in March. • Older Adult: Overall API Older Adult FSP will not meet target, but for those assigned to the API Alliance, they have already exceeded their allocation.	1. Reallocate and/or add funding and/or slot allocations to API FSP programs to build greater capacity in the SAs and age groups where it's most needed. 2. Evaluate the impact on FSP slots and funding when the consolidation of FSP and Field Capable Clinical Services (FCCS) take place on July 1, 2017. 3. DMH is adding staff resources for 10 FSP slots to its two directly operated API programs by shifting available DMH FSP resources.

2 5/30/2017

Attachment III

County of Los Angeles Department of Mental Health
Summary of Gaps and Recommendations to Reduce Mental Health Disparities Among API Communities

	Identified Gaps/ Barriers/Problem Areas	Facts	Recommended Solutions/Priority Service Area/Pop
6	Limited self-help and family support services available in API languages.	Self-help, peer support and family support services are not available to all API sub-population groups in each SA.	1. Determine the current level of support resources available to API communities within each SA for language needs and API sub-population. 2. Increase peer support, self-help and family support groups in each SA for the languages that are needed.
7	Lack of recovery-based and wellness-focused services for API clients.	Funding for field capable, recovery and wellness services does not support expansion to serve more API who are in need of these services.	1. Further review of funding is needed to ensure that recovery and wellness services are available to API sub-populations especially since Fiscal Year 2017-18 will be the first year of consolidating MHSA funding.
8	Lack of API specific Anti-Stigma and Anti-Discrimination Efforts.	Media campaigns are not available in all major API language or to the most underserved API sub-populations.	1. Design a countywide API media campaign that will address the needs of the API sub-populations.
9	Referral processes create barriers to access to care.	Certain referral protocols impede direct and easy access to services.	1. Develop and implement culturally appropriate guidelines for referrals.
10	Lack of Community Development Evidence (CDE) Practices for API.	Limited number of API CDEs and promising practices available to serve the API population.	1. Pilot and support API-focused CDEs and Promising Practices.

3 5/30/2017

Attachment IV

API Stakeholder Statements and Vignettes

Statement from A3PCON

Given the diversity in Los Angeles County especially among Asian Pacific Islander (API) communities, it is not a surprise that disparity and the attendant reduced access to services remains a major barrier even after decades of funding for direct services. The Board of Supervisors motion asked the Department of Mental Health (DMH) to present strategies to address disparity and to identify gaps specifically for APIs. The intent was to use this as a model to address disparities in other ethnic communities such as the African groups, Middle Eastern, Eastern European, American Indian and many more.

Working collaboratively, DMH and a network of API mental health agencies saw this as an opportunity to use the data based on the outcomes and results of the API ISM Programs, the API FSP Countywide programs and the Prevention and Early Intervention transformation to address disparity. It is clear that stigma, shame and lack of information about mental illness are some of the major causes of disparity for APIs. Equally clear was that the strategies of outreach, engagement and education conducted by linguistically appropriate and culturally sensitive staff and community organizations helped to overcome the disparity to some extent. But the nagging question remained – why did the usage of mental health services for APIs remain stubbornly the same year after year? The answer is two-fold – the lack of sufficient infrastructure to provide the services and the need to apply a holistic approach to OEE and treatment on a system-wide basis.

Over the years, a backbone of culturally competent API providers formed, made up of private community based organizations and directly operated clinics. When the population of APIs was less than 5%, this API provider network could provide sufficient culturally competent services. Today's APIs make up over 16% of the population in the County, but the funding for the organizations has not been matched to accommodate that growth. As a result, the staffing of the culturally competent network of organizations is spread too thinly to meet the diversity of the different communities. More funding must be allocated to strengthen and enhance this proven and experienced network. At the same time, community organizations that are not contract providers can become effective partners for prevention and early interventions.

Addressing disparity requires more than translated materials and bilingual staff. Outreach has to be performed at the grassroots level by established and trusted community based organizations and outreach workers with shared experience of that target population. Education needs to be delivered at the most fundamental levels of what constitutes emotional well-being, not at the crisis levels of mental illness. Integrated care must include areas beyond mental health and medical treatment such as housing, clothing and food. And last, the continuum of care must extend beyond the recovery period for a consumer to overcome social isolation and accomplish community acceptance.

The selection of reducing disparity among APIs as a pilot for other underserved populations is a wise one for there are significant elements inherent in the current API system of care that will help to increase its chance for success. First and foremost, there is already an established network of API agencies and directly operated clinics that provide direct services. These agencies work with other agencies throughout the county that serve also APIs. In addition, the network has mentored and subcontracted to a significant number of smaller API non-profits.

Second, for forty years under the umbrella of A3PCON, API agencies have learned the art of collaboration and consensus building to determine priorities and needs. In the early years when our numbers were small, the API groups had to work together to survive. Now that the

1

population numbers have increased and continue to be the fastest growing population in LA County, the API agencies continue to work cooperatively and to outreach to emerging populations like the Mongolians and Hmong.

Third, for some 20 years the API Alliance and the development of API FSP collaboratives have proven how a countywide approach to services can successfully manage the diverse linguistic needs by pooling staff. If an API client is identified in one part of the county and the designated agency in that service area does not have staff who speak that language, another agency that has that capacity will send staff to serve that client. This is oftentimes done at some sacrifice of time and expenses by the staff, but the goal of providing culturally competent care is primary.

Last but not least, the four API ISMs under the Innovation Plan One showed how the use of community based outreach, education and engagement must be individualized to each specific community. The data supports the use of non-traditional healing practices as an integral part of the mental health treatment plan. And the consumers showed strong improvement when a culturally sensitive approach was embedded in the program.

With these elements forming a strong foundation and a framework to look at disparity for APIs, we present a series of recommendations that over the next five years should reduce the barriers to service.

CONSUMER STORIES

Leo's Story

Leo, a Transition Age Youth male was referred to the SSG's APCTC's TAY Full Service Partnership Program (FSP). He was evicted from a family member's home and was temporarily couch surfing at a friend's house. His eviction was due to his aggressive threats toward his family members, which were triggered by symptoms of his severe mental illness (paranoid delusions, auditory hallucination). He was fired from his job at least twice due to paranoid delusions about his co-workers. His mental illness likely started in college and symptoms progressed to being suspicious of family members and coworkers having a "gay agenda", leading to conflicts and accusations of coworkers sexually harassing him. He has a history of psychiatric hospitalizations, residential drug treatment for abusing LSD, Ecstasy, and Marijuana, and inconsistent adherence to his psychiatric medication.

Leo was uninsured and unable to find employment despite graduating from UC Berkeley. Through intensive, culturally competent engagement and mental health services provided by a team of API staff, Leo was stabilized on psychotropic medication and linked to SSG-APCTC's vocational rehabilitation, housing services, health insurance and SSI. FSP staff assisted him on almost a daily basis and helped him with essential living habits; such as, groceries, taking and receiving his medication, as well as general counsel and therapy. As his substance abuse decreased, he was able to find employment and lived independently in a shared apartment. His FSP team was able to remain in contact with him to provide support throughout his struggles controlling the symptoms of his mental illness. With support from his FSP team, Leo was also able to reconnect his family members who were provided psychoeducation about Leo's mental illness and encouraged to support his recovery. Since his graduation from his FSP program, Leo hasn't had any psychiatric hospitalizations or episodes of homelessness. He successfully graduated from his FSP program after 7 months and transitioned to a lower level of care within APCTC. The continuum of care provided within APCTC enabled Leo to continue his mental

health recovery, in which he later was trained and employed as a Peer/Consumer Advocate. Today, Leo furthers his recovery by giving hope and helping other TAY and adults recover from their severe mental illness.

Steven's Story

Three-year old Korean boy Steven (a pseudonym) and his mother were referred to SSG-APCTC by a domestic violence shelter program for services. The mother was several months pregnant and had been experiencing psychotic symptoms for years (hearing voices, paranoid beliefs that someone is hurting her 3-year old son). She did not seek treatment due to strong mental health stigma. The family exhausted their stay at the shelter and had to move out. Steven's mother is monolingual Korean, undocumented and did not qualify for government subsidized housing. They were going to become homeless. His mother was unemployed and had no family, relatives or social support around her. Steven was referred to SSG-APCTC's Child Full Service Partnership (FSP) program due to his history of trauma – witnessing domestic violence by his father towards his mother—and developmental delays, which were likely due to his trauma exposure and growing up in a deprived environment. His family had been homeless in the past. Steven was at high risk of DCFS involvement due to parental incapacitation with mother giving birth and her mental illness.

The FSP team used flex funds to temporarily place Steven and his mother at a motel to prevent homelessness. DCFS involvement was prevented when the team identified a Korean family who was willing to care for Steven, with mother's permission, while mother gave birth and recovered post-partum. Steven and his mother were soon placed with another domestic violence shelter that had Korean speaking staff who could provide additional social support to Steven's family. After much engagement efforts by Korean staff, Steven's mother finally agreed to her own mental health treatment, was linked to Adult FSP, and has since improved with intensive therapy, case management and psychotropic medication. The FSP team has provided intensive parenting coaching to Steven's mother, and linked Steven to daycare to foster his development. The family started attending a church where they are receiving much needed social and spiritual support. Steven's mental health, social, and language development have significantly improved with FSP services. He is thriving in a safe home, good daycare, and increased social support system.

Homelessness in API population-

It may seem that homelessness is not prevalent in the API community. However, through our work in FSP and ICP, we have encountered a number of homeless individuals that we now serve and house using DMH funding. And, through our experience, we have found that it is not that there is no homelessness in the API community but APIs are creative in finding ways to find shelter that is not considered traditional places that homelessness is identified. APIs use the casinos, Korean spas, churches, temples, and other non-traditional homeless shelters and thus are hidden from society. Often this occurs because of shame or even feeling unsafe in traditional shelters or lacking the understanding or ability as to how to access traditional homeless services.

One example of homelessness in the API community is the Kim family, mother and son, who participated in A3PCONs Measure H press conference. Mother and son entered the country many years ago with the support of family but due to family dispute, they were put out on the streets. Mrs. Kim found employment, but she lost her sight. She was unable to work and required ongoing assistance. Mr. Kim found employment working as an assistant at an unlicensed board and care. This board and care became over

populated and then was shut down by the city for mismanagement. They became homeless again. While trying to get back on his feet, Mr. Kim suffered a debilitating stroke that left him wheelchair bound. The ICP assisted the mother and son in obtaining mental health services and housing through DHS housing funds. SSG is providing ongoing support for mother and son though ICP. Mister and missus Kim's story is not atypical as many homeless API individuals will seek employment as a live-in housekeeper or caregiver as a way of securing housing.

Success stories from an API Provider

Since I work with older adults, I believe that this age group more than others truly require the culturally specific interventions that we provide through our collaborative. A good understanding of the history of the individual whether it is reason for immigration or significant social event in the home country is important in serving the API older adult regardless of their English proficiency. There are so many cases that we have worked with that without this program, there be the same outcome. Here is one example.

A Vietnamese man who developed significant symptoms of PTSD while watching footages of the Iraq war following 9/11. He was in the Vietnam War many years ago but did not develop symptoms of PTSD and was able to work successfully in the United States as a chef in a Vietnamese restaurant. However, soon after 9/11, begin experiencing symptoms of PTSD. He believed that because he and his comrades left the bodies of the dead soldiers in the field exposed and not buried, the spirits are not at rest and are now haunting him in his home. As a devout Buddhist, he believed that he needed to repent for his sins. Since this is a culturally accepted believe, he did not feel that he had a mental illness and refused traditional mental health treatment including medications. His family became frustrated but had no solutions. He was up every night talking to the spirits and hiding behind furniture in his home. He refused to leave the home. Through work with the API program, the client received a Buddhist chanting machine to help him calm his mind and repent for his sins. The client was also brought to a Buddhist temple so that he can obtain spiritual guidance. The client and his wife then went to Vietnam to participate in a ceremony to honor the dead. Through this work, the client agreed to begin psychotropic medications through the program. The program also provided family counseling to restore the client's relationship with his adult son as the client had believed that he had lost the respect of his son and is no longer a fit head of the household. At the end of the program, the client had begun to participate in activities at a local adult day health care center and was again cooking meals for his family which was a major role for him prior to his illness.

Overcoming Stigma: A Case for Outreach. In 2001 SSG launched an API older adult mental health program through a one-time funding from the California Endowment. The project targeted a number of communities including Chinese, Japanese, Filipino, Cambodian, and Thai over a three year period. Over the years, SSG has applied the learnings from this project in our education efforts in these communities to increase access and utilization to mental health services. However, we still have a long way to go. APIs consider themselves to be a part of a larger community and are fearful of brining shame onto their families. They oftentimes seek out support from spiritual leaders that often have a different explanation for the disorder and how to address it. Some clients feel that utilization of mental health services goes against their faith others need assurance that there is buy in from their entire family and extended family before they can consent to treatment. The term working with the Village is often used when engaging with an API client as we need to outreach to not only the client but their family members and sometimes community leaders.

Attachment IV

API Stakeholder Statements and Vignettes

API FSP

One example is a Cambodian woman that we worked with through our FSP program. She was a victim in the Khmer Rouge. She witnessed the slaughter of her husband and 11 of her 12 children. At the time of referral, she was living in a Cambodian Temple. She had made multiple suicide attempts and regularly bangs her head on the wall as a way of punishing herself. She was blind in both eyes for excessive crying. The client when engaged with initially refused services. She reported that the head monk for the temple that she was residing in told her that this was her sin from her past life and that she needed to focus on repenting. She was homeless at the time as her only surviving child held resentment towards her for continuously grieving the loss of her other children and not appreciating the live that they had together. This child also only survived because her mother had given her away at a young age to a cousin who was unable to bare children. The client was completely dependent on the temple and felt that accepting services would be a betrayal. Program staff spent months engaging with the temple monk and nuns to gain their trust and understanding of the program and worked collaborative to help the client understand that her faith and mental health treatment can co-exist.

Cases being assigned to non-API agencies are common but if the client speaks even broken English that the client may be referred to a Non-API agency. Since the API FSP slots assigned to the collaborative is so limited, we are often full. However, after the case is opened, I often receive requests from the service provider for resources within the API community or for case consultation. Sometimes providers will open a case because they have a student intern that is API. Again, because language often gets confused with cultural competency, the agency's lack the understanding that the client require the support and connection to the community and not just a clinician that can speak their language. Once the student leaves the agency, the case often gets transferred to the API collaborative. It is at this time that we often find that the care provided was substandard. Sometimes we are transferred cases and told that the client does not engage only to find out that the provider was not speaking to the client in his/her preferred dialect or language.

5

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Los Angeles

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Debbie Innes-Gomberg, Ph.D.
Telephone Number: (213) 738-4601	Telephone Number: (213) 738-2756
Email: JSherin@dmh.lacounty.gov	Email: digomberg@dmh.lacounty.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
550 S. Vermont Avenue, 3rd Floor
Los Angeles, CA 90020

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

This Three Year Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Three Year Program and Expenditure Plan attached hereto, was adopted by the County Board of Supervisors on May 30, 2017.

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

All documents in the attached MHSA 3 Year Program and Expenditure Plan are true and correct.

Jonathan E. Sherin, M.D., Ph.D.
Local Mental Health Director (Print)

Signature

5/31/17
Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

- [x] Three-Year Program and Expenditure Plan
- [ ] Annual Update
- [ ] Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: John Naimo
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-8484
E-mail: JSherin@dmh.lacounty.gov	E-mail: jnaimo@auditor.controller.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
Adult System of Care Bureau
550 S. Vermont Avenue, 3rd Floor
Los Angeles, CA 90020

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

Jonathan E. Sherin, M.D., Ph.D.
Local Mental Health Director

Signature 4/4/17
Date

I hereby certify that for the fiscal year ended June 30, 2016, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/15/16 for the fiscal year ended June 30, 2016. I further certify that for the fiscal year ended June 30, 2016, 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 MSHA funds may not be loaned to a county general fund or any other county fund.

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

John Naimo
County Auditor Controller (PRINT)

John Naimo 4/5/17
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

Mental Health Commission Approval Letter

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

March 23, 2017

Jonathan Sherin, MD, PhD
Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Sherin:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
THREE YEAR PROGRAM & EXPENDITURE PLAN
FISCAL YEAR 2017-18 THROUGH 2019-20
NOTICE OF PLAN APPROVAL

On March 23, 2017 the Chair and a quorum of the Los Angeles County Mental Health Commission (Commission) made the following motion of the Mental Health Services Act Fiscal Three Year Program & Expenditure Plan for Fiscal Years 2017-18 through 2019-20:

MOTION: The Los Angeles County Mental Health Commission moves to approve the Three Year Program & Expenditure Plan for Fiscal Year 2017-18 through 2019-20.

It is, therefore, with pleasure that the Commission approves your Department's submission of the Fiscal Years 2017-18 through 2019-20 Three Year Program & Expenditure Plan, which was publically posted on January 23, 2017 and presented at the February 23, 2017 Public Hearing. We commend the Department for continuing to engage the Service Area Advisory Committees in the ongoing planning and implementation of the Mental Health Services Act and on the outcomes achieved thus far.

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

Best,

Caroline Kelly, JD
Chair

550 South Vermont Avenue, 12th Floor, Los Angeles, California 90020 – Phone: 213.738.4772 – Fax: 213.738.2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://wcmprd1.ilis.lacounty.gov:10039/wps/portal/dmh/about_dmh/mhc

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
29 May 30, 2017
LORI GLASGOW
EXECUTIVE OFFICER

May 02, 2017

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 THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEARS 2017-18, 2018-19 and 2019-20 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Three-Year Program and Expenditure Plan for Fiscal Years 2017-18, 2018-19 and 2019-20.

IT IS RECOMMENDED THAT THE BOARD.

Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FYs) 2017-18. 2018-19 and 2019-20 (Attachment). The MHSA Three-Year Program and Expenditure Plan has been certified by the County Mental Health Director and the County Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Board approval of the recommended action will allow DMH to submit the MHSA Three-Year Program and Expenditure Plan to the Mental Health Services Oversight and Accountability Commission which is required by WIC Section 5847. Recent amendments to the MHSA require that the MHSA Three-

Year Program and Expenditure Plan and the Annual Updates be adopted by the County Board of Supervisors. Additionally, it is required that the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller attesting that the County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the MHSA requirements. Under the MHSA, a draft of the MHSA Three-Year Program and Expenditure Plan and the Annual Updates must be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interestsand any interested party who has requested a copy of the draft plans. Additionally, the MHSA requires that the County's Mental Health Commission conduct 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 order to fulfill the latter requirements, DMH posted the MHSA Three-Year Program and Expenditure Plan on its website for 30 days for public comments on January 23, 2017. DMH also convened a Public Hearing on February 23, 2017, where DMH presented the update and addressed public questions and/or concerns. The County's Mental Health Commission voted to approve the MHSA Three-Year Program and Expenditure Plan at its meeting on March 23, 2017.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County's Strategic Plan Goal I, Make Investments That Transform Lives, via Strategy I.1- Increase Our Focus on Prevention Initiatives, I.2 - Enhance Our Delivery of Comprehensive Interventions and I.3 Reform Service Delivery Within Our Justice System, and Goal II, Foster Vibrant And Resilient Communities, via Strategy II.2 - Support theWellness of our Communities.

FISCAL IMPACT/FINANCING

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB 1467 requires each county mental health program to prepare and submit the MHSA Three-Year Program and Expenditure Plan and the Annual Updates, adopted by the County Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission. It also requires that the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the County Mental Health Director and the County Auditor-Controller. This includes the County Mental Health Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions.

The Mental Health Services Oversight and Accountability Commission provided direction to the counties to complete MHSA Annual Updates through a memo dated August 2, 2013, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the County Mental Health Director and County Auditor-Controller.

The public hearing notice requirements referenced in WIC Section 5848, subdivisions (a) and (b) have been fulfilled and are recorded in the MHSA Three-Year Program and Expenditure Plan.The County Auditor-Controller and County Mental Health Director have both signed the MHSA Fiscal

Accountability Certification Form included in the MHSA Three-Year Program and Expenditure Plan.

The MHSA Three-Year Program and Expenditure Plan for FYs 2017-18, 2018-19 and 2019-20 contains a summary of MHSA programs for FY 2015-16, including clients served by MHSA program and Service Area as well as program outcomes. In addition, the MHSA Three-Year Program and Expenditure Plan contains an increase in Full Service Partnership slots needed for the service components of key County and State initiatives such as Whole Person Care, No Place Like Home and the Los Angeles, California, Homelessness Reduction and Prevention Housing, and Facilities Bond Issue, Measure HHH.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Three-Year Program and Expenditure Plan for FYs 2017-18, 2018-19 and 2019-20 will ensure compliance with AB 1467 requirements and ensure timely access to appropriate services.

Respectfully submitted,

Jonathan E. Sherin, M.D., Ph.D.
Director

JES:DIG:MM:SLD:j
v

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

Acronyms and Definitions

ACS:	Alternative Crisis Services
ACT:	Assertive Community Treatment
ADLS:	Assisted Daily Living Skills
AF-CBT	Alternatives for Families - Cognitive Behavioral Therapy
AI:	Aging Initiative
AILSP:	American Indian Life Skills Program
APF:	American Psychiatric Foundation
ARF:	Adult Residential Facility
ART:	Aggression Replacement Training
ASD:	Anti-Stigma and Discrimination
ASIST:	Applied Suicide Intervention Skills Training
ASL:	American Sign Language
BSFT:	Brief Strategic Family Therapy
CalSWEC:	CA Social Work Education Center
CAPPS:	Center for the Assessment and Prevention of Prodromal States
CBITS:	Cognitive Behavioral Intervention for Trauma in Schools
CBO:	Community-Based Organizations
CBT:	Cognitive Behavioral Therapy
CDE:	Community Defined Evidence
CDOL:	Center for Distance and Online Learning
CEO:	Chief Executive Office
CF:	Capital Facilities
CFOF:	Caring for our Families
CiMH:	California Institute for Behavioral Health
CMHDA:	California Mental Health Directors' Association
CORS:	Crisis Oriented Recovery Services
COTS:	Commercial-Off-The-Shelf
CPP:	Child Parent Psychotherapy
CSS:	Community Services & Supports
C-SSRS:	Columbia-Suicide Severity Rating Scale
CTF:	Community Treatment Facility
CW:	Countywide
DBT:	Dialectical Behavioral Therapy
DCES:	Diabetes Camping and Educational Services
DCFS:	DCFS Los Angeles County Department of Children and Family Services
DHS:	Department of Health Services
DMH:	Department of Mental Health
DPH:	Department of Public Health
EBP(s):	Evidence Based Practice(s)
ECBI:	Eyeberg Child Behavioral Inventory
ECC:	Education Coordinating Council
EESP:	Emergency Shelter Program
EPSDT:	Early Periodic Screening, Diagnosis and Treatment
ER:	Emergency Room
FCCS:	Field Capable Clinical Services
FFP:	Federal Financial Participation
FFT:	Functional Family Therapy
FOCUS:	Families Overcoming Under Stress
FSP(s):	Full Service Partnership(s)
FSP/PSS:	Full Service Partnership
FSS:	Family Support Services
FY:	Fiscal Year
Group CBT:	Group Cognitive Behavioral Therapy
GROW:	General Relief Opportunities for Work
GVRI:	Gang Violence Reduction Initiative
HIPAA:	Health Insurance Portability and Accountability Act
HOME:	Homeless Outreach and Mobile Engagement
HSRC:	Harder-Company Community Research
HWLA:	Healthy Way Los Angeles
IBHIS:	Integrated Behavioral Health System
ICC:	Intensive Care Coordination
ICM:	Integrated Clinic Model
IEP(s):	Individualized Education Program
IFCCS:	Intensive Field Capable Clinical Services
IHBS:	Intensive Home Base Services
ILP:	Independent Living Program
IMD:	Institution for Mental Disease
Ind CBT:	Individual Cognitive Behavioral Therapy
IMHT:	Integrated Mobile Health Team
IMPACT:	Improving Mood-Promoting Access to Collaborative Treatment
IMR:	Illness Management Recovery
INN:	Innovation
IPT:	Interpersonal Psychotherapy for Depression
IS:	Integrated System
ISM:	Integrated Service Management model
ITP:	Interpreter Training Program

DTQI:	Depression Treatment Quality Improvement
KEC:	Key Event Change
KHEIR:	Korean Health, Education, Information and Research
LACDMH:	Los Angeles County Department of Mental Health
LAPD:	Los Angeles Police Department
LGBTQ:	Lesbian/Gay/Bisexual/Transgender/Questioning
LIFE:	Loving Intervention Family Enrichment
LIHP:	Low Income Health Plan
LPP:	Licensure Preparation Program
MAP:	Managing and Adapting Practice
MAST:	Mosaic for Assessment of Student Threats
MDFT:	Multidimensional Family Therapy
MDT:	Multidisciplinary Team
MFT:	Masters in Family and Therapy
MH:	Mental Health
MHC:	Mental Health Clinic
MHCLP:	Mental Health Court Linkage Program
MHFA:	Mental Health First Aide
MHIP:	Mental Health Integration Program
MHRC:	Mental Health Rehabilitation Center
MHSA:	Mental Health Services Act
MHSOAC:	Mental Health Services Oversight and Accountability Commission
MMSE:	Mini-Mental State Examination
MORS:	Milestones of Recovery Scale
MOU:	Memorandum of Understanding
MP:	Mindful Parenting
MPAP:	Make Parenting a Pleasure
MPG:	Mindful Parenting Groups
MST:	Multisystemic Therapy
NACo:	National Association of Counties
NFP:	Nurse Family Partnerships
OA:	Older Adult
OACT:	Older Adult Care Teams
OASCOC:	Older Adult System of Care
OBPP:	Olweus Bullying Prevention Program
OEF:	Operation Enduring Freedom
OEP:	Outreach and Education Pilot
OND:	Operation New Dawn
OQ:	Outcome Questionnaire
PATHS:	Providing Alternative Thinking Strategies
PCIT:	Parent-Child Interaction Therapy
PDAT:	Public Defender Advocacy Team
IY:	Incredible Years
PE:	Prolonged Exposure
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors
PEI:	Prevention and Early Intervention
PEMR(s):	Probation Electronic Medical Records
PE-PTSD:	Prolonged Exposure Therapy for Post-Traumatic Stress Disorder
PMHS:	Public Mental Health System
PMRT:	Psychiatric Mobile Response Team
PRISM:	Peer-Run Integrated Services Management
PRRCH:	Peer-Run Respite Care Homes
PSH:	Permanent Supportive Housing
PSP:	Partners in Suicide Prevention
PST:	Problem Solving Therapy
PTSD:	Post-Traumatic Stress Disorder
PTSD-RI:	Post-Traumatic Stress Disorder – Reaction Index
QPR:	Question, Persuade and Refer
RFS:	Request For Services
RFSQ:	Request For Statement of Qualifications
ROSTCP:	Recovery Oriented Supervision Training and Consultation Program
RPP:	Reflective Parenting Program
RRSR:	Recognizing and Responding to Suicide Risk
SA:	Service Area
SAAC:	Service Area Advisory Committee
SAPC:	Substance Prevention and Control
SED:	Severely Emotionally Disturbed
SF:	Strengthening Families Program
SH:	State Hospital
SLT:	System Leadership Team
SNF:	Skilled Nursing Facility
SPC:	Suicide Prevention Center
SPMI:	Severe and Persistently Mentally Ill
SS:	Seeking Safety
START:	School Threat Assessment And Response Team
TAY:	Transitional Age Youth
TF-CBT:	Trauma Focused-Cognitive Behavioral Therapy
TN:	Technological Needs
Triple P:	Triple P Positive Parenting Program
OMA:	Outcome Measures Application
UC:	Usual Care
UCC(s):	Urgent Care Center(s)
UCLA:	University of California, Los Angeles
UCLA TTM:	UCLA Ties Transition Model

UREP:	Under-Represented Ethnic Populations
USC:	University of Southern California
TSV:	Targeted School Violence
VALOR:	Veterans' and Loved Ones Recovery
WCRSEC:	Women's Community Reintegration Service and Education Centers
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.

Client contacts are based on Exhibit 6 reporting by program leads for FY 2013-14.

Client Run Center counts are based on client contacts using Community Outreach Services billing. Data as of February 9, 2015.

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.

Older Adult Age Group: Age range is 60+.

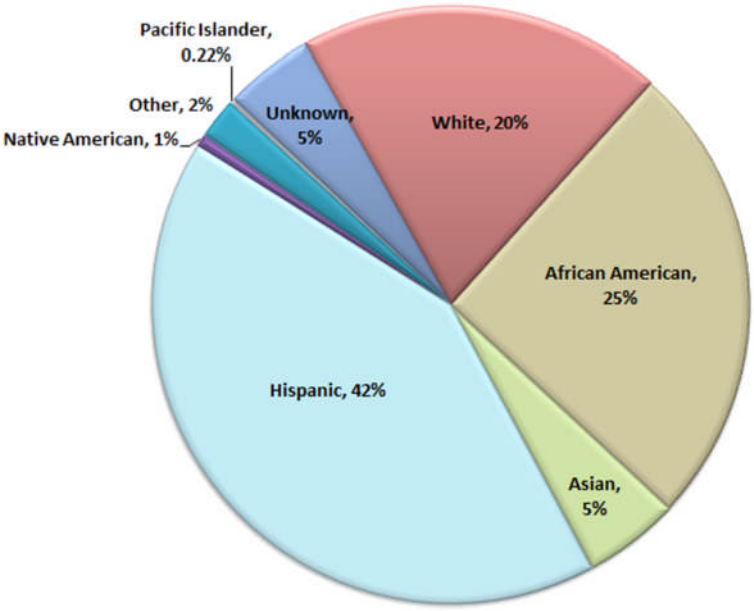
Transitional Age Youth Age Group: Age range is 16 to 25 years old.

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. Data as of January 4, 2016

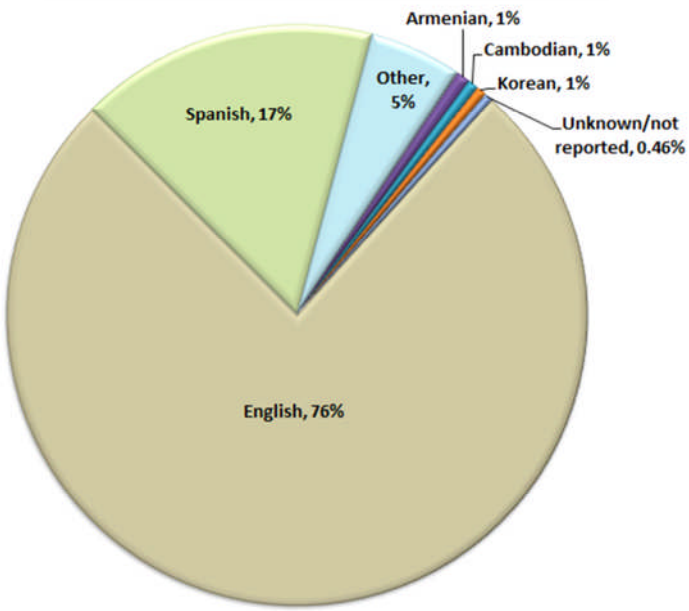
Unique client means a single client claimed in the Integrated System. Data as of January 4, 2016

The number of unique clients receiving a direct mental health service through the Community Services and Supports (CSS) Plan for Fiscal Year 2016-17: **119,277**

Ethnicity

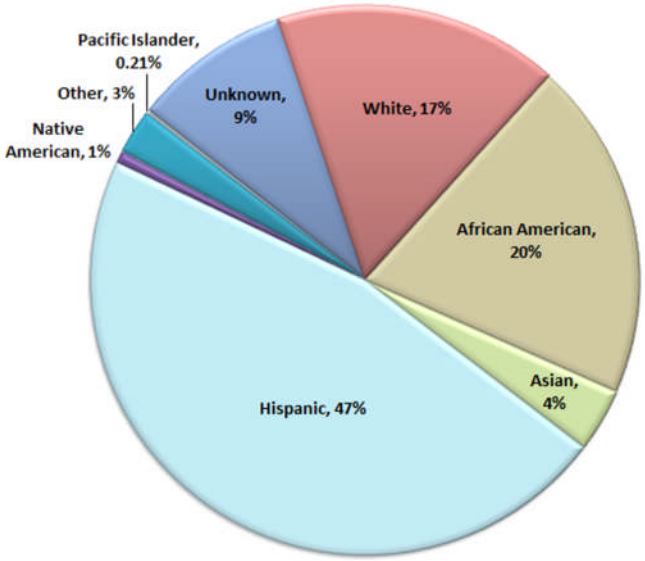


Primary Language

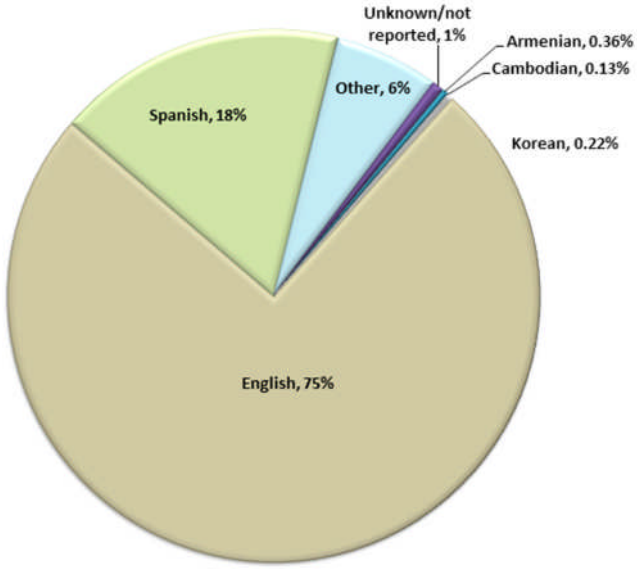


The number of new clients receiving CSS services Countywide with no previous MHSA service: 47,957

Ethnicity



Primary Language



Full Service Partnership (FSP)

Children's FSP Programs (C-01)

Total Unique Clients Served: 3,042
Average Cost per Client: $ 15,186

CHILDREN'S FSP PROGRAM

Slots Allocated: 1,771 (as of 7/01/2016)

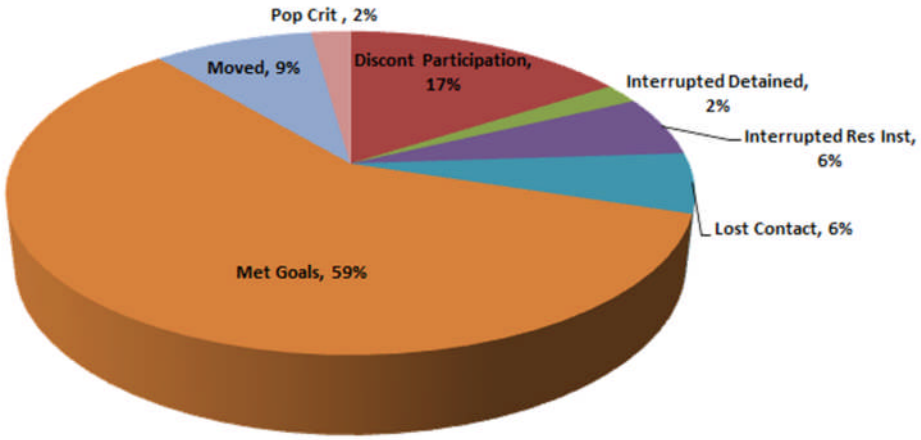
Focal Population Targeted: Children ages, 0-15 with serious emotional disturbance (SED) and one or more risk factors: 0-5: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder; DCFS or risk of involvement; In transition to a less restrictive placement; experiencing in school: suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation; involved with probation and is on psychotropic medication and transitioning back into a less structured home/community setting.

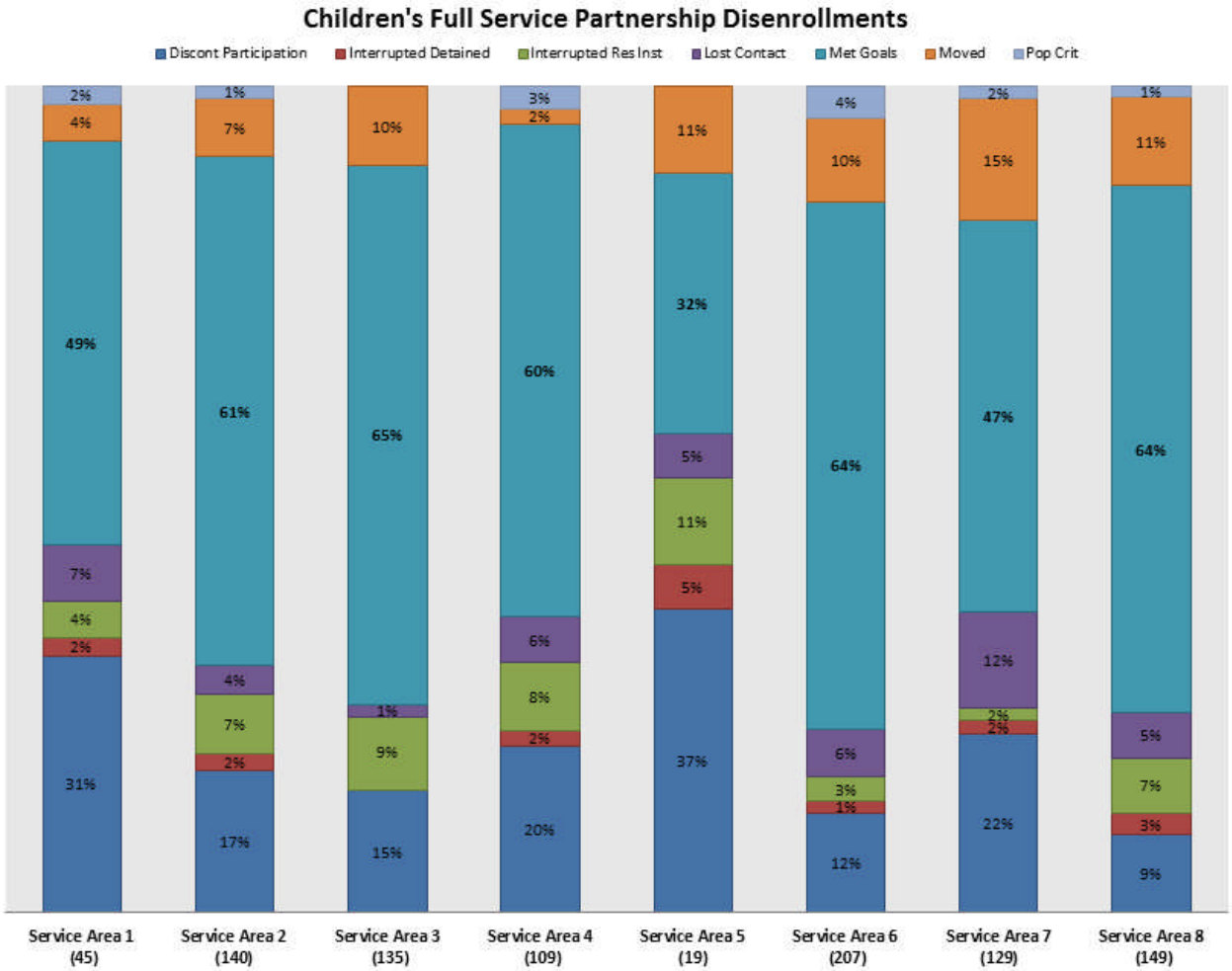
Program: The Children's Full Service Partnership (FSP) program is an intensive in-home mental health services program for children ages 0 – 15 and their families. Child FSP provides services to more than 2,000 new children and families annually. The Child FSP program is comprised of resiliency-focused services created in collaboration with family/caretakers and a multi-disciplinary team, which develops and implements individualized treatment plans.

Child FSP providers are dedicated to working with children and their families to assist them in planning and accomplishing goals that are important to the health, well-being, safety and stability of the family. Services are intensive and may include, but are not limited to, individual and family counseling, 24/7 assessment and crisis services, substance abuse and domestic violence counseling and other types of assistance. Services are provided in the family's preferred language, and primarily in the field.

Disenrollments:*

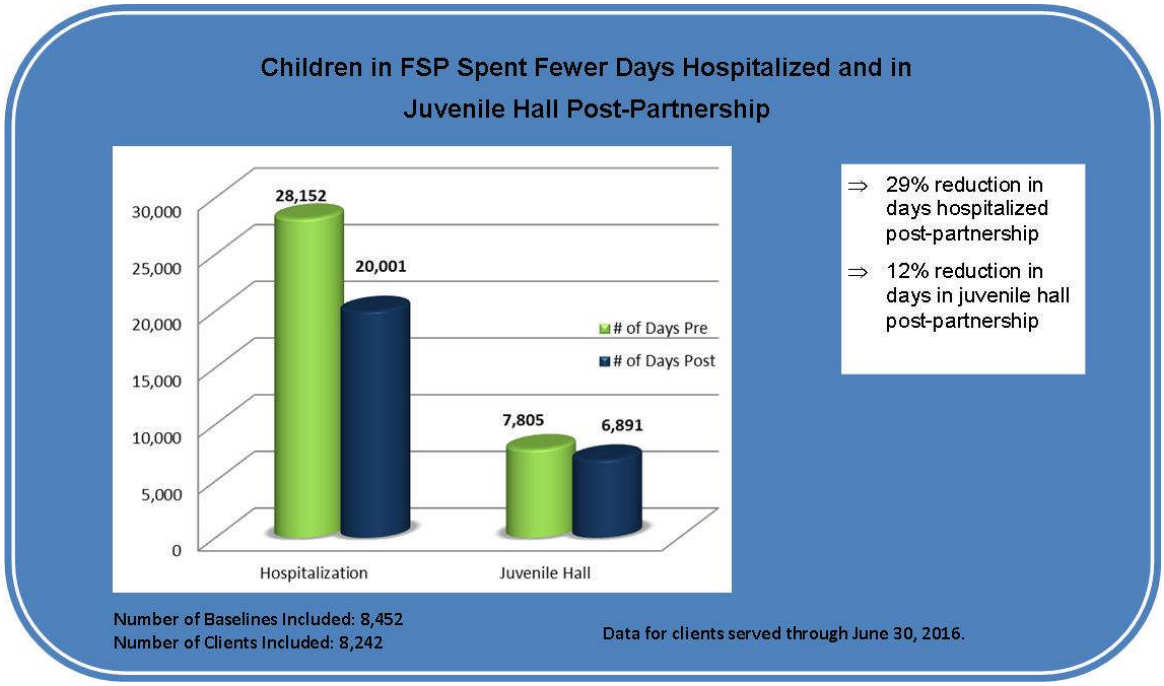
- Total of 934 disenrollments
- 59% of disenrolled clients met their goals

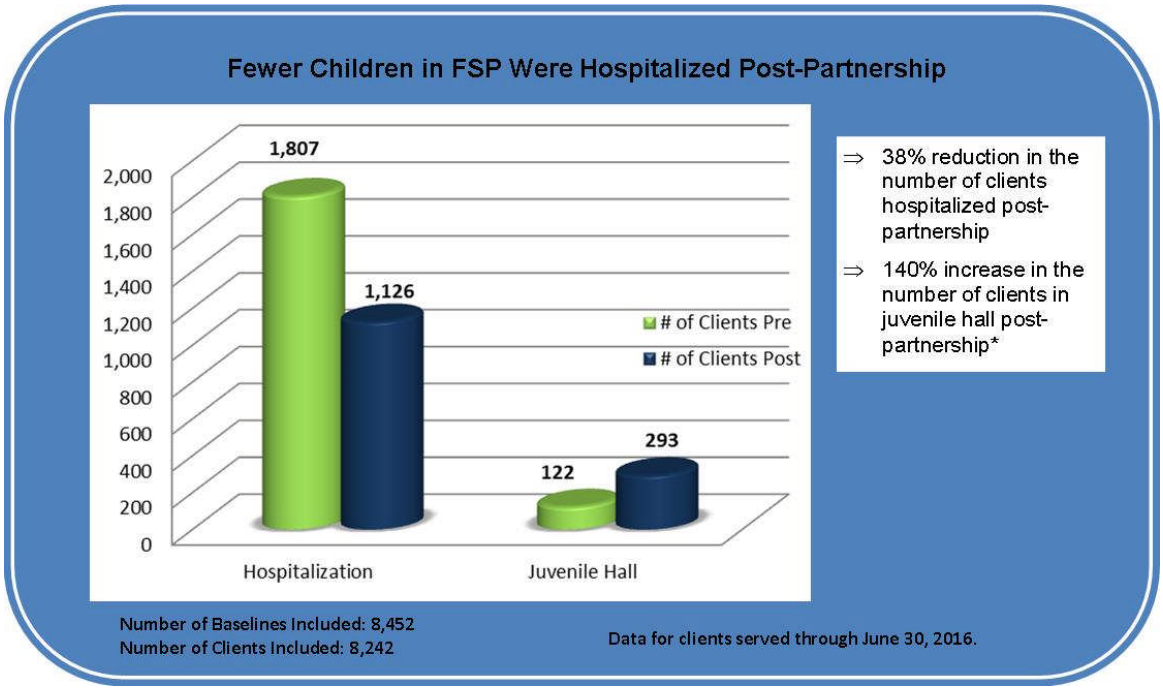




*Data extracted from the FSP authorization application on September 9, 2016 and represents disenrollments for Fiscal Year 2015-16. See Appendix I for an explanation of disenrollment reasons.

Outcomes: Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.





* There was a 140% increase in the number of clients in juvenile hall post-partnership. Data indicates 122 children FSP clients (approximately 1% of the children's baselines included) reported being in juvenile hall 365 days prior to partnership and 293 children FSP clients (approximately 3% of the children's baselines included) after partnership was established.

Family Support Services (C-02)

Client Contacts:

Family Support Services (FSS) provide access to mental health services such as individual psychotherapy, couples/group therapy, psychiatry/medication support, crisis intervention, and co-occurring disorders services to parents, caregivers, and/or other significant support persons of Full Service Partnership's (FSP) enrolled children who need services, but who do not meet the criteria to receive their own mental health services.

CHILDREN'S WRAPAROUND FSP PROGRAM

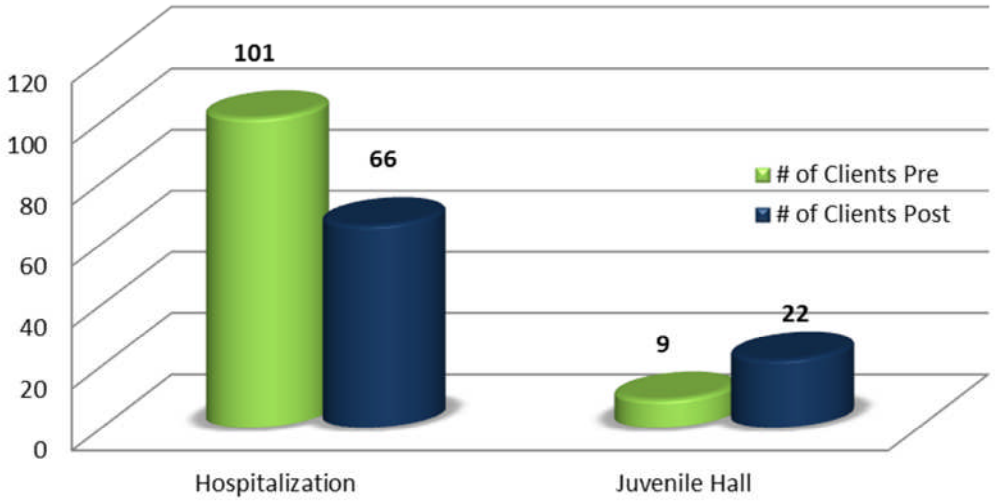
Slots Allocated: 524 (as of 7/1/2016)

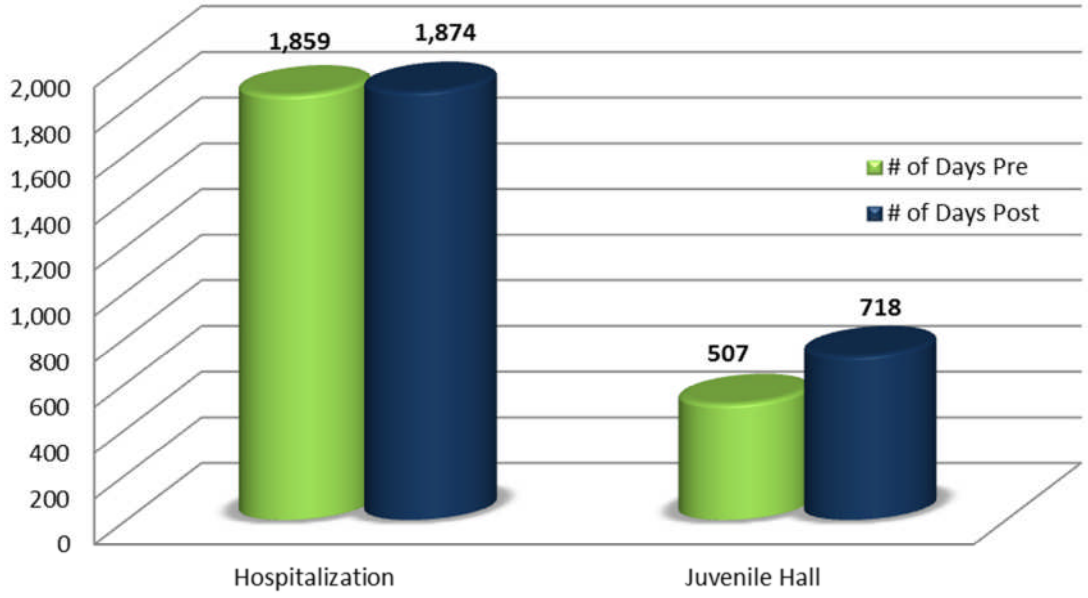
Focal Population Targeted: Children ages, 5-21 with serious emotional disturbance (SED) and one or more risk factors: 0-5: at high risk of expulsion from pre-school, DCFS involvement and/or caregiver is SED, mentally ill or has substance abuse disorder or co-occurring disorder; DCFS or risk of involvement; In transition to a less restrictive placement; experiencing in school: suspension, violent behaviors, drug possession or use, and/or suicidal and/or homicidal ideation; involved with probation and is on psychotropic medication and transitioning back into a less structured home/community setting.

Program: The Wraparound FSP Child program is an intensive mental health program providing Wraparound services and support to children, ages 0-15, and their families.
In this FSP-supported program, Wraparound provides services that address a child and families identified needs. It is a child and youth-focused, family-centered, strengths-based, needs-driven planning process that creates a plan to address a family's needs in various life domains that include family, emotional, social, educational, legal, cultural, economic, and housing, etc. Wraparound supports family voice and choice, the use of informal supports, and other rehabilitative activities provided in the most homelike setting. Wraparound includes a commitment to create and provide a highly individualized planning process. The plan includes flexible funding to support the child and family's material and psychological needs. The Child and Family Team (CFT) is a primary Wraparound program component that includes a team composed of the youth, parent-caregiver, the Wraparound facilitator, a child family specialist, parent-partner, a clinician, and natural/informal supports including relatives and friends participating in a community-based service delivery system. The CFT persists toward goal attainment until the desirable outcomes for the child and family are achieved.

Wraparound also provides access to an array of mental health services including individual psychotherapy, intensive-care coordination, and intensive home-based services. In addition, 24/7 crisis intervention is provided. Service delivery objectives are to assist youth in returning home and successfully remaining home, preventing out of home care/placement, symptom reduction, and overall improvement of family functioning, successful school adjustment, and prevention of psychiatric hospitalizations.

Outcomes:


101
66
9
22
120
100
80
60
40
20
0
# of Clients Pre
# of Clients Post
Hospitalization
Juvenile Hall


1,859
1,874
507
718
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
# of Days Pre
# of Days Post
Hospitalization
Juvenile Hall

* There was a 144% increase in the number of clients in juvenile hall post-partnership. Data indicates 9 Wraparound Child FSP clients (approximately 0.48% of the children's baselines included) reported being in juvenile hall 365 days prior to partnership and 22 Wraparound Child FSP clients (approximately 1.16% of the children's baselines included) after partnership was established.

There was a 42% increase in the number of days child Wraparound FSP clients spent in juvenile hall post-partnership. Data indicates 507 days (0.05% of total tenure) were reported spent in juvenile hall 365 days prior to partnership and 718 days (0.07% of total tenure) were reported spent in juvenile hall after partnership was established for child Wraparound FSP clients. Total tenure is 988,899 days for all included baselines.

Transition Age Youth FSP Programs (T-01)

Total Unique Clients Served: 1,883
Average Cost per Client: $ 12,227

TRANSITION AGE YOUTH FSP PROGRAM

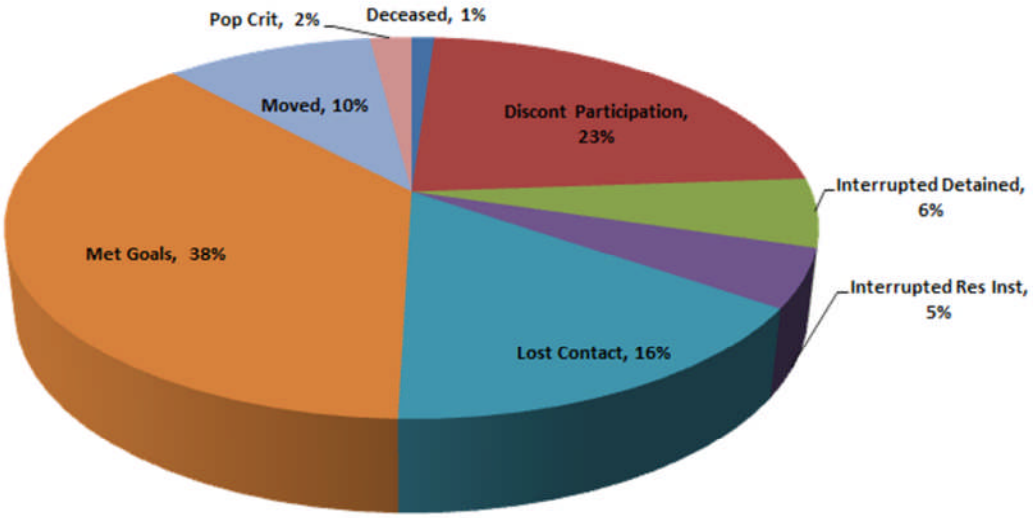
Slots Allocated: 1,315 (as of 6/30/2016)

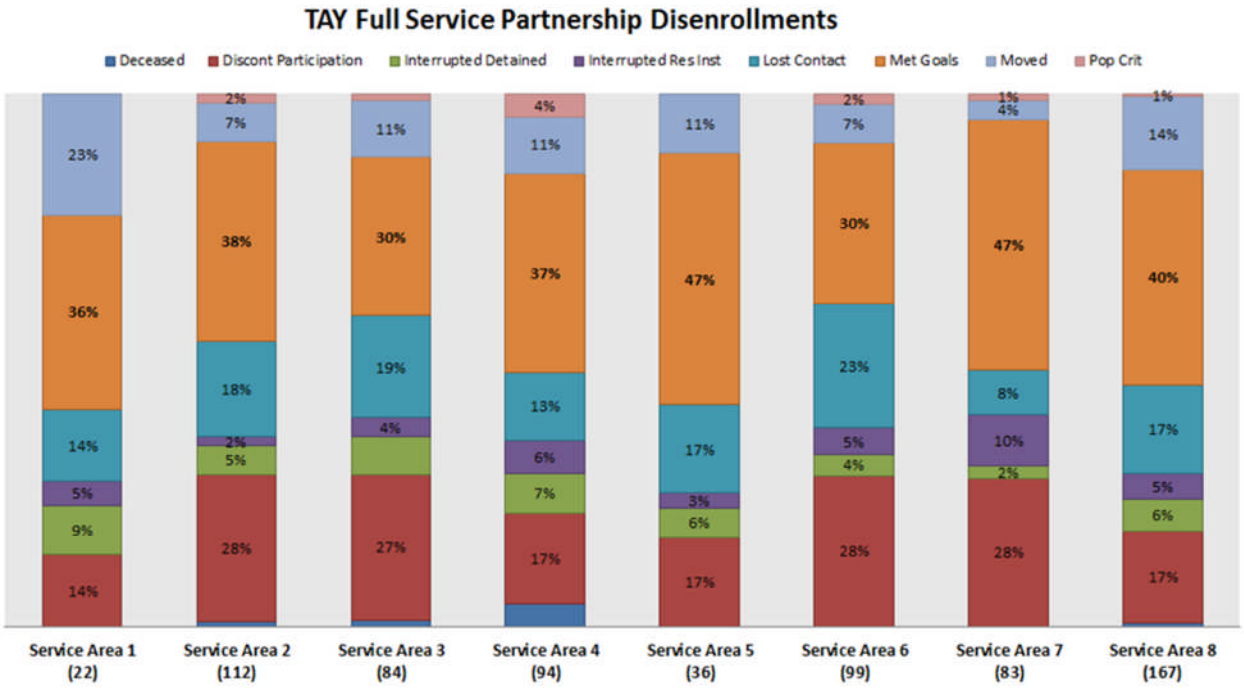
Focal Population Targeted: TAY ages 16-25 with serious emotional disturbance and or/severe and persistent mental illness and one or more of the following risks: homeless or at risk of homelessness; aging out of child mental health system, child welfare system or juvenile justice system; leaving long term institutional care; or experiencing 1st psychotic break.

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

Disenrollments:*

- Total of 697 disenrollments
- 38% of disenrolled clients met their goals

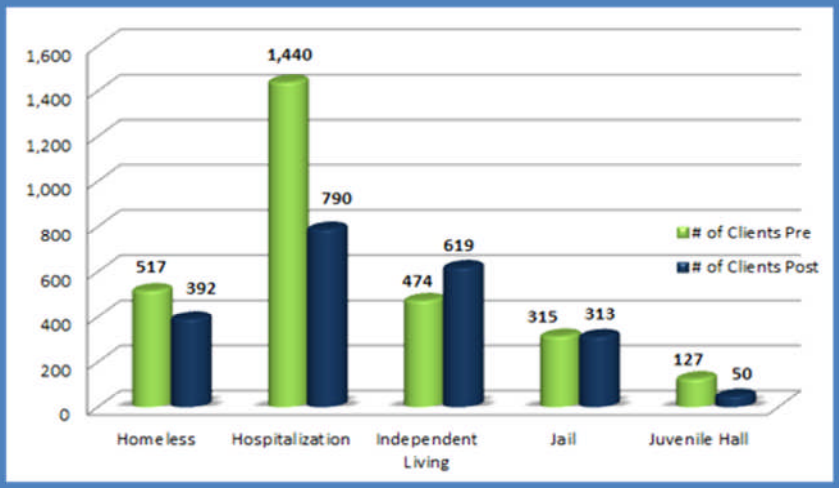




*Data extracted from the FSP authorization application on September 9, 2016 and represents disenrollments for Fiscal Year 2015-16. See Appendix I for an explanation of disenrollment reasons.

Outcomes: Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.

Fewer TAY FSP Clients Were Homeless, Hospitalized and in Jail/Juvenile Hall and More Clients Lived Independently Post-Partnership

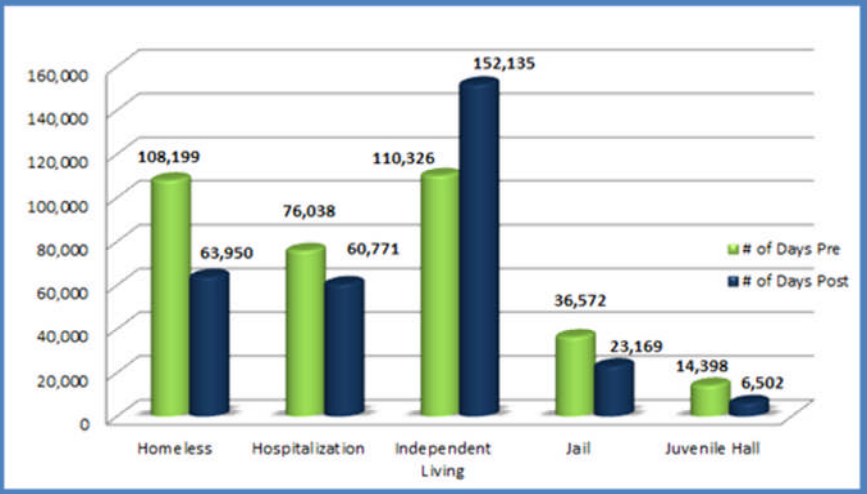


- ⇒ 24% reduction in the number of clients homeless post-partnership
- ⇒ 45% reduction in the number of clients hospitalized post-partnership
- ⇒ 31% increase in the number of clients living independently
- ⇒ 1% reduction in the number of clients in jail post-partnership
- ⇒ 61% reduction in the number of clients in juvenile hall post-partnership

Number of Baselines Included: 4,295
Number of Clients Included: 4,183

Data for clients served through June 30, 2016.

TAY FSP Clients Spent Fewer Days Homeless, Hospitalized, and in Jail/Juvenile Hall and More Days Living Independently Post-Partnership

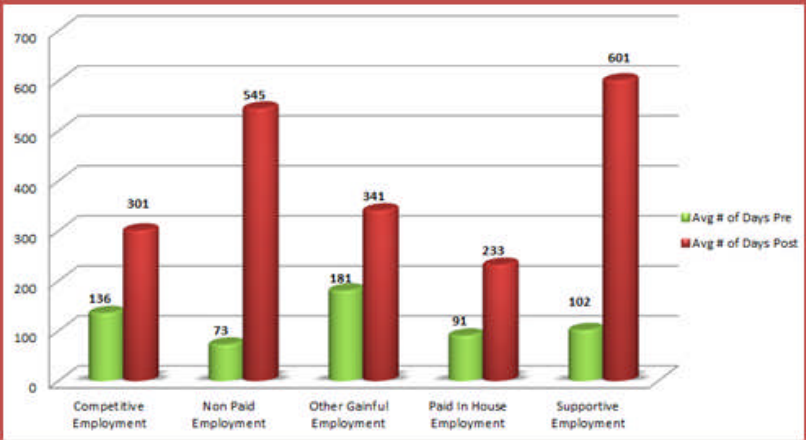


- ⇒ 41% reduction in days homeless post-partnership
- ⇒ 20% reduction in days hospitalized post-partnership
- ⇒ 38% increase in the number of days living independently
- ⇒ 37% reduction in days in jail post-partnership
- ⇒ 55% reduction in days in juvenile hall post-partnership

Number of Baselines Included: 4,295
Number of Clients Included: 4,183

Data for clients served through June 30, 2016.

TAY FSP Clients, on Average, Spent Fewer Days Unemployed and More Days in Employment Post-Partnership



⇒ 122% increase in the number of days spent in competitive employment

⇒ 646% increase in the number of days spent in non-paid employment

⇒ 89% increase in the number of days spent in other gainful employment

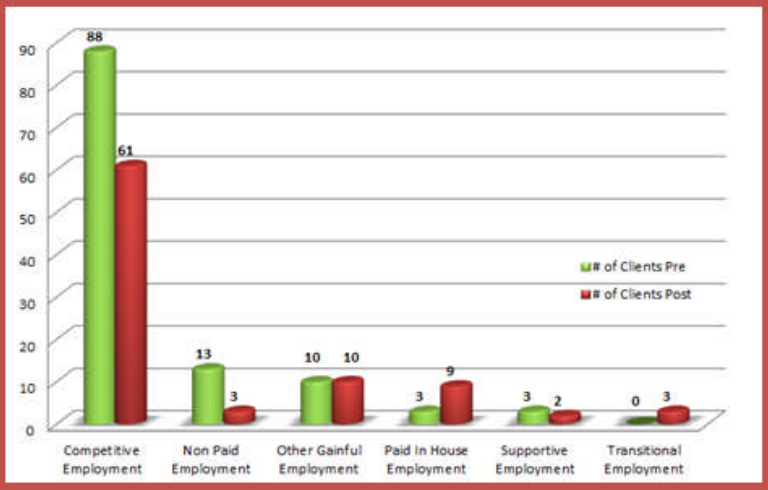
⇒ 156% increase in the number of days spent in paid in house employment

⇒ 490% increase in the number of days spent in supportive employment

⇒ 24% reduction in the number of days spent unemployed

Number of Baselines Included: 1,185
Data for clients served through June 30, 2016.

More TAY FSP Clients were in Transitional and Paid in House Employment Post-Partnership



⇒ 31% reduction in the number of clients spent in competitive employment

⇒ 77% reduction in the number of clients in non-paid employment

⇒ 200% increase in the number of clients in paid in house employment

⇒ 33% reduction in the number of clients in supportive employment

⇒ 2% reduction in the number of clients spent unemployed

Number of Baselines Included: 1,185
Data for clients served through June 30, 2016

See Appendix III for employment status definitions. Clients can participate in more than one employment category at a time.

TRANSITION AGE YOUTH WRAPAROUND FSP PROGRAM

Slots Allocated: 225 (as of 7/1/2016)

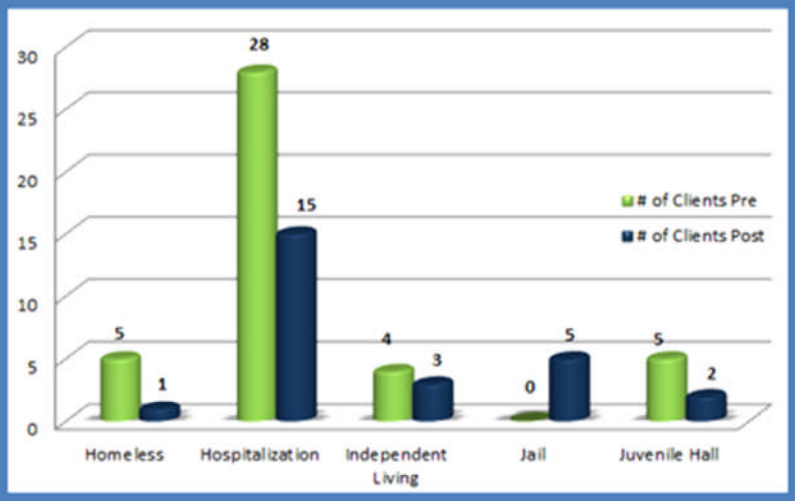
Focal Population Targeted: TAY ages 16-25 with serious emotional disturbance and or/severe and persistent mental illness and one or more of the following risks: homeless or at risk of homelessness; aging out of child mental health system, child welfare system or juvenile justice system; leaving long term institutional care; or experiencing 1st psychotic break.

Program: Wraparound provides services that address a child and families identified needs. It is a child and youth-focused, family-centered, strengths-based, needs-driven planning process that creates a plan to address a family's needs in various life domains that include family, emotional, social, educational, legal, cultural, economic, and housing, etc. Wraparound supports family voice and choice, the use of informal supports, and other rehabilitative activities provided in the most homelike setting. Wraparound includes a commitment to create and provide a highly individualized planning process. The plan includes flexible funding to support the child and family's material and psychological needs. The Child and Family Team (CFT) is a primary Wraparound program component that includes a team composed of the youth, parent-caregiver, the Wraparound facilitator, a child family specialist, parent-partner, a clinician, and natural/informal supports including relatives and friends participating in a community-based service delivery system. The CFT persists toward goal attainment until the desirable outcomes for the child and family are achieved.

Wraparound also provides access to an array of mental health services including individual psychotherapy, intensive-care coordination, and intensive home-based services. In addition, 24/7 crisis intervention is provided. Service delivery objectives are to assist youth in returning home and successfully remaining home, preventing out of home care/placement, symptom reduction, and overall improvement of family functioning, successful school adjustment, and prevention of psychiatric hospitalizations

Outcomes: Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.

Fewer TAY Wraparound FSP Clients Were Homeless, Hospitalized and in Juvenile Hall Post-Partnership



⇒ 80% reduction in the number of clients homeless post-partnership

⇒ 46% reduction in the number of clients hospitalized post-partnership

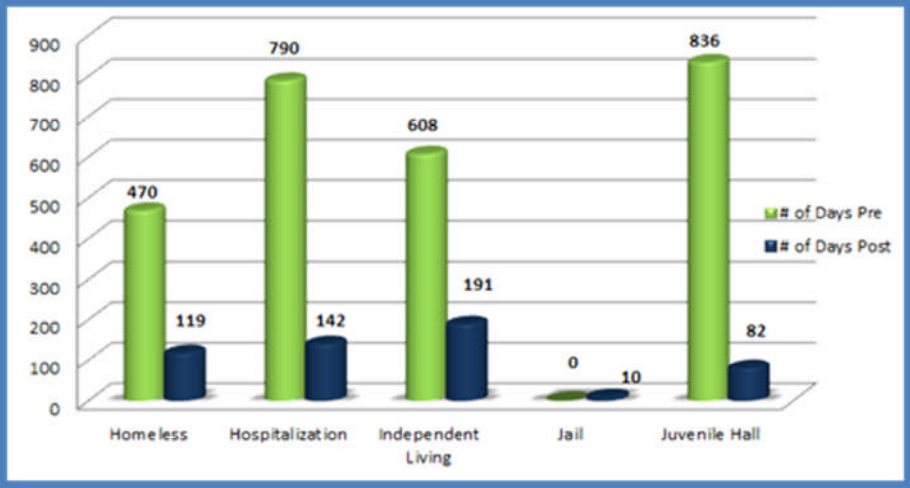
⇒ 25% reduction in the number of clients living independently*

⇒ 60% reduction in the number of clients in juvenile hall post-partnership

Number of Baselines Included: 359
Number of Clients Included: 359

Data for clients served through June 30, 2016.

TAY Wraparound FSP Clients Spent Fewer Days Homeless, Hospitalized, and in Juvenile Hall Post-Partnership



⇒ 75% reduction in days homeless post-partnership

⇒ 82% reduction in days hospitalized post-partnership

⇒ 69% reduction in days living independently*

⇒ 90% reduction in days in juvenile hall post-partnership

Number of Baselines Included: 359
Number of Clients Included: 359

Data for clients served through June 30, 2016.

*There was a 25% increase in the number of clients living independently post-partnership. Data indicates 4 Wraparound TAY FSP clients (approximately 1% of the Wraparound TAY baselines included) reported living independently 365 days prior to partnership and 3 Wraparound TAY FSP clients (approximately 0.84% of the Wraparound TAY baselines included) after partnership was established.

There was a 69% reduction in the number of days TAY Wraparound FSP clients spent living independently post-partnership. Data indicates 608 days (0.37% of total tenure) were reported living independently 365 days prior to partnership and 191 days (0.12% of total tenure) were reported living independently after partnership was established for TAY Wraparound FSP clients. Total tenure is 163,058 days for all included baselines.

Adult FSP Programs (A-01)

Unique Clients Served: 5,591
Average Cost per Client: $ 11,463

ADULT FSP PROGRAM

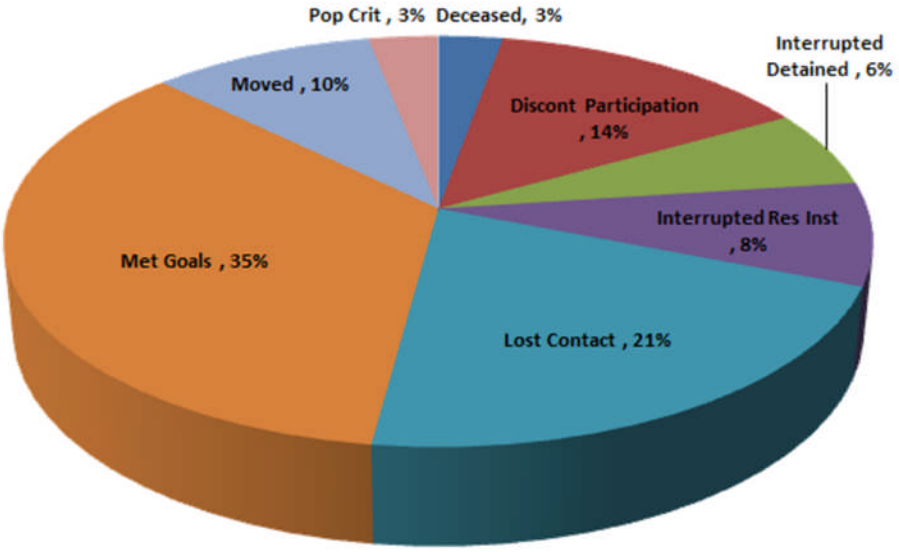
Slots Allocated: 5,105 (as of 7/1/2016)

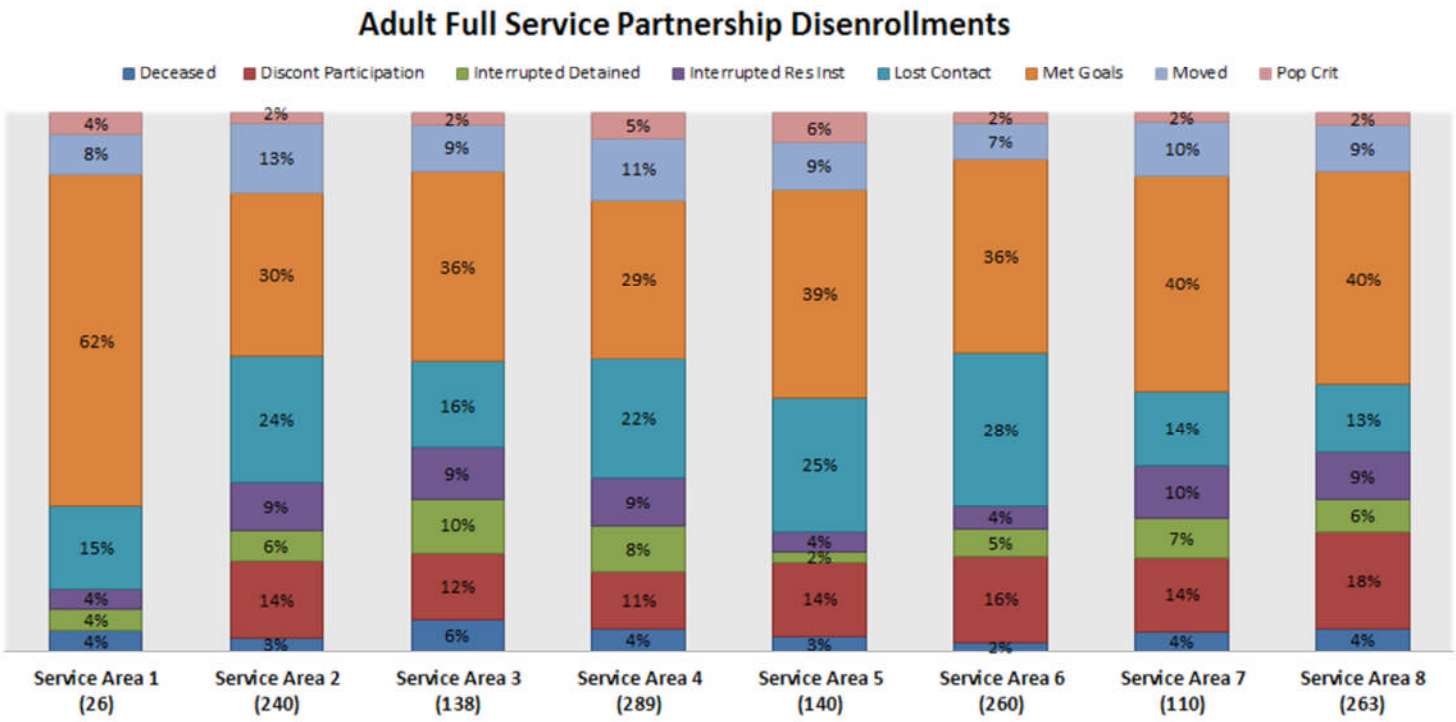
Focal Population Targeted: Adults with serious mental illness and involved with one or more of the following: Homeless; Jail; Institutionalized (State Hospital, Institution for Mental Disease, Psychiatric Emergency Services, Urgent Care Center, County Hospital and/or Fee for Service Hospital); and/or living with family members without whose support the individual should be at imminent risk of homelessness, jail or institutionalization.

Program: Serves adults, ages 26-59, who have been diagnosed with a severe mental illness and would benefit from an intensive service program, who are homeless, incarcerated, transitioning from institutional settings, or for whom care is provided solely through the family and would be at risk of the above if it were not for the family's support. Services include a wide array of mental health services, medication support, linkage to community resources, housing, employment and money management services and assistance in obtaining needed medical care. Programs target clients from all ethnic communities, with a collaborative focusing specifically on the Asian Pacific Islander communities.

*Disenrollment**

- Total of 1,467 disenrollments
- 35% of disenrolled clients met their goals

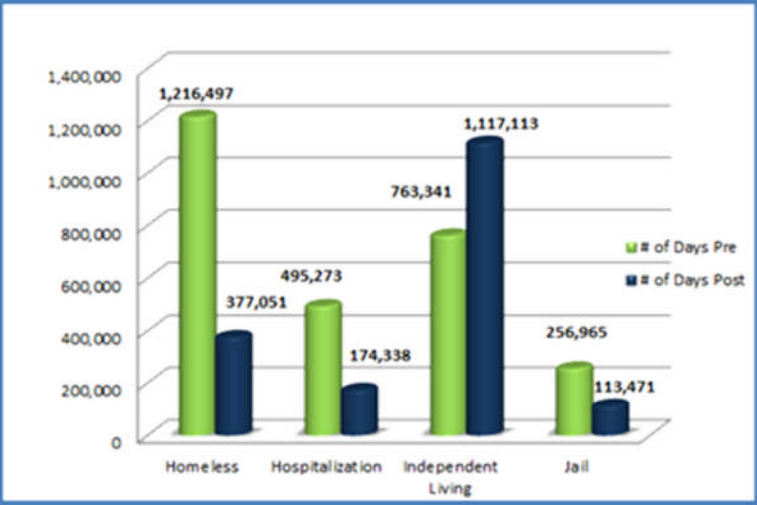




*Data extracted from the FSP authorization application on September 9, 2016 and represents disenrollments for Fiscal Year 2015-16. See Appendix I for an explanation of disenrollment reasons.

Outcomes: Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.

Adult FSP Clients Spent Fewer Days Homeless, Hospitalized, and in Jail and More Days Living Independently Post-Partnership



⇒ 69% reduction in days homeless post-partnership

⇒ 65% reduction in days hospitalized post-partnership

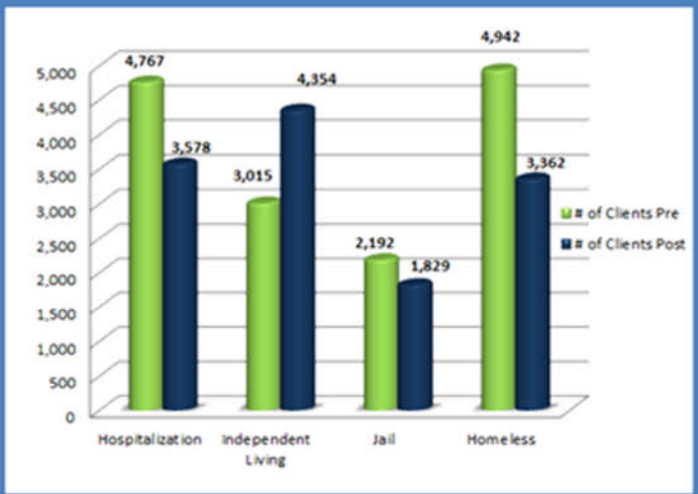
⇒ 56% reduction in days in jail post -partnership

⇒ 46% increase in the number of days living independently

Number of Baselines Included: 12,527
Number of Clients Included: 11,970

Data for clients served through June 30, 2016.

Fewer Adult FSP Clients Were Homeless, Hospitalized and in Jail and More Clients Lived Independently Post-Partnership



⇒ 32% reduction in the number of clients homeless post-partnership

⇒ 25% reduction in the number of clients hospitalized post-partnership

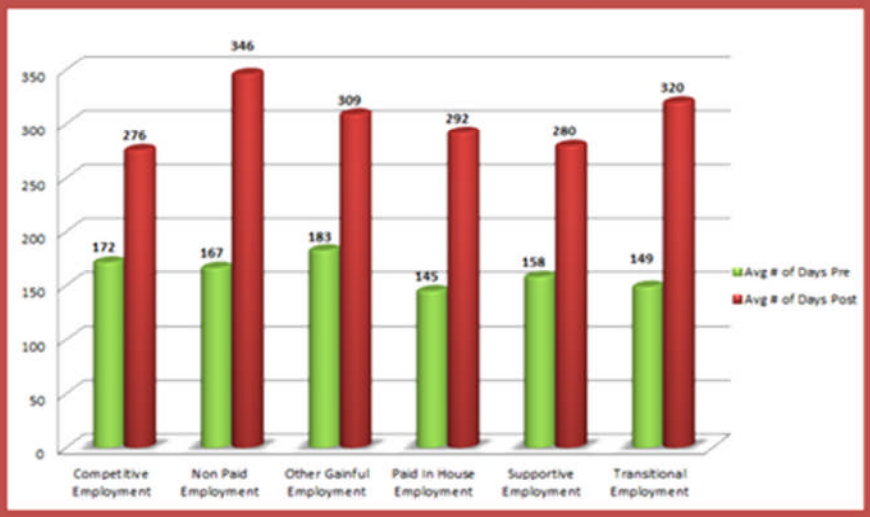
⇒ 17% reduction in the number of clients in jail post-partnership

⇒ 44% increase in the number of clients living independently

Number of Baselines Included: 12,527
Number of Clients Included: 11,970

Data for clients served through June 30, 2016.

Adult FSP Clients, on Average, Spent Fewer Days Unemployed and More Days in Employment Post-Partnership



⇒ 60% increase in the number of days spent in competitive employment

⇒ 107% increase in the number of days spent in non-paid employment

⇒ 69% increase in the number of days spent in other gainful employment

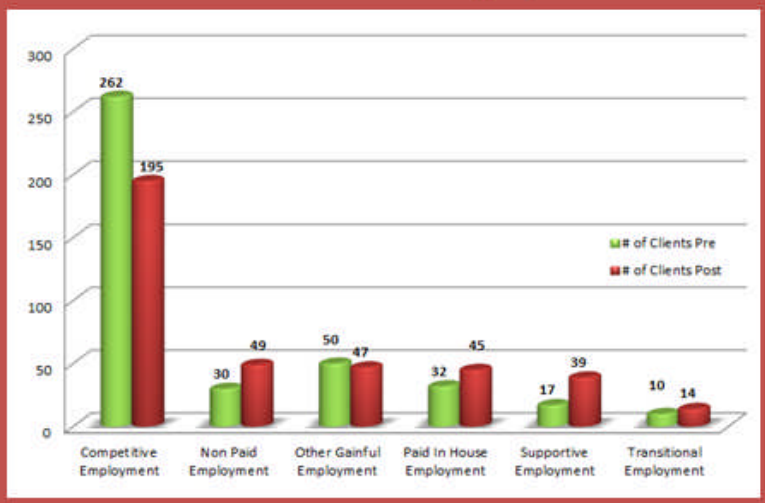
⇒ 101% increase in the number of days spent in paid in house employment

⇒ 77% increase in the number of days spent in supportive employment

⇒ 115% increase in the number of days spent in transitional employment

Number of Baselines Included: 4,624
Data for clients served through June 30, 2016.

More Adult FSP Clients Were in Non-paid, Paid in House, Supportive, and Transitional Employment Post-Partnership



⇒ 26% reduction in the number of clients spent in competitive employment

⇒ 63% increase in the number of clients in non-paid employment

⇒ 6% reduction in the number of clients in other gainful employment

⇒ 41% increase in the number of clients in paid in house employment

⇒ 129% increase in the number of clients in supportive employment

⇒ 40% increase in the number of clients spent in transitional employment

Number of Baselines Included: 4,624
Data for clients served through June 30, 2016.

Data for clients served through June 30, 2016.

See Appendix III for employment status definitions. Clients can participate in more than one employment category at a time.

ASSISTED OUTPATIENT TREATMENT (AOT) FSP PROGRAM

Slots Allocated: 300 (as of 7/1/2016)

Program: The Assisted Outpatient Treatment – Los Angeles (AOT-LA) Full Service Partnership (FSP) provides comprehensive, field-based intensive community-based mental health services for individuals referred to and screened by the Emergency Outreach Bureau (EOB) AOT Outreach Teams. Individuals meeting the eligibility criteria under Laura's Law (Welfare and Institutions Code [WIC] Section 5346 et seq.) will be referred for enrollment into AOT-LA FSP by Countywide Resource Management (CRM). The purpose and intent of Laura's Law is to identify certain high risk individuals with chronic serious mental illness who have demonstrated a history of non-compliance with outpatient mental health treatment, assess whether there is substantial risk for deterioration and/or detention under WIC 5150 which could be mitigated by provision of appropriate services, and, if so, mandate participation in AOT through a formal judicial process.

Focal Population Targeted: Persons 18 years of age and older with chronic, serious mental illness and demonstrated histories of treatment non-compliance who are at substantial risk for deterioration and/or detention under WIC 5150 which could be mitigated by provision of appropriate services and meet the eligibility criteria specified in Laura's Law.

IMHT FSP PROGRAM

Slots Allocated: 300 (as of 7/1/2016)

Focal Population Targeted: The IMHT-FSP target population is individuals with SMI that meet Medi-Cal medical necessity criteria for receiving specialty mental health services who are homeless and have other vulnerabilities. Vulnerabilities include but are not limited to age, years homeless, substance use or other physical health conditions that require ongoing primary care such as diabetes, hypertension, cardiovascular disease, asthma or other respiratory illnesses, obesity, cancer, arthritis and chronic pain.

It is expected that at least 50% of individuals receiving ongoing IMHT-FSP services will have a medical condition that falls in one or more of the following categories:

- Cardiopulmonary, e.g. hypertension, hyperlipidemia, other cardiovascular conditions, asthma, emphysema, chronic obstructive pulmonary disease (COPD)
- Type II diabetes and/or obesity
- Sexually transmitted diseases including HIV/AIDS and hepatitis

Program:

The Integrated Mobile Health Team (IMHT-FSP) Full Service Partnership provides comprehensive, intensive community-based mental health, physical health and substance use services designed to improve and better coordinate the quality of care for individuals with Severe Mental Illness (SMI)) that meet Medi-Cal medical necessity criteria for receiving specialty mental health services who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities. Vulnerabilities include but are not limited to age, years homeless, substance abuse and/or other physical health conditions that require ongoing primary care. Improving the quality of care shall be accomplished by having the IMHT-FSP consist of multidisciplinary staff that works as one integrated team to provide mental health, physical health and substance use services.

IMHT-FSP services are intended to increase immediate access to housing by using a Housing First Approach to immediately assist individuals and their families, if applicable, to transition from homelessness to housing by locating and securing a housing option of their choice without any prerequisites/conditions for mental health treatment or sobriety.

Older Adult FSP Programs (OA-01)

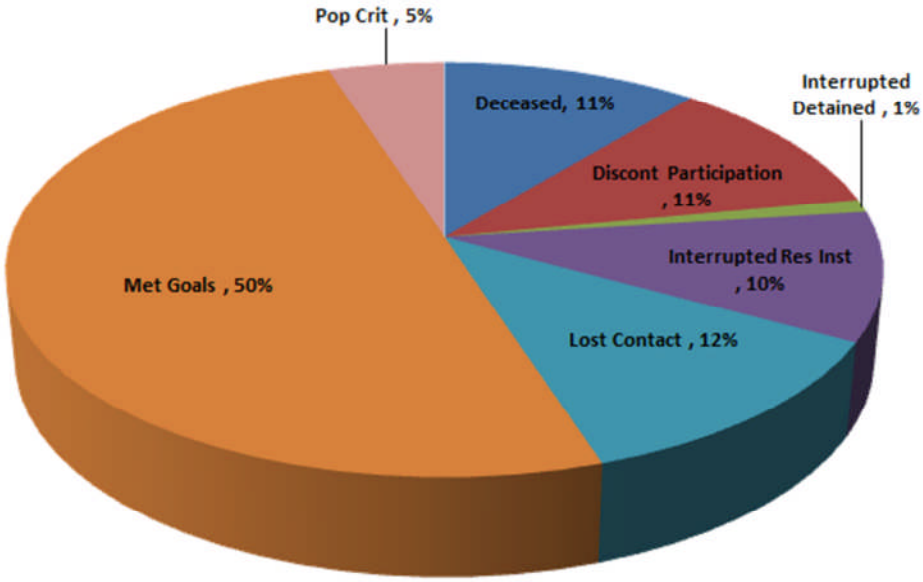
Unique Clients Served: 1,043
Average Cost per Client: $ 9,093

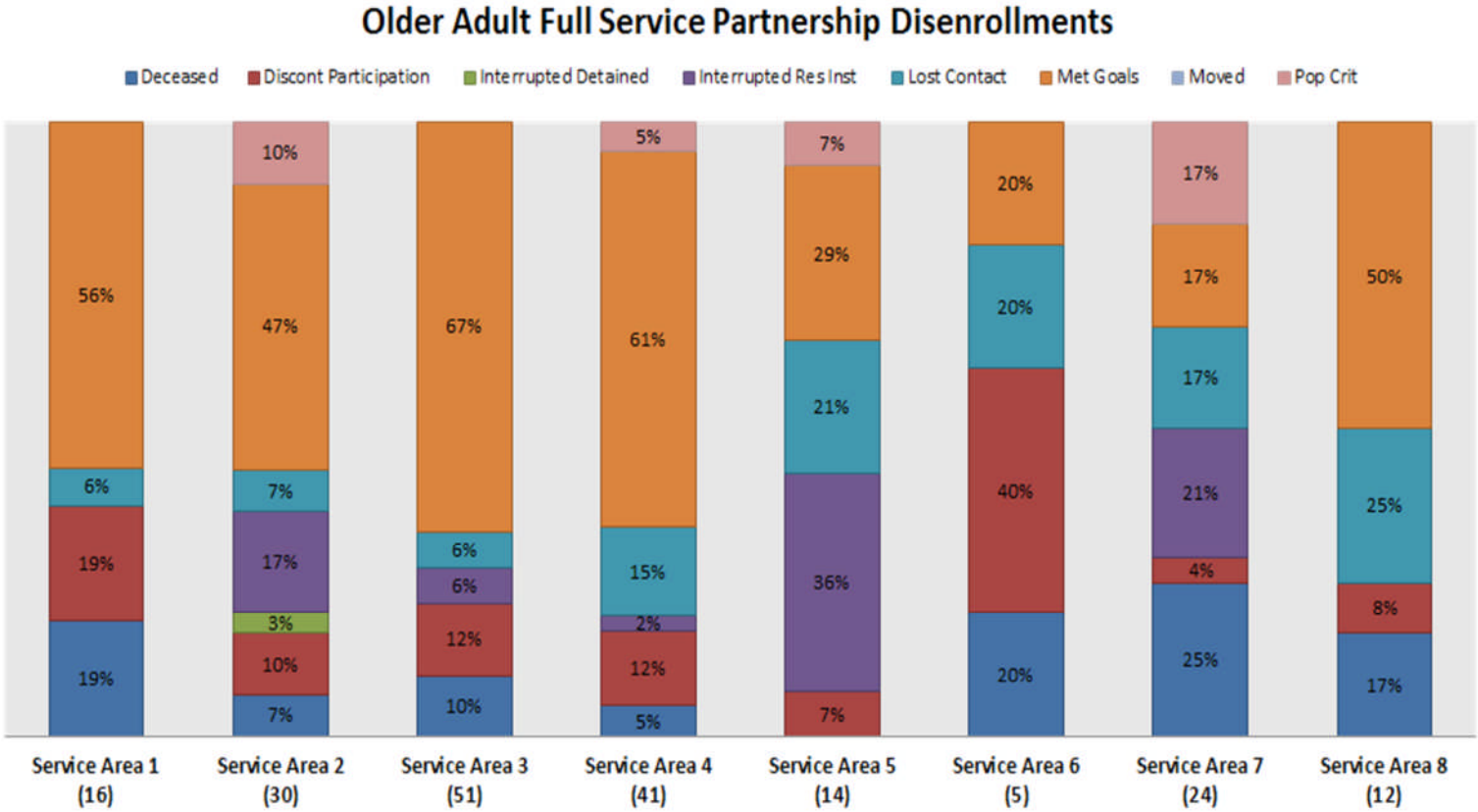
Focal Population Targeted: Older Adult ages 60+ with serious mental illness and one or more of the following risks: homeless or at imminent risk of homelessness; hospitalizations; jail or at risk of going to jail; imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home; presence of a co-occurring disorder; serious risk of suicide or recurrent history; or is at risk of abuse or self-neglect.

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

*Disenrollment**

- Total of 193 disenrollments
- 50% of disenrolled clients met their goals

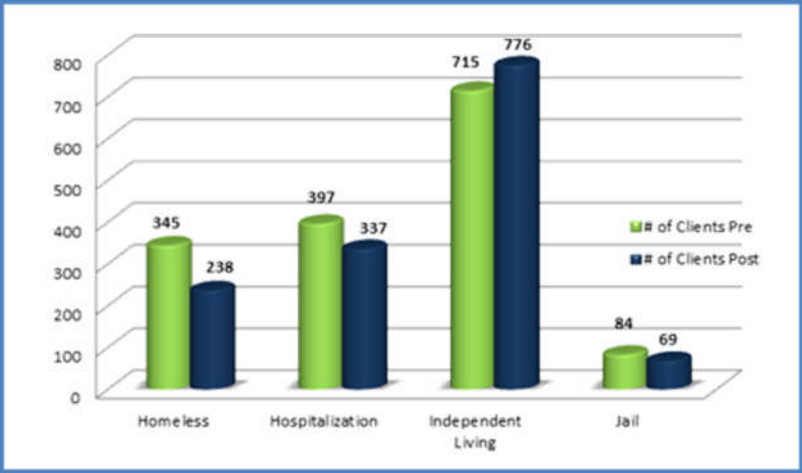




*Data extracted from the FSP authorization application on September 9, 2016 and represents disenrollments for Fiscal Year 2015-16. See Appendix I for an explanation of disenrollment reasons.

Outcomes: Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.

Fewer Older Adult FSP Clients Were Homeless, Hospitalized and in Jail and More Clients Lived Independently Post-Partnership

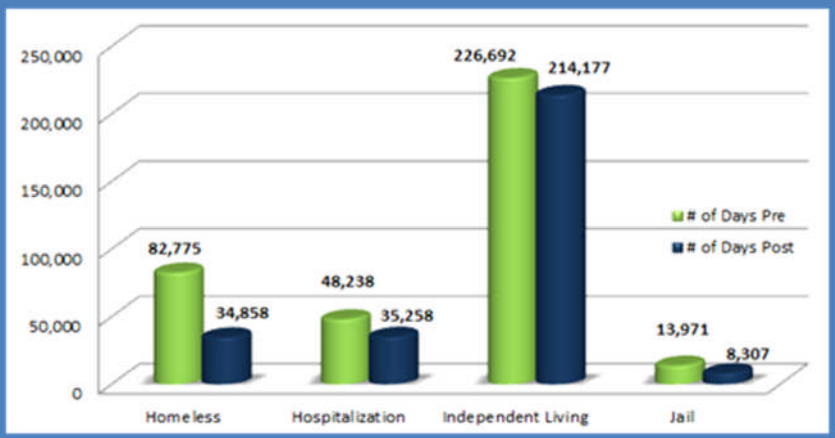


- ⇒ 31% reduction in the number of clients homeless post-partnership
- ⇒ 15% reduction in the number of clients hospitalized post-partnership
- ⇒ 9% increase in the number of clients living independently
- ⇒ 18% reduction in the number of clients in jail post-partnership

Number of Baselines Included: 1,595
Number of Clients Included: 1,563

Data for clients served through June 30, 2016.

Older Adult FSP Clients Spent Fewer Days Homeless, Hospitalized, and in Jail Post-Partnership



- ⇒ 58% reduction in days homeless post-partnership
- ⇒ 27% reduction in days hospitalized post-partnership
- ⇒ 6% reduction in the number of days living independently
- ⇒ 41% reduction in days in jail post-partnership

Number of Baselines Included: 1,595
Number of Clients Included: 1,563

Data for clients served through June 30, 2016.

Community Recovery, Resilience and Reintegration

Field Capable Clinical Services (FCCS)

CHILDREN'S FCCS PROGRAM (C-05)

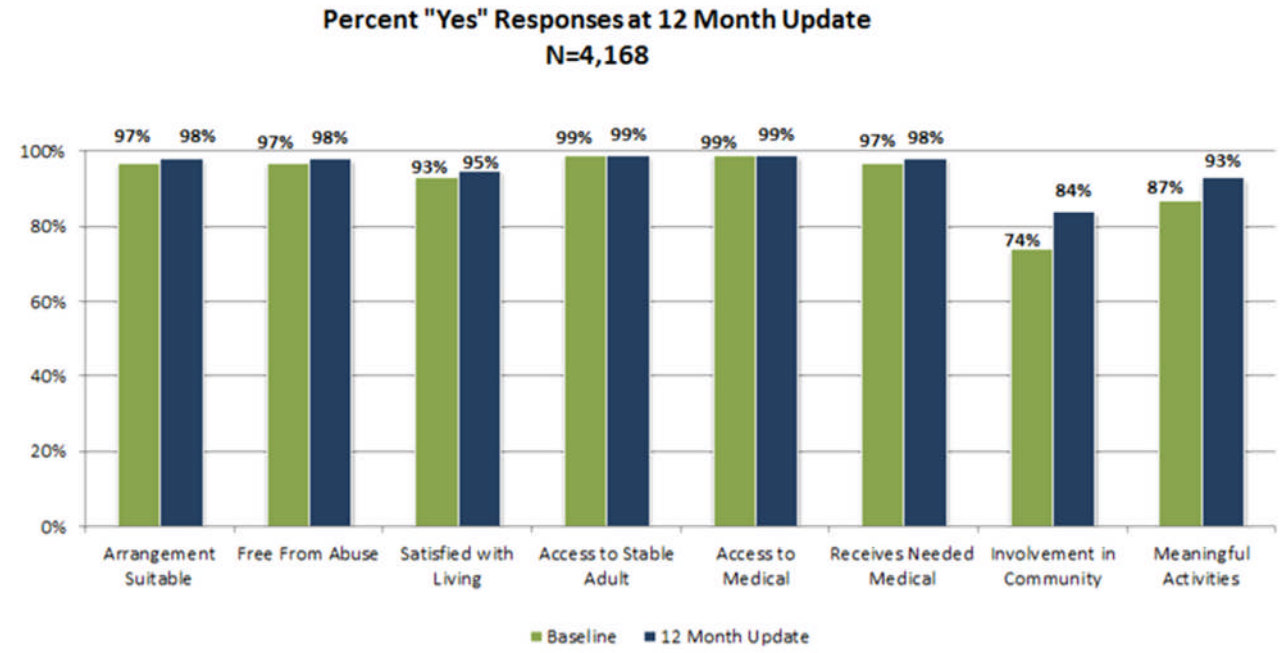
Unique Clients Served: 19,777
Average Cost per Client: $5,285

Children's Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented and field-based mental health services to children and families. Children's FCCS programs provide specialized mental health services delivered by a team of professional and para-professional staff. The focus of FCCS is working with community partners to provide a wide range of services that meet individual needs.

Intensive Field Capable Clinical Services (IFCCS) was developed in direct response to the State's implementation of an array of services called Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) related to the Katie A. lawsuit settlement. It has been in operation in Los Angeles County since June 1, 2013. .The goal of these services is to provide a coordinated child and family team approach to service delivery by engaging children and their families and assessing their strengths as well as their underlying needs to minimize psychiatric hospitalizations, out-of-home placements, and/or placement in juvenile detention centers. The IFCCS team is tasked with identifying resources and providing linkage to help meet those needs. For example, IFCCS providers have collaborated with the Federal Bureau of Investigations (FBI) and the specialized DCFS CSEC units to engage CSEC youth, deliver support, and identify resources. Through the implementation of IFCCS, the Child Welfare Division (CWD) has identified a significant shift associated with crisis intervention and stabilization indicating that the child and family team approach has a positive influence on developing pro-active plans on working with children.

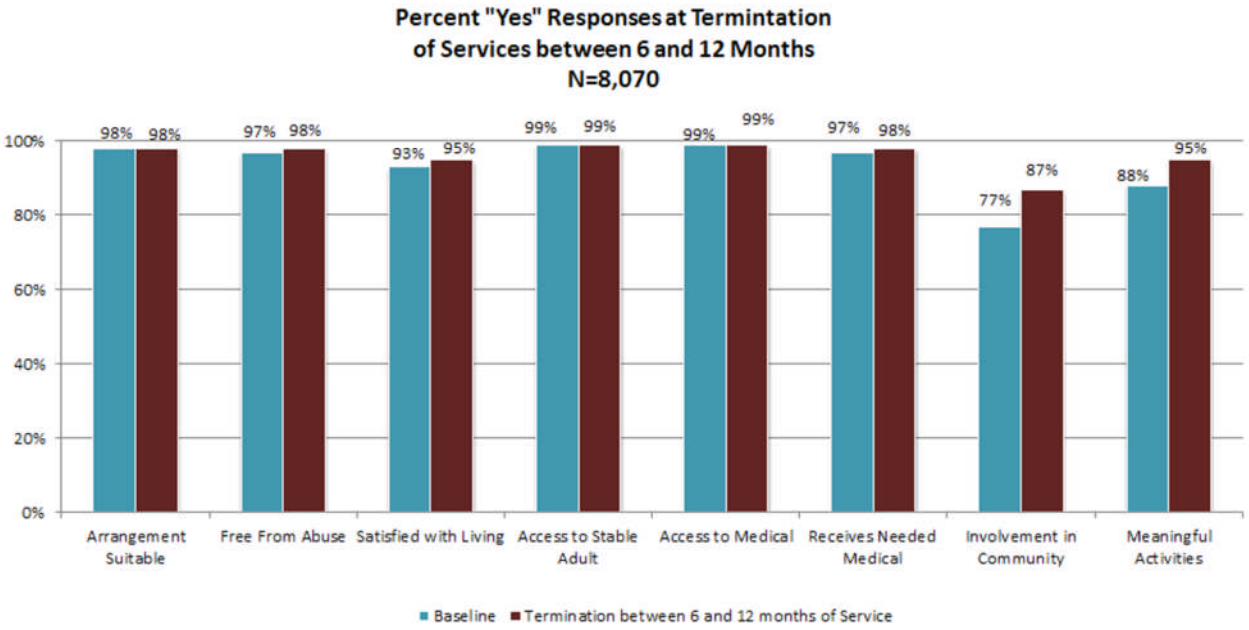
Outcomes (as of 11/21/16)

Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.



After 12 months of child FCCS services, clients showed a positive change in the following areas:

- 14% increase with their involvement in the community
- 7% increase in their participation in meaningful activities

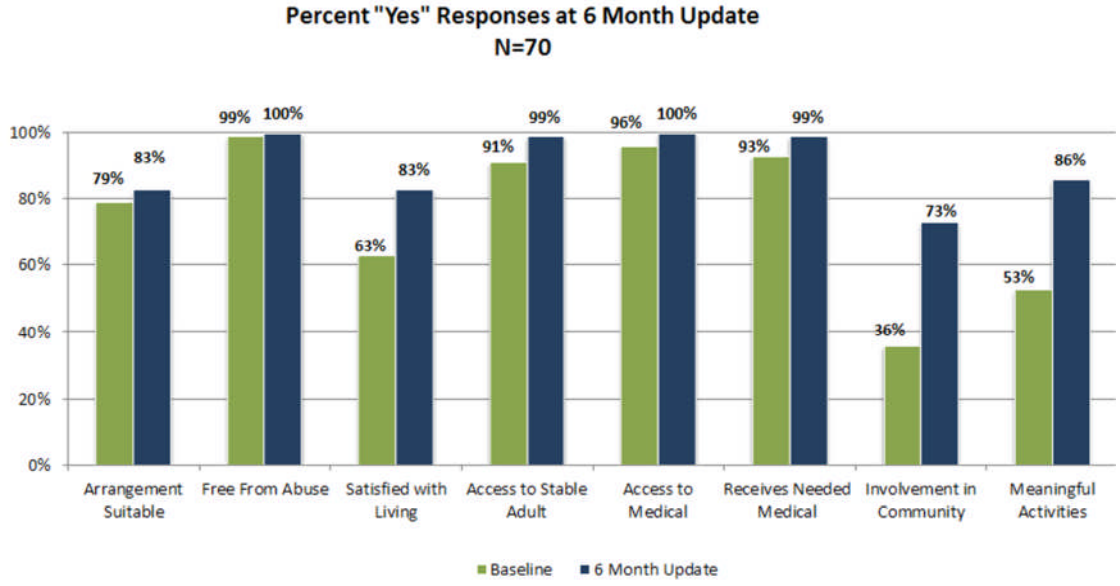


For those terminating between 6-12 months of services, child FCCS clients showed a positive change in the following areas:

- 13% increase with their involvement in the community
- 8% increase in their participation in meaningful activities

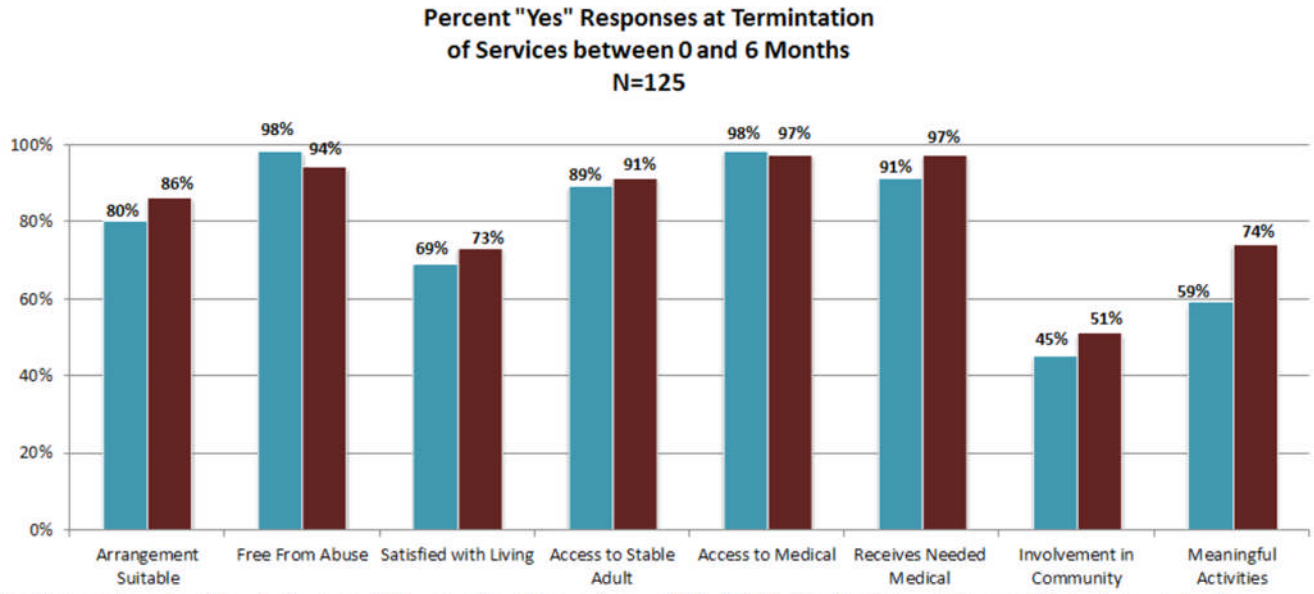
Outcomes (as of 11/21/16)

Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.



After 6 months of IFCCS services, clients showed a positive change in the following areas:

- 103% increase with their involvement in the community
- 62% increase in their participation in meaningful activities



For those terminating between 0-6 months of services, child FCCS clients showed a positive change in the following areas:

- 13% increase with their involvement in the community
- 25% increase in their participation in meaningful activities

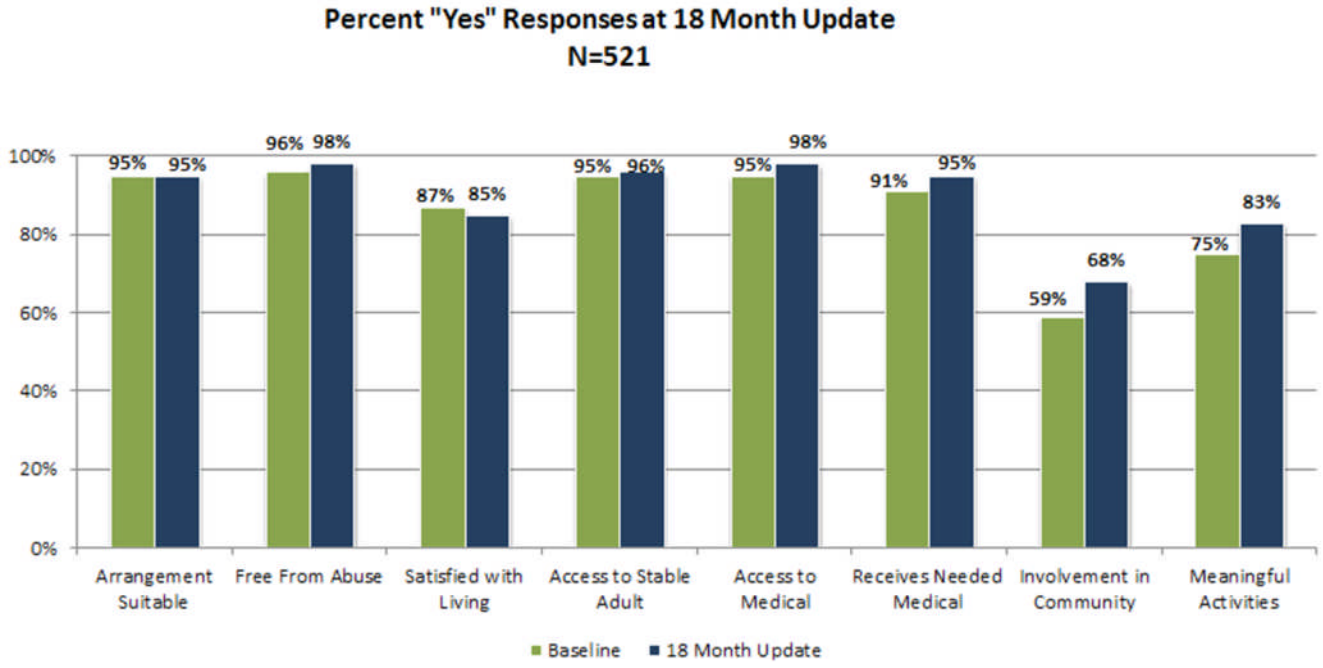
TAY FCCS PROGRAM (T-05)

Unique Clients Served: 5,420
Average Cost per Client: $4,631

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

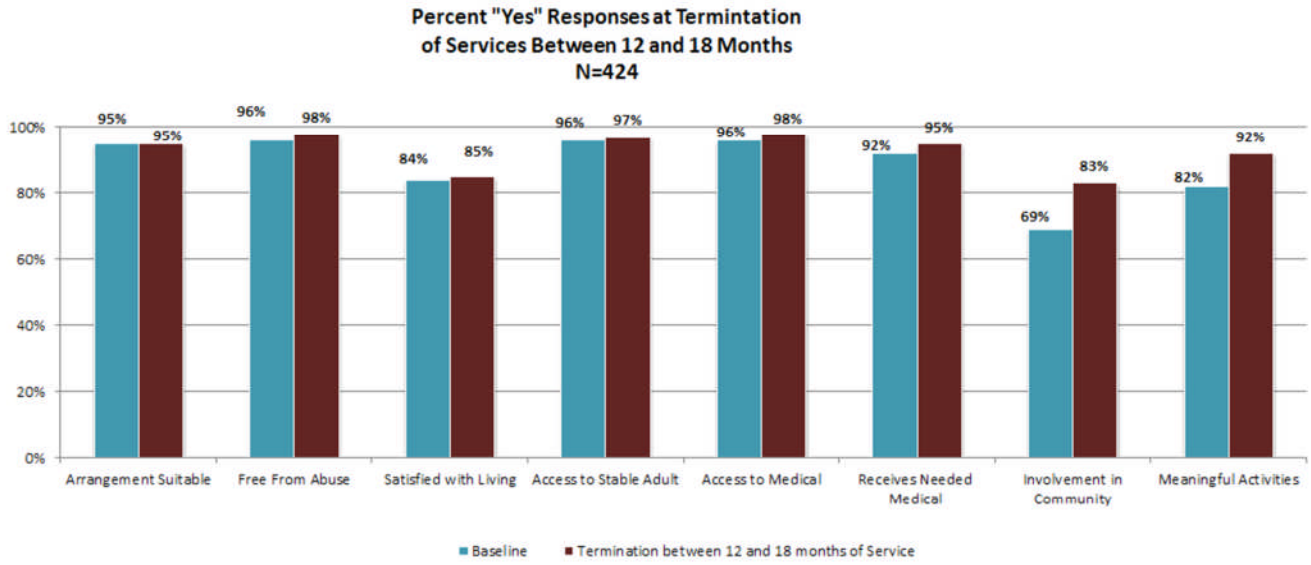
Outcomes (as of 11/21/16)

Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.



After 18 months of TAY FCCS services, clients showed a positive change in the following areas:

- 15% increase with their involvement in the community
- 11% increase in their participation in meaningful activities



For those terminating between 12-18 months of services, TAY FCCS clients showed a positive change in the following areas:

- 20% increase with their involvement in the community
- 12% increase in their participation in meaningful activities

ADULT FCCS PROGRAM (A-06)

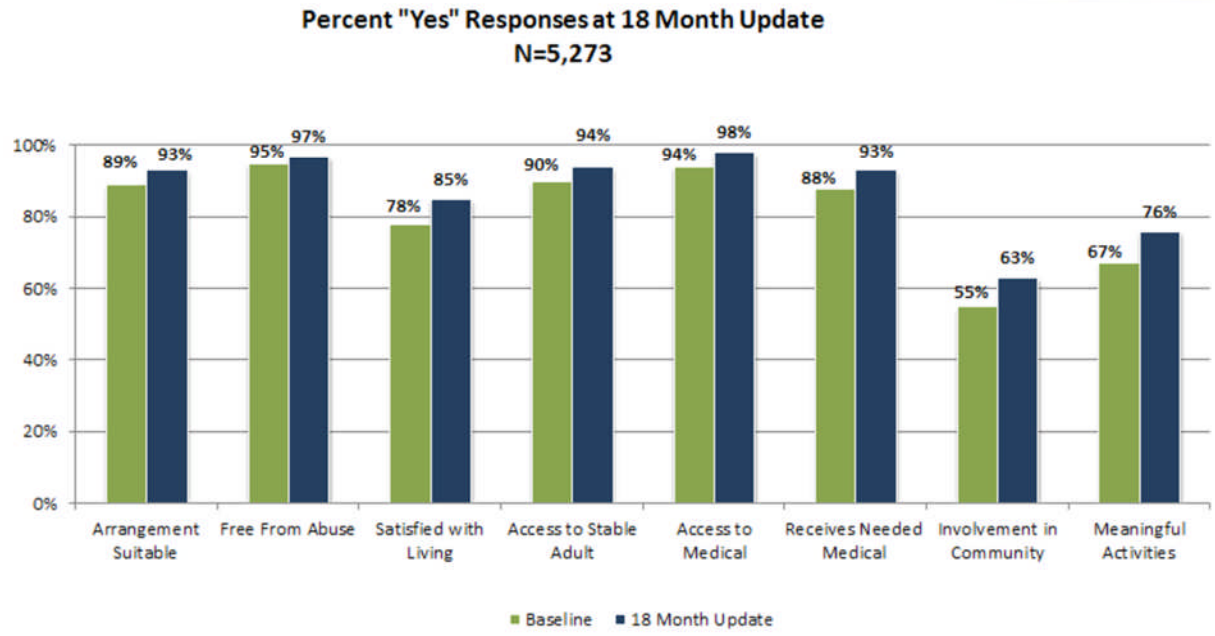
Unique Clients Served: 8,538

Average Cost per Client: $4,681

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

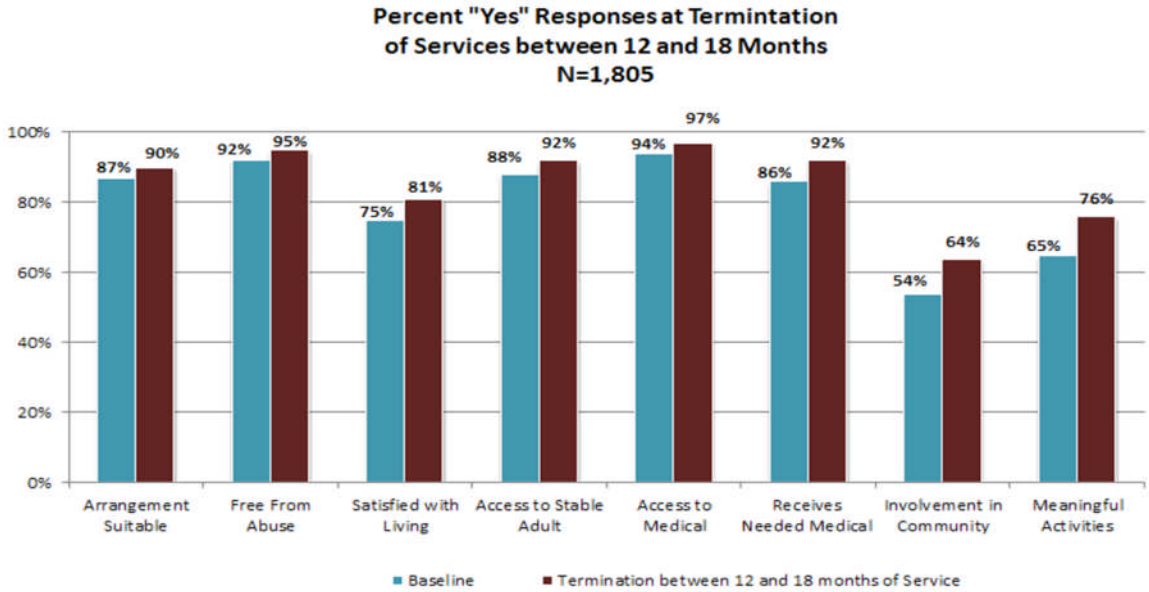
Outcomes (as of 11/21/16)

Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.



After 18 months of services, adult FCCS clients showed a positive change in the following areas:

- 15% increase with their involvement in the community
- 13% increase in their participation in meaningful activities
- 9% increase with those satisfied with their living arrangement
- 6% increase in clients receiving needed medical services



For those terminating between 12-18 months of services, adult FCCS clients showed a positive change in the following areas:

- 19% increase with their involvement in the community
- 17% increase in their participation in meaningful activities
- 8% increase with those satisfied with their living arrangement
- 7% increase in clients receiving needed medical services

OLDER ADULT FCCS PROGRAM (OA-03)

Unique Clients Served: 2,733
Average Cost per Client: $5,774

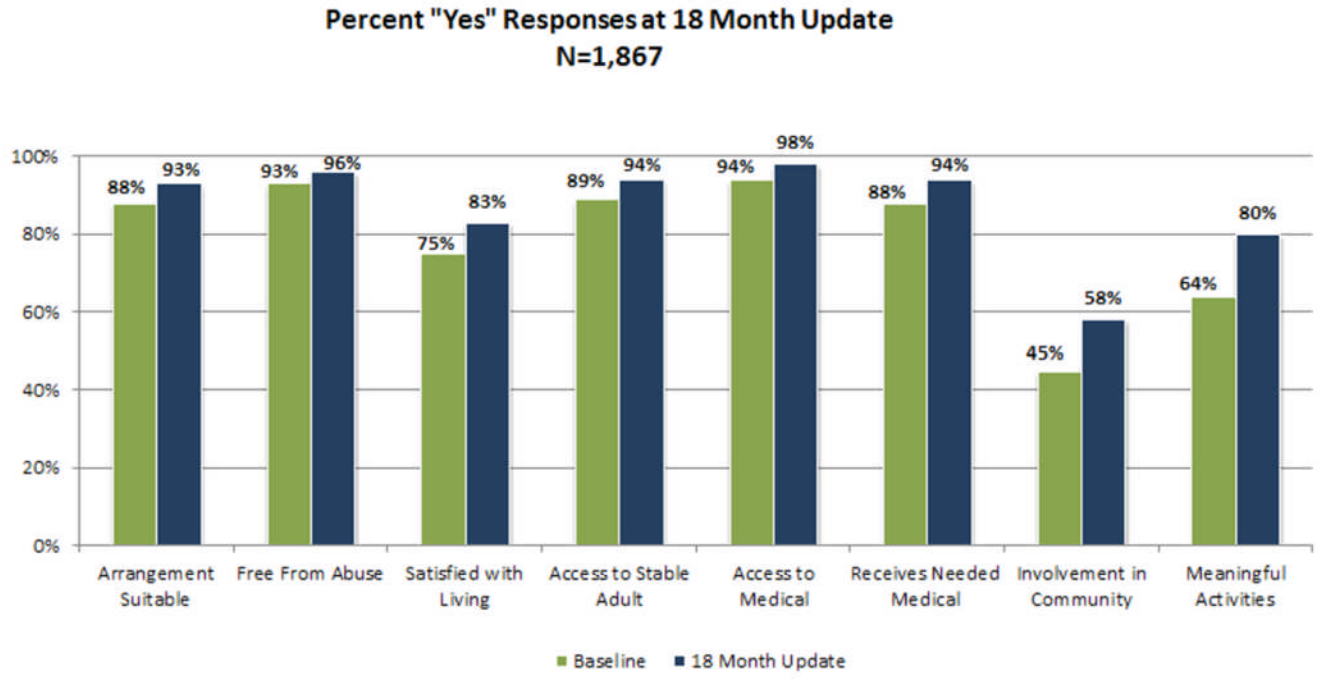
Field Capable Clinical Services, also known as FCCS, are specialized services designed to meet the unique needs of older adults, ages 60 and above, as well as some transitional age older adults, age 55 and above.

FCCS offers an alternative to traditional mental health services for older adults who may be unable to access services due to impaired mobility, frailty or other limitations. For individuals who may be uncomfortable seeking services in a traditional clinic, FCCS may be a welcome alternative.

Services and support are provided in home and in the community in settings such as senior centers or health care provider offices. Currently there are 29 agencies, both directly-operated and contracted, who provide OA FCCS and are monitored by our team. Services provided include outreach and engagement, bio-psychosocial assessment, individual and family treatment, medication support, linkage and case management support, and treatment for co-occurring disorders. FCCS will directly respond to and address the needs of unserved/underserved older adults by providing screening, assessment, linkage, medication support, and gero-psychiatric consultation

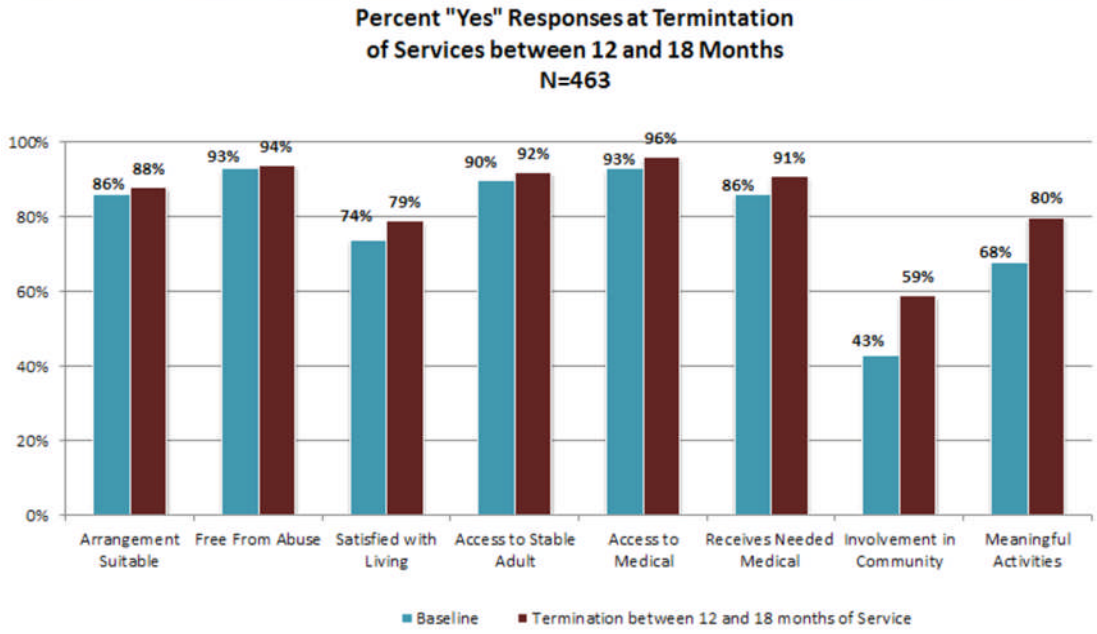
Outcomes (as of 11/21/16)

Client's baselines are excluded when data does not meet reporting requirements. See Appendix II for a list of reasons data does not meet reporting standards.



After 18 months of Older Adult FCCS services, clients showed a positive change in the following areas:

- 29% increase with their involvement in the community
- 25% increase in their participation in meaningful activities



For those terminating between 12-18 months of services, Older Adult FCCS clients showed a positive change in the following areas:

- 37% increase with their involvement in the community
- 18% increase in their participation in meaningful activities

Wellness/Client Run Center (A-02)

Unique Clients Served: 57,817

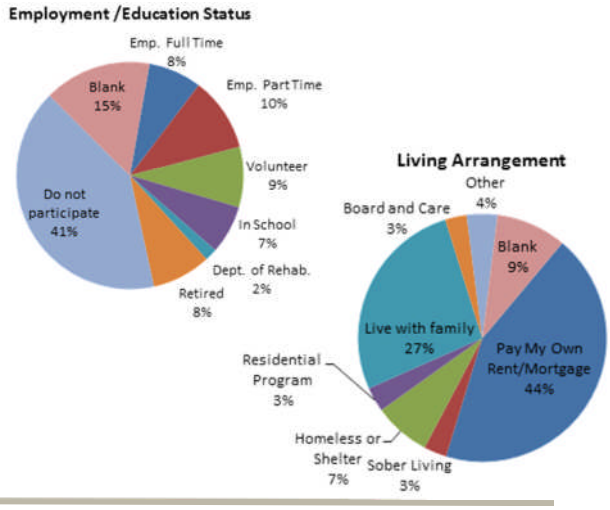
Client Contacts: 94,417 *(Services provided at Peer-Run Centers)*

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

Outcomes

According to a sample survey from 13 providers and 2,389 clients, Wellness/Client Run Centers' consumers reported improvement in their daily and experienced the following:

- 62% usually or sometime did well in work/ school/ preferred activities.
- 87% usually or sometime made progress in wellness/ recovery goals.
- 18% worked part or full time
- 75% usually or sometime able to manage symptoms.
- 85% usually or sometime felt welcomed and respected by staff.
- 74% usually or sometime have opportunities to join social, spiritual, and/ or recreational activities in their life.
- 44% involved in meaningful activities.
- 88% usually or sometime satisfied with their role in making decisions about their care.
- 70% reported living in their own place (house, apartment, etc.), living with family, or living with roommates.



Transition Age Youth Drop-in Centers (T-02)

Client Contacts: 680

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

The following is a status on the expansion of the Drop-in Centers. The expansion was recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17. Contracts have been signed and documents are being finalized for submission to the Los Angeles County Board of Supervisors.

Below is a list of locations identified for TAY Drop-in Centers:

SERVICE AREA	AGENCY NAME – Drop-in Center Name	ADDRESS
1	Penny Lane Centers – Yellow Submarine	43520 Division Street Lancaster, CA 93535
2	The Village Family Services -TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd. North Hollywood, CA 91606
3	Pacific Clinics – Hope Drop-In Center	13001 Ramona Blvd. Irwindale, CA 91706
4	Los Angeles LGBT Center – Youth Center On Highland	1220 N. Highland Ave. Los Angeles, CA 90038
5	Daniel's Place - Step-Up on Second Street, Inc.	1619 Santa Monica Blvd Santa Monica, CA 90405
6	Good Seed Church of God in Christ, Inc.- Good Seed Youth Drop-in Center	2814 W. Martin Luther King Jr. Blvd. Los Angeles, CA 90008
7	Penny Lane Centers – With A Little Help From My Friends	5628 East Slauson Ave. Commerce, CA 90040
8	Good Seed Church of God In Christ, Inc. Good Seed on Pine Youth Drop-In Center	1204 Pine Avenue Long Beach, CA 90813

Transition Age Youth Probation Camps (T-04)

Client Contacts: 1,575

Department of Mental Health (DMH) staff provides MHSA-funded services to youth in Los Angeles County Probation Camps, including youth with Severe Emotional Disturbance/Severe and Persistence Mental Illness. DMH staff and contract providers are co-located in the Probation Camps along with Probation, Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education (LACOE). Within the Probation Camps this inter-departmental team provides coordinated care to the youth housed there.

Youth housed in the Probation Camps receive an array of mental health services, including: Assessments; Individual Group, and Family Therapy; Medication Support; Aftercare and Transition Services. These services are individually tailored to meet the youth's needs, including co-occurring disorders and trauma. Interventions include evidence-based practices such as Aggression Replacement Training (ART), Adapted Dialectical Behavior Therapy (DBT) and Seeking Safety (SS).

TAY MHSA funds mental health staff at the following Probation camps: Rockey; Paige-Afflerbaugh; Scott-Scudder, Gonzales, Challenger and Miller. MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

Integrated Care Program (A-07)

Unique Client Count: 2,270

Integrated Care Programs (ICP) are designed to integrate mental health, physical health, substance abuse, and other needed care such as nontraditional services to more fully address the spectrum of needs of individuals. The ICP service array will support the recovery of individuals with particular attention to those who are homeless, uninsured, and/or members of UREP. ICPs promote collaboration and partnerships by and between service providers and community-based organizations utilizing an array of services that may include traditional and non-traditional services.

The target population for the ICP is individuals with Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED) that meet the Medi-Cal medical necessity criteria for receiving specialty mental health services, including those with co-occurring substance abuse and/or physical health issues, who are economically disadvantaged or uninsured, and/or members of a UREP.

Transformation Design Team (OA-02)

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

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

The Older Adult Systems of Care Bureau (OASOC) Transformation team is comprised of two health program analysts. The goal of the team is to ensure that our OA consumers receive appropriate and timely mental health services from our provider agencies, and they do this by providing data and analytic support to the Program Manager and the Client Supportive Services (CSS) team as they complete their regular site visits. Additionally, the Transformation Team reviews all aspects related to contracts, compliance, service delivery, operations, and budgets, and generates detailed reports to evaluate programmatic design and effectiveness.

Service Extenders (OA-04)

Stipend Recipients: 29

Service Extenders are volunteers and part of the Older Adult FCCS inter-disciplinary team. They are consumers in recovery, family members, or other individuals interested in working with Older Adults. They receive specialized training to serve as members of the team and are paid a small stipend. Service extenders receive supervision from professional clinical staff within the program in which they are placed.

Older Adult Training (OA-05)

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

Training	Description/Dates
Older Adult Consultation Medical Doctor's (OACT-MD) Series:	OA Systems of Care conducted OACT-MD Series for training and consultation for psychiatrists, nurse practitioners, nurses & mental health clinicians to improve the accessibility and quality of mental health services for Older Adults.
Public Speaking Club Graduate Curriculum	OASOC held Speaker Club graduate programs for consumers who successfully completed Public Speaking curriculum to enhance and practice on their public speaking skills. These took place on the 3rd Friday of every month throughout the fiscal year.
Justice-Involved Older Adults Training Series	This included "Beginning the Conversation-Working with Older Adults Involved or at Risk of Involvement in the Criminal Justice System" 11-16-15; "Housing, Case Management and other Tools for Working with Justice-Involved Older Adults" 12-7-15; "Community Re-Entry" 2-25-16, "Community Re-entry Part #2 Assessment & Treatment Interventions" 4-19-16, "Community Re-entry Part #3 Community Engagement and Resources" 5-26-16.

Training	Description/Dates
After a Suicide Loss: What to Expect, What to Do	This training discussed what are known as "postvention" techniques for clinicians regarding what to do if a suicide occurs. 11-18-15 and 5-19-16.
15th Annual Gero-Psychiatric Breakfast	L.A. County Department of Mental Health in collaboration with L.A. Care, and Health Net, provided the 15th Annual Geropsychiatry Breakfast a free continuing medical education activity for primary care physicians and psychiatrists, focusing on adult behavioral health.
PEARLS	EBP training for homebound older adults, structured format. 3-17-16 and 3-18-16.
Problem Solving Therapy (PST):	PST training included a brief intervention approach that is evidence-based for those experiencing mild to moderate depression and anxiety. 3-26-16 and 5-17-16.
Conducting Grief & Loss Support Groups	The purpose of these workshops was to train clinicians to conduct support groups for older adults experiencing grief and loss. 9-29-15 and 11-23-15.
Southwestern Legal Training Series	This 4 night training series was facilitated and taught by our geriatrician as well as attorneys to inform and educate on the needs of older adults with mental illness particularly around issues of conservatorship and other legal concerns. 1-4 through 1-7-16.
Group Facilitation Skills Training	Service Extenders and others who work in a volunteer capacity with our Older Adults were trained on how to effectively facilitate groups within their agencies or senior centers. 3-15-16
Hoarding Forum	The primary goal of this training is to provide tools and strategies for the treatment of Compulsive Hoarding. 6-8-16
Suicide prevention trainings included Applied Suicide Intervention Skills Training ASIST (multiple); Question Persuade & Refer (QPR) (multiple); 5th Annual Suicide Prevention Summit; Two (2) Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR), & three (3) Assessing and Managing Suicide Risk (AMSR) trainings	ASIST is a (2) day training intended to help participants become ready, willing and able to provide suicide first aid to persons at risk of dying by suicide. QPR is a 2.0 hour training to reduce suicidal behaviors and save lives by providing innovative, practical and proven suicide prevention training. The 5th Annual Suicide Prevention Summit, is a 1 day summit. The theme for 2015-16 was "The Power of Voice: Hope, Help and Healing for College & High School Students." This Summit took place on October 27, 2015 in collaboration with California State University Northridge (CSUN). AMSR is a one-day workshop focuses on competencies that are core to assessing and managing suicide risk and is a collaboration of the American Association of Suicidology and the Suicide Prevention Resource Center.

The following is a status on programs recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17 that have not been implemented:

Program		Estimated Implementation Date
Children		
Family Wellness/Resource Centers **Status:** Directly Operated Providers: Duty statements have been submitted for new positions. Conversations with the directly operated clinics regarding implementation are ongoing. Contracted Providers: In the process of preparing documents to begin the solicitation process to contract services with two Legal Entities, one in the Northern Region of LA County and one in the Southern Region.		July 2017
Transition Age Youth		
Train current TAY mental health providers in implementing supportive employment services **Status:** The Request for Service was released in December 2016.		Mid FY 2016-17
Adult		
Expand Client Run Centers to ensure availability in every service area. **Status:** Solicitation for services is being reviewed.		TBD

Alternative Crisis Services

Alternative Crisis Services (ACS-01)

Client Contacts: 63,752

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

COUNTYWIDE RESOURCE MANAGEMENT

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

RESIDENTIAL AND BRIDGING PROGRAM

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

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

The following is a status on the development of three Urgent Care Centers: The development was recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17. The Board letter to execute the service contracts for the UCCs was adopted on December 6, 2016. UCCs will be located in the following areas:

- Antelope Valley: The previous provider that DMH intended to contract on a sole source basis was not able to materialize. DMH has since found an existing provider with experience in operating UCCS in other Counties to implement the UCC in the AV. Stars Behavioral Health Group (Stars) has been selected as the new provider for this site. DMH and Stars are currently working collaboratively with the Supervisorial District to find an appropriate site to house the UCC.

- San Gabriel UCC: The site is El Monte was not a viable option for the County. DMH, with help from DHS, has connected with Molina Healthcare to potentially offer space that would allow Telecare Corporation, the UCC awardee, to occupy and operate this UCC.

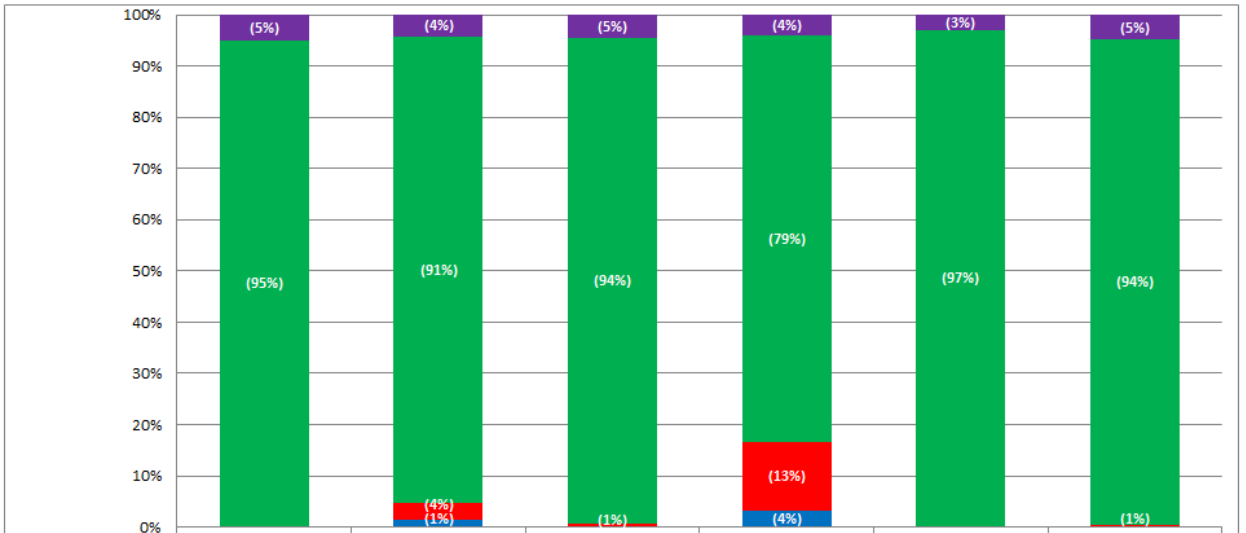
- Long Beach UCC: Stars was awarded a service contract to operate a UCC in Long Beach. The provider has been working with the City of Long Beach Planning Department to process and approve a Conditional Use Permit for their site. DMH, along with Stars, has met with Long Beach officials to provide an overview of the services and the potential impact to the city of Long Beach. Stars continues to conduct community outreach and site preparation to successfully site the UCC. A lease between the site's landlord and the County is currently being reviewed by the Chief Executive Office, Real Estate Division (CEO-RED).

The following is a status on the development of 35 news Crisis Residential Treatment Programs (CRTP) to increase capacity by 560 beds countywide: The development was recommended by System Leadership Team (SLT) to the Department and to the Mental Health Commission proposed through the MHSA Three Year Program and Expenditure Plan Fiscal Years 2014-15 through 2016-17. DMH received 34 proposals for CRTPs. Of the 34 proposals, 23 met the minimum mandatory requirements. Of the 23 proposals accepted by DMH Executive Management Team, three have since repealed their award. Currently, DMH is working side-by-side with the Department of Public Works, CED-RED, and County Counsel to assess the status of each awardee and complete the specific site requirements to enter into a lease with the County. DMH is also in the stages of preparing a board letter to award the service contracts to all successful bidders with sites identified. In addition, due to the fact that the Request for Proposal did not yield sufficient proposals for CRTPs in the Antelope Valley area, DMH is seeking to enter into an agreement with Star View Children and Family Services on a sole source basis to develop and operate a CRTP in the Antelope Valley area for a maximum of 16 beds. This could bring the total number of new CRTP beds in the County to 326 beds.

Outcomes

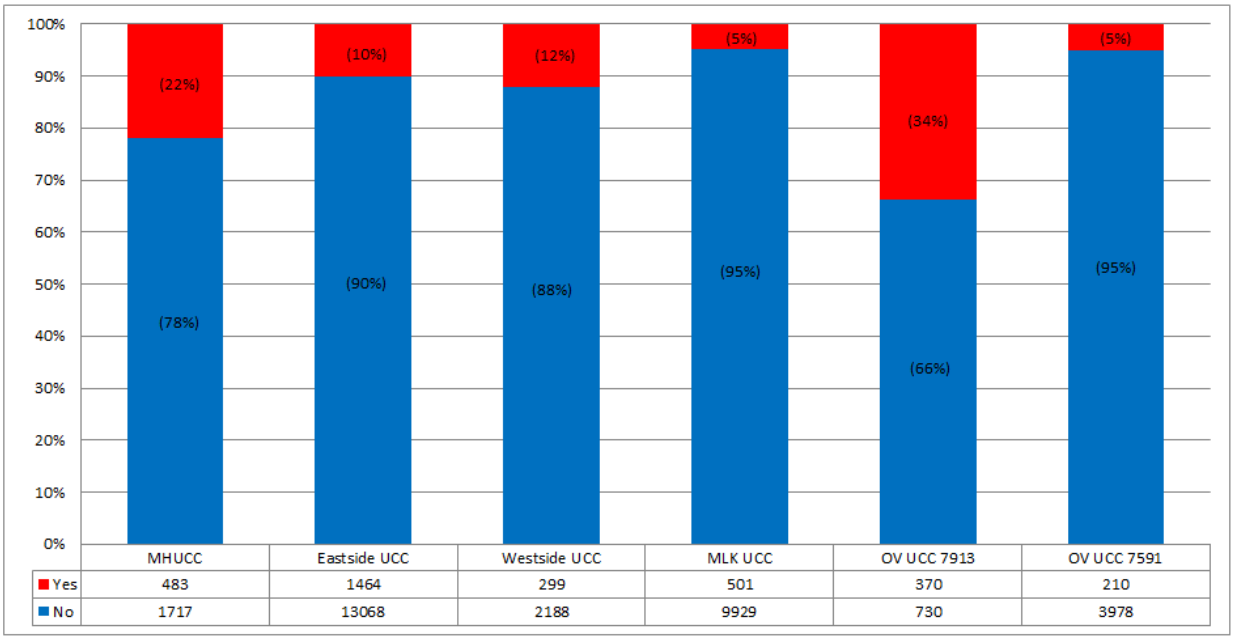
July 1, 2015 through June 30, 2016

New Admissions at Urgent Care Centers (UCCs) by Age Category



	MHUCC	Eastside UCC	Westside UCC	MLK UCC	OV UCC 7913	OV UCC 7591
Unknown*	0	0	0	0	0	1
Older Adult (60+)	109	629	114	424	32	203
Adult (18-59)	2091	13202	2357	8266	1066	3968
TAY (13-16)	0	509	13	1412	1	16
Child (12 & under)	0	192	3	328	1	0

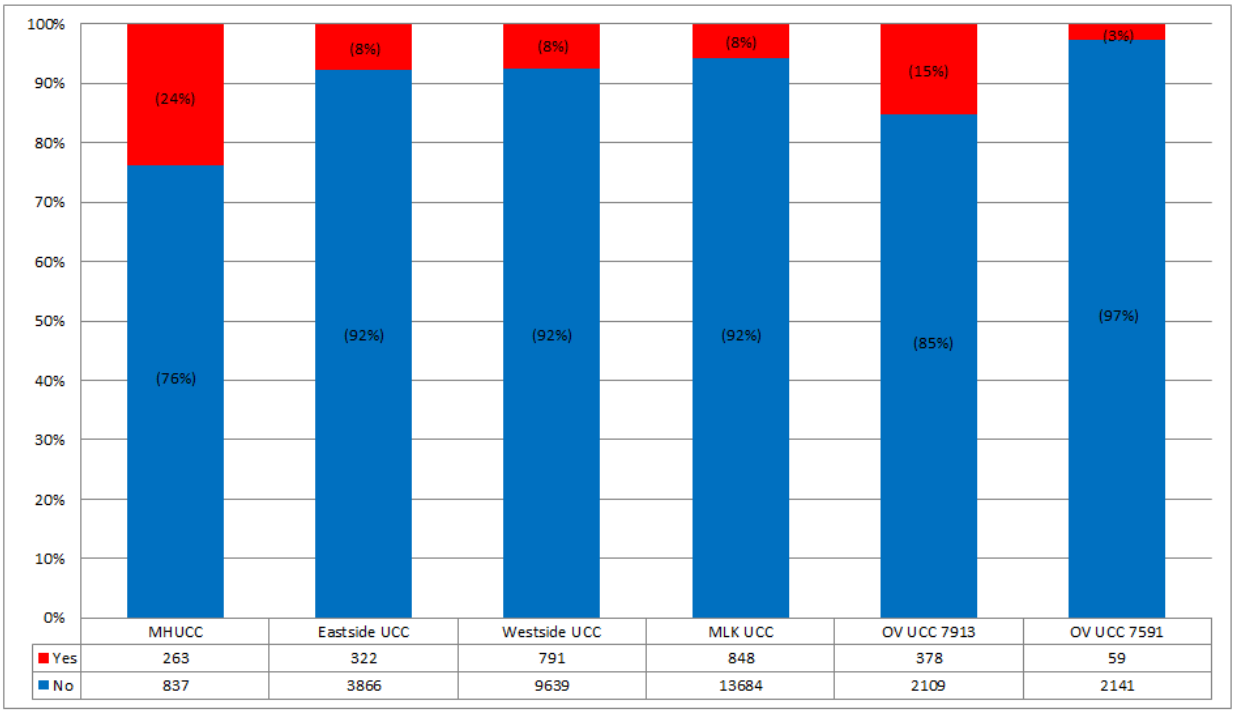
New Admissions at UCCs Who Were Homeless upon Admission



	MHUCC	Eastside UCC	Westside UCC	MLK UCC	OV UCC 7913	OV UCC 7591
Yes	483	1464	299	501	370	210
No	1717	13068	2188	9929	730	3978

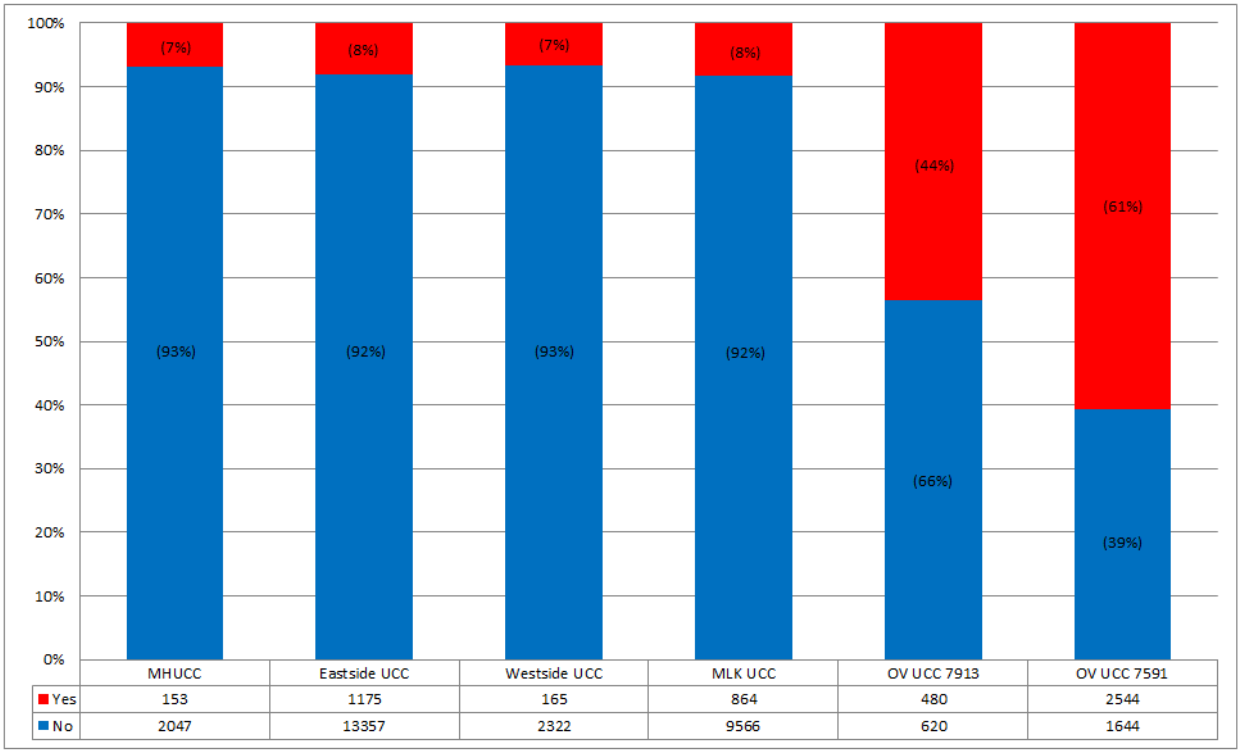
Note that OVMC has two components: The Crisis Stabilization Unit (CSU) (7913) and the Outpatient UCC (7591). Data from the CSU are from Sept. 21, 2015 through June 30, 2016 only. *One client did not report their age to the Outpatient UCC (7591).

Percent of those with an Assessment at a Psychiatric Emergency Room within 30 Days of a UCC Assessment



	MHUCC	Eastside UCC	Westside UCC	MLK UCC	OV UCC 7913	OV UCC 7591
Yes	263	322	791	848	378	59
No	837	3866	9639	13684	2109	2141

Percent of Those Who Return to a UCC within 30 Days of a UCC Assessment



	MHUCC	Eastside UCC	Westside UCC	MLK UCC	OV UCC 7913	OV UCC 7591
Yes	153	1175	165	864	480	2544
No	2047	13357	2322	9566	620	1644

Note that OVMC has two components: The Crisis Stabilization Unit (CSU) (7913) and the Outpatient UCC (7591). Data from the CSU are from Sept. 21, 2015 through June 30, 2016 only.

IMD Step-Down Facilities (A-03)

Unique Client Count: 981

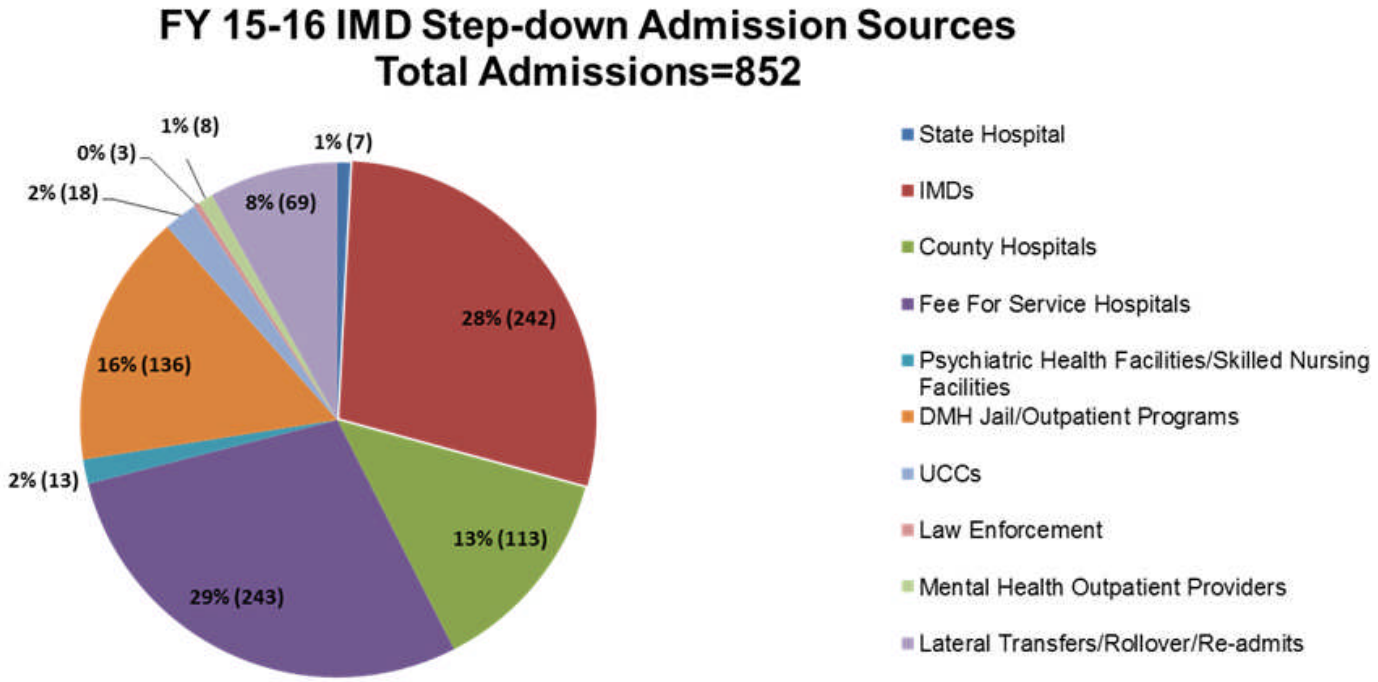
Enriched Residential Services

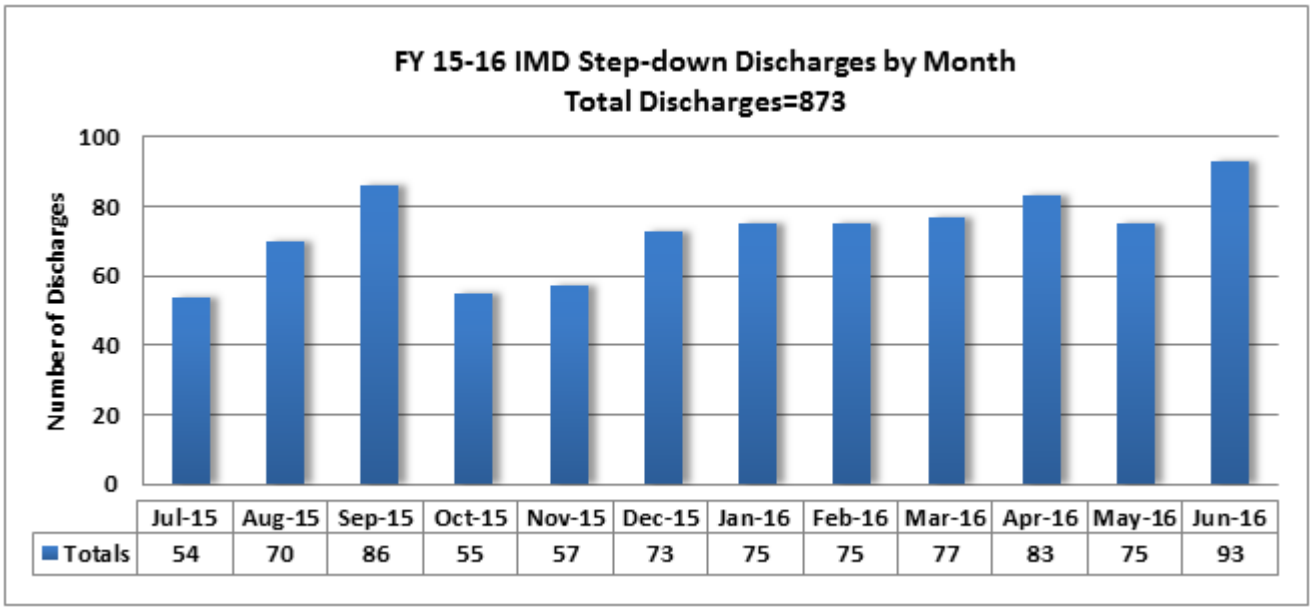
Enriched Residential Services are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from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

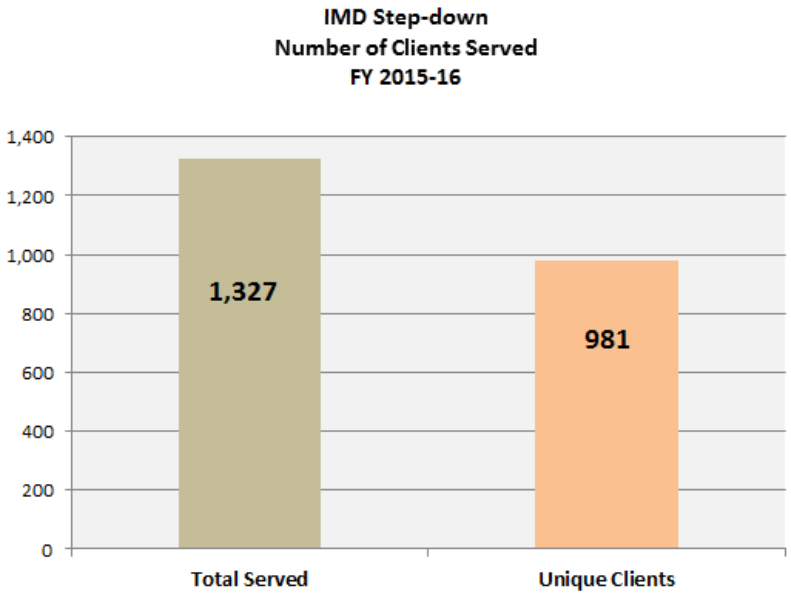
Project 50

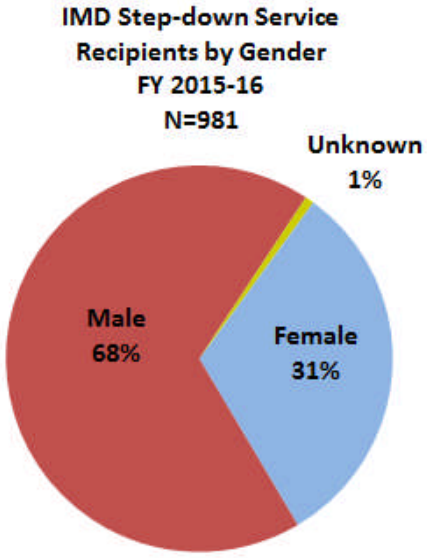
Project 50 is a County demonstration project that transitioned 50 of the most vulnerable, chronically homeless persons from the most concentrated area of homelessness in Los Angeles County (Skid Row) to permanent-supportive housing. Project 50 was approved by the Board of Supervisors on November 20, 2007 and is a collaborative effort that includes County departments, the City of Los Angeles, Los Angeles Homeless Services Association, and Veteran's Administration, and other community agencies. The program expanded to serve 74 individuals at any given time in 2010 and offers housing and comprehensive integrated supportive services for chronically homeless individuals with serious mental illness and co-occurring substance abuse disorders and/or complex medical conditions.

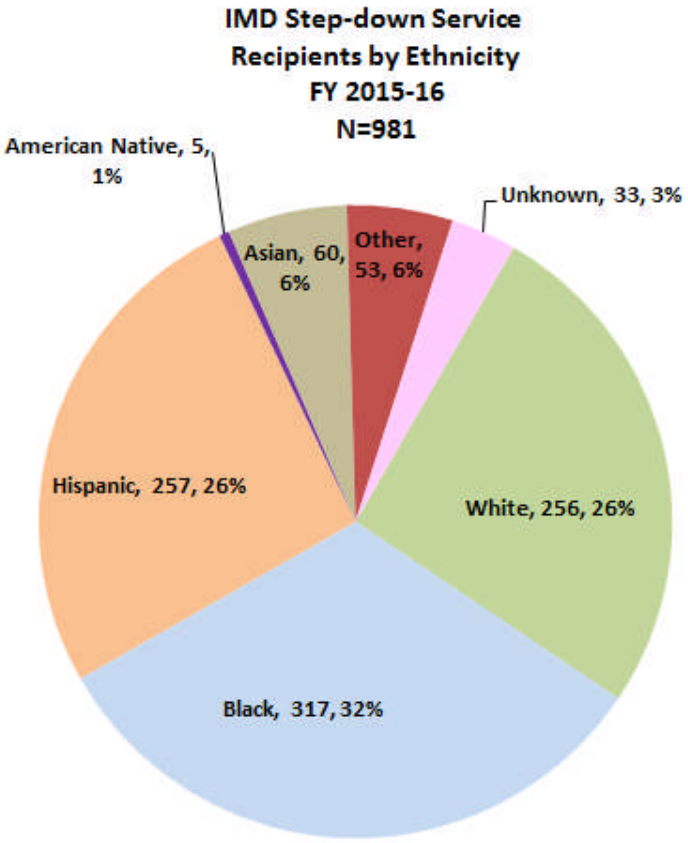
Outcomes

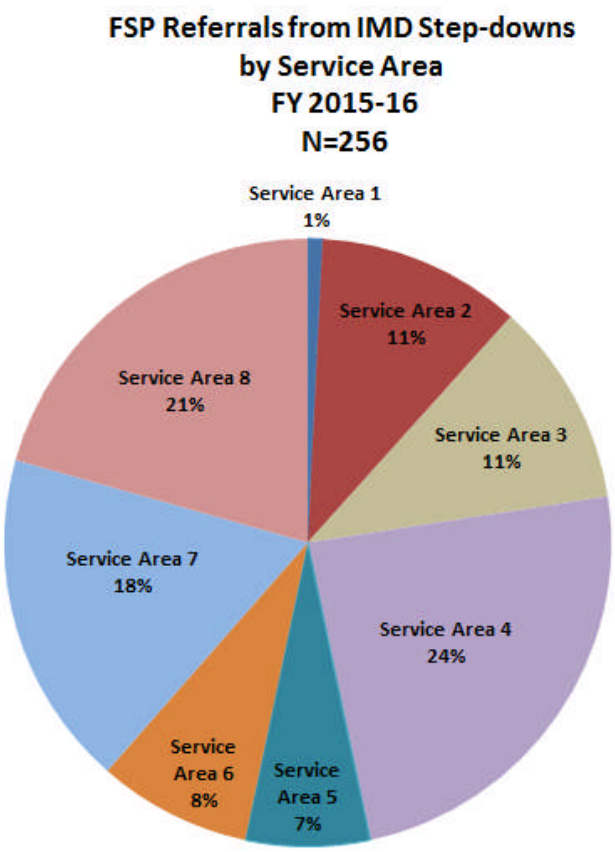


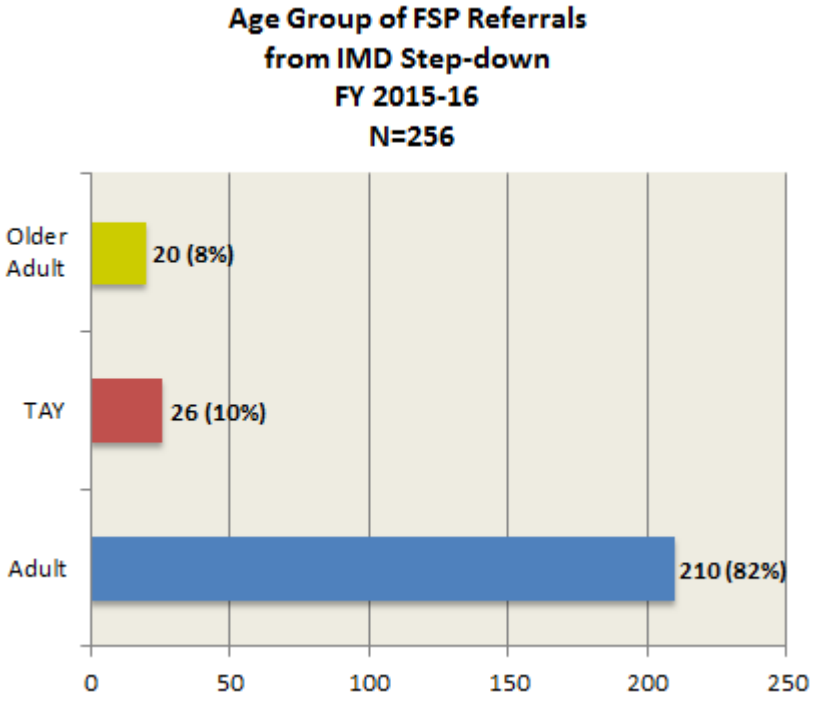

FY 15-16 IMD Step-down Discharges by Month
Total Discharges=873
Number of Discharges
100
80
60
40
20
0
Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16
Totals 54 70 86 55 57 73 75 75 77 83 75 93


IMD Step-down
Number of Clients Served
FY 2015-16
1,400
1,200
1,000
800
600
400
200
0
1,327
981
Total Served
Unique Clients


IMD Step-down Service
Recipients by Gender
FY 2015-16
N=981
Unknown
1%
Male
68%
Female
31%


IMD Step-down Service Recipients by Ethnicity
FY 2015-16
N=981
American Native, 5, 1%
Asian, 60, 6%
Other, 53, 6%
Unknown, 33, 3%
Hispanic, 257, 26%
White, 256, 26%
Black, 317, 32%


FSP Referrals from IMD Step-downs by Service Area
FY 2015-16
N=256
Service Area 1 1%
Service Area 2 11%
Service Area 3 11%
Service Area 4 24%
Service Area 5 7%
Service Area 6 8%
Service Area 7 18%
Service Area 8 21%


Age Group of FSP Referrals from IMD Step-down
FY 2015-16
N=256
Older Adult
20 (8%)
TAY
26 (10%)
Adult
210 (82%)
0
50
100
150
200
250

Housing Services

Adult Housing Services (A-04)

Client Contacts: 1,741

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

MHSA Housing Program

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

Below is a list of projects that opened during fiscal year 2015-16 through the MHSA Housing Program:

Project Sponsor	Project Name	Service Area	Supivisorial District	Target Population	MHSA Units	Total Units	Date of Occupancy	MHSA Capital Committed	MHSA Subsidy Committed	Total Committed
Century Villages at Cabrillo	Cabrillo Gateways	8	4	Families; TAY (16-25 ages); Single Adults 18+; Older Adults (ages 60+)	16	81	July 6, 2015	$ 1,600,000	$ -	$ 1,600,000
PATH Ventures	Long Beach & 21st Street	8	4	Older Adults (60+)	21	41	July 14, 2015	$ 1,897,450	$ -	$ 1,897,450
Women Organizing Resources Knowledge and Services, Inc.	Teague Terrace	4	5	Single Adults 18+; Older Adults (ages 60+)	5	56	August 24, 2015	$ 524,150	$ -	$ 524,150
PATH Ventures	Villas at Del Rey	5	2	Adults & Families	22	23	September 1, 2015	$ 2,100,000	$ -	$ 2,100,000
				Total Number of Units	**64**	**201**	**Total**	**$ 6,121,600**	**$ -**	**$ 6,121,600**

Transition Age Youth Housing Services (T-03)

Client Contacts: 810

Housing related systems development investments for the TAY population include:

- Enhanced Emergency Shelter Program (EESP) (previously Motel Voucher Program) for TAY that are homeless, living on the streets and in dire need of immediate short-term shelter while more permanent housing options are being explored.
- A team of 8 Housing Specialists develop local resources and help TAY find and move into affordable housing.

Planning, Outreach & Engagement

Planning Outreach & Engagement (POE-1)

Client Contacts: 27,292

UNDERSERVED CULTURAL COMMUNITIES (USCC) (FORMERLY KNOWN AS UNDER-REPRESENTED ETHNIC POPULATIONS)

Projects are aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities.

For Fiscal Year 2016 - 2017 the following projects have been approved and are scheduled to be implemented:

- September 1, 2016
  - Black Male Mental Health Awareness Campaign
  - African American Women Leadership and Wellness Mental Health Outreach Project
  - African Immigrants and Refugees Mental Health Outreach Projects
  - Farsi Peer-Run Outreach Project
  - Mental Health Education & Stigma Reduction for Arabic Speaking College Students
  - The Armenian Talk Show Project II
- August 15, 2016
  - Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities
  - Youth Speak Your Mind Academy Mental Health Outreach Project

Achievements/Highlights

African/African American (AAA) UsCC subcommittee

Ethiopian Community Mental Health Training and Education Project: The Ethiopian Community Mental Health Training and Education (ECMHTE) Project was implemented on September 1, 2014 and completed by June 30, 2015. This project aimed to reduce the stigma of mental illness in the Ethiopian community and set a precedent of using culturally appropriate mental health education when working with ethnic communities. Community members were recruited to become 'lay-experts' on mental health issues, crisis intervention, and culturally appropriate mental health resources. These community members are referred to as Ethiopian Community Advocates (ECAs).

Outcomes

- 20 community members were trained to become Ethiopian Community Advocates
- There were over 55 different community presentations completed by these Advocates
- 385 community members were outreached

AAA Resource Mapping Project: Funds were allocated to develop a community resource directory called Life Links. Community resources, service providers, and agencies were identified in South Los Angeles County, where there is a large African/African-American (AAA) population. This director, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers. This community resource directory has been updated three times and the fourth reprint is scheduled for October 2016.

Outcomes

- 12,000 copies were printed and distributed between July 1, 2013 through March 2015.
- They were successfully distributed in SA 6

AAA Mental Health Informational Brochures: Brochures will be used to outreach and engage underserved, inappropriately served and hard-to-reach AAA ethnic communities such as African-American, African immigrants, and Pan-African community members. The brochures will be used to educate and inform these ethnically diverse communities of the benefits of utilizing mental health services and to provide referrals and contact information. The informational brochure will be translated into two (2) different African languages: Amharic and Somali. The content, translations, and graphic of the brochures have been completed. The print of these brochures is expected to be completed by November 2016.

AAA Community Mental Health Stigma Reduction Project: Funds were allocated to community service providers in Los Angeles County to provide tailored community awareness and service strategies to specific, underserved subpopulations in the African/African-American community. The focus of this project was to reduce the stigma of mental illness by funding agencies to provide outreach, engagement, training, education and non-traditional wellness activities. Technological approaches were also employed, as each agency targeted a subpopulation with unique concerns and needs. The targeted subpopulations were the LGBTQ community, the Somali community and the Pan-African community.

Outcomes

- Projects for all three subpopulations were successfully completed by April 2015 and each agency met its service deliverables.
- AAA LGBTQ Community Stigma Reduction Project – more than 120 unduplicated participants (men and women) participated in the support group activities. 80% of participants attended at least two sessions and based on satisfaction surveys completed at each group session, 97% reported either learning something new or feeling support as a result of attendance.
- AAA Community Mental Health Stigma Reduction Project for the Somali Community - For a period of 6 months, Somali community members participated in mental health educational workshops that included the following topics: anxiety, PTSD, child abuse, substance abuse, schizophrenia, sexual abuse, and domestic violence. Due to the stigma associated with mental illness, it was very difficult to recruit Somali community members to participate in the workshops. This demonstrates that greater outreach efforts are needed in this community.
- AAA Community Mental Health Stigma Reduction Projection for the Pan African Community – A total of 13 Pan African parenting sessions were conducted from

November 2014 through March 11, 2015. Approximately 84 unduplicated community members participated in the parenting sessions. The parenting topics included: family rules, methods of discipline and positive communication; importance of keeping children safe from sexual abuse and child molestation; and how to develop effective communication with young children.

Sierra Leone Community Mental Health Training and Education: Sierra Leone community members were trained as advocates and facilitated community mental health awareness presentations to the larger community. Additionally, they provided assistance to community members and helped them cope with their losses and concerns related to the Ebola outbreak. This project was implemented on October 1, 2015 and it was completed on April 30, 2016.

Outcomes

- 15 community members were trained to become Sierra Leone Community Advocates.
- There were 48 different community presentations completed by these Advocates.
- 480 community members were outreached to.

American Indian/Alaska Native (AI/AN) UsCC subcommittee

The American Indian/Alaska Native Mental Health Conference 2012-14: For three consecutive years (2012-2014), the AI/AN Mental Health Conference took place during the month of November at the California Endowment Center. The conference themes included:

- Weaving Wellness Into Our Spirits – November 6, 2012
- Integrating Services To Heal Our Generations – November 20, 2013
- Strengthening Native Voices to Build a Health Community – November 4, 2014

Through the sharing of information and training on effective integrated treatment for the AI/AN community, the conferences promoted a greater understanding of the special treatment needs of this community in the County of Los Angeles. A special focus in the conference was the integration of services across different generations.

American Indian/Alaska Native Community Spirit Wellness Project: As part of this project, five (5) AI/AN community members (called Community Spirit Healers) were trained to outreach, engage and educate the AI/AN community, as well as facilitate linkage to mental health services through community trainings and forums. This project was implemented on August 1, 2014 and was successfully completed by July 30, 2015.

Outcomes

- A total of 30 community presentations targeting the American Indian/Alaska Native community were conducted countywide.
- There were a total of 329 community members who participated in the trainings and forums.

AI/AN Media Outreach Campaign: The media outreach campaign consisted of Advertisements (Ads) and PSAs that aired on a local television (KABC – Channel 7) and radio (KNX-AM) station to increase awareness of mental health issues and community resources. The television and radio commercials aired on a daily basis between December 1, 2015 and January 3, 2016.

Outcomes

- The KABC-TV report shows an achieved rating of 29.1, which means 29.1% of adults over the age of 18 in the Los Angeles market were reached.
- The KNX-AM report shows a gross rating point of 14.4, which means the radio spots reached approximately 14.4% of adults over the age of 18 in the Los Angeles market.

AI/AN 2016 National Mental Health Awareness Month Media Outreach Campaign: The media outreach campaign consisted of advertisements that aired on two local television channels (CBC and KCAL) and one radio station (KNX1070) in order to increase awareness of mental health issues faced by the Native American community and to provide community resources. The advertisements aired throughout the month of May 2016, which was National Mental Health Awareness Month. The media campaign also included a digital media campaign on the CBSLA.com website. Additionally, an interview of Mirtala Parada Ward, Mental Health Clinical Program Head, was conducted by Tami Heidi of the CBS Radio public service broadcast show Openline. The interview was approximately 8 minutes long and was broadcast 5 times (one time each on 94.7FM KTWV, 101FM KRTH, 106.7FM KROQ, 97.1FM KAMP, and 93.1FM JACKFM).

Outcomes

- The television advertisements on CBS and KCAL aired a total of 196 times.
- The radio advertisements on KNX1070 aired a total of 170 times.
- The CBS report shows that 89.3% of the Los Angeles households were reached, with a total of 12,202,000 Impressions (the total number of times households exposed to the commercials). These households saw the TV exposure with a frequency of 2.5 times.
- The advertisements that ran on KNX1070 delivered 4,649,600 impressions and reached 1,539,900 unduplicated adults (age 18+) an average of 3 times during the campaign period.
- The digital media campaign on CBSLA.com provided a total of 153,641 Impressions.
- The Openline program delivered an estimated 61,000 additional listeners.

Asian Pacific Islander (API) UsCC subcommittee

API Consumer Leadership Council (CLC): The API CLC project was implemented on October 1, 2011 and it was completed on June 30, 2013. The API CLC included consumer leadership and public speaking trainings as well as consumer participation and presentations at LACDMH and mental health related community meetings.

Outcomes

- 17 consumers were selected into the API CLC out of 68 interested consumers
- Of the initial members selected, there were representatives from 6 API communities (Chinese, Filipino, Japanese, Korean, Samoan, and Vietnamese) and 7 Service Areas (all except for SA 1) and one third of the members selected were monolingual in an API language

- 12 CLC trainings were provided on topics such as the public mental health system, community engagement, leadership, advocacy and self-care to orient members to the role of advocacy
- 26 trainings on public speaking were provided as well as monthly supervised presentations at public meetings for each member
- The API CLC also conducted outreach events, developed an API CLC website and established an API CLC newsletter as part of this project

The API Consumer and Family Member Training and Employment Program: The goal of this project was to train API consumers and family members to become culturally competent Peer/Family Advocates. The Peer/Family Advocates participated in a training academy where they learned how to assist API consumers, especially those with limited English-speaking skills, to navigate the public mental health system and access mental health services.

Outcomes

- 12 API consumers and family members graduated from the training academy and became Peer/Family Advocates.
- 8 of the 12 Peer/Family Advocates were employed by mental health agencies that served the API community in Los Angeles County.
- The language capacity of the Peer/Family Advocates included Korean, Thai, Vietnamese, Burmese, Chinese, and Cambodian/Khmer.

The API Family Member Mental Health Outreach, Education and Engagement Program: This project was implemented on August 17, 2015 and is scheduled to be completed by August 30, 2016. This purpose of this project is to increase awareness of mental illness signs and symptoms for API families so that they know when and how to connect family members to mental health services. The ethnic communities being targeted include the following: Chinese community (Cantonese and Mandarin-speaking), Vietnamese community, Korean community, South Asian (Indian/Hindi-speaking) community, Cambodian community, and the Samoan community.

The Samoan Outreach and Engagement Program: This program was implemented to increase awareness of mental illness, knowledge of mental health resources and decrease mental health related stigma in the Samoan Community. As part of the program, mental health workgroups are being conducted by two Samoan community based agencies. The workshops include topics related to mental health awareness, mental health and nutrition, stress management, substance abuse, teen stress, depression, healthy eating habits, peer pressure, and culture and mental health. All the workshops are tailored to be culturally and linguistically appropriate for the Samoan community. This project was implemented on July 1, 2015 and is part of the Department's 3-Year MHSA Plan.

Outcomes

As of February 2016, 249 mental health educational workshops have been conducted and 1284 individuals have been reached. Each attendee completed a survey about the impact of the workshops which is summarized below:

- 93% strongly agree or agree that their knowledge of mental health issues in the community increased as a result of the workshops.
- 94% strongly agree or agree that their knowledge about mental health services available for the Samoan community increased as a result of the workshops.

- 95% strongly agree or agree that they can better recognize the signs of mental health issues as a result of the workshops.
- 93% strongly agree or agree that they know where to go for help for mental health issues.
- 93% strongly agree or agree that Samoan culture can influence how one views mental health.

- 94% strongly agree that stigma can keep individuals from getting help for mental health issues.

Eastern European/Middle Eastern (EE/ME) UsCC subcommittee

EE/ME Mental Health Outreach and Engagement Materials: For FY 2012/2013, promotional items such as brochures, pens, and posters were produced and distributed to outreach and engaged underserved, inappropriately served and hard-to-reach EE/ME communities such as Armenian, Russian, Iranian, and Arabic community members. The promotional items were used to educate and inform these ethnically diverse communities about the MHSA and when and how to access services. The brochure on mental health were created and translated into 4 threshold languages (Arabic, Armenian, Farsi and Russian). All brochures and promotional items include the 24/7 Toll Free ACCESS number for mental health services. A total of 6,000 promotional materials were distributed at key locations throughout the County of Los Angeles in an effort to promote mental health services with these underserved communities.

Armenian and Russian Mental Health Media Outreach Campaign: For FY 2013-2014, the Eastern European and Middle Eastern committee launched a Media Campaign targeting the Armenian and Russian communities. The media campaign included the production and broadcasting of 30 seconds Public Service Announcements (PSA's) in the Armenian and Russian languages. Once the PSA were produced, they were broadcast on the local Armenian and Russian television stations. The PSAs provided education and information about mental health, substance abuse, and domestic violence issues to the Armenian and Russian communities.

Farsi-Speaking Mental Health Radio Talk Show: A total of forty four (44) different educational mental health radio talk shows aired on the local Farsi-speaking radio station from September 1, 2014 - November 28, 2014 and from September 1, 2015 – December 1, 2015. The radio talk show topics included, but not limited to the following topics: Basic mental health education and awareness, mental health issues related to aging, the psychological effects of violence, and healthy interpersonal relationships.

Outcomes

- The radio station reported that they received positive feedback from their listeners and that this project educated the community about common mental health issues and how to access services.

The Armenian Mental Health Talk Show: Mental health TV talk shows, conducted in Armenian, were developed to target the Armenian community in order to increase awareness of mental health issues. A total of 44 half-hour mental health TV talk show aired on the Armenian-Russian Television Network (ARTN-Shant), every Saturday and Sunday from 3:30 pm – 4:00 pm. The TV shows included, but not limited to the following mental health topics: Introduction to mental health, immigration and acculturation, loss and

grief, older adults, divorce and its effects on children, bullying, depression, and parenting. The shows were also uploaded onto YouTube and a Facebook page was created. This project was implemented on September 29, 2015 and was successfully completed on March 6, 2016.

Outcomes

- The Charter Communications report indicates that 41,337 homes in the Glendale/Burbank area and 64,103 homes in the San Gabriel Valley area viewed the shows.
- The YouTube data indicates that 8,303 individuals viewed the shows in the United States and 1,640 individuals in Armenia.
- Didi Hirsch's Armenian ICP-ISM Program service capacity was increased as a result of this project.

The Arabic-Speaking Community Mental Health Project: This project was funded to increase mental health awareness among Arabic-speaking community members in the County of Los Angeles. This was project was implemented on December 1, 2014 and it was completed on May 13, 2016. This project provided outreach and engagement services by partnering with faith-based and other community-based organizations to conduct mental health presentations targeting Arabic-speaking community members. This project was extremely difficult to implement due to the high level of mental health stigma in this community. As a result of this, the project was extended three times and it took 17 months to be implemented.

Outcomes

- A total of 28 community presentations and in-home meetings were completed in a period of 17 months.
- Approximately 95% of the community presentations and in-home meetings took place after the San Bernardino shooting.
- There was a stronger than anticipated level of stigma and fear from the Arabic-speaking community and it required multiple attempts for individuals and organizations to agree to participate in the mental health presentations and in the in-home meetings.
- External events such as the San Bernardino shooting created the need for conversations related to the mental health, but prior to that it took more than a year to engage this community.
- It was very difficult for the presenters to build positive rapport and engage this community and as a result, presentations were cancelled and instead private meetings took place in people's home.
- It was recommended for LACDMH to develop stronger community relations with small non-profit or for-profit organizations that provide services to the Arabic community in order to increase mental health awareness.

Latino UsCC subcommittee

The Promotoras de Salud Qualitative Research Study Project was funded to measure the effectiveness of the Promotoras de Salud (Health Promoters) as an Outreach and Engagement strategy to target the Latino

community. The Latino community continues to be the fastest growing ethnic population in the County of Los Angeles and is underserved, inappropriately served, and underrepresented by the public mental health system in the County of Los Angeles. The findings of this research project provided the County of Los Angeles Department of Mental Health with culturally-specific or culturally-defined recommendations related to Outreach and Engagement strategies for the Latino community. In addition, the finding and data of this research project will be utilized to recognize the Mental Health Promoters Model as an effective Community Defined Evidence, Practice-Based Evidence, and/or Promising Practice Model within the public mental health system. The findings of this study serves as a stepping stone to address mental health disparities for this underserved groups.

Latino Media Outreach Campaign: The media outreach campaign consisted of Advertisements (Ads) and PSAs that aired on the local Spanish-speaking television and radio stations to increase awareness of mental health issues and community resources. The television and radio commercials aired on a daily basis between December 10, 2015 and January 3, 2016 on the local Spanish stations. The Ads aired on KMEX on television and KLVE-FM on the radio. This project was implemented on October 1, 2015 and was successfully completed by January 3, 2016.

Outcomes

- The KMEX report shows that 17.9% of Spanish-speaking adults over the age of 18 in the Los Angeles market were reached.
- The KLVE-FM report shows 36.4% of Spanish-speaking adults over the age of 18 in the Los Angeles market were reached.
- Tarzana Treatment Center's Latino ICP-ISM Program service capacity was increased as a result of this project.

Latino 2016 National Mental Health Awareness Month Media Outreach Campaign:
This Media Campaign aimed to promote mental health services and increase the capacity of the public mental health system in the County of Los Angeles. Univision Communications, Inc. was contracted to launch this Media Campaign that included TV, Radio and Digital elements. In total, 99 commercials, billboards, PSA's, News integrations, and Digital elements (Banners, Takeovers, and Social Media) were delivered. The advertisements were aired 26 times on television (KMEX – Channel 34) and 69 on radio (KLVE-FM). Further, a twenty five (25) minute Public Service Announcement pertaining to mental health was recorded and aired on four different local Spanish speaking radio stations (KSCA, KRCD, KTNQ, and KLVE). As an added value to this campaign, a 3-minute mental health information segment called, "Una Mente, Una Vida" aired during the local 11 pm Nightly News Broadcast.

Outcomes

- The KMEX report shows that the television campaign delivered a total of 2,853,000 impressions (the total number of times households were exposed to the commercials) from viewers ages 18 and above.
- The KLVE-FM report shows that the radio campaign delivered a total of 2,636,400 impressions from viewers ages 18 and above.
- The online rotating media that includes Homepage Takeover and Social Media Post delivered a total of 60,809 impressions from viewers 18 and above.
- A gross total of 5,550,209 impressions were delivered from viewers and listeners ages 18 and above.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning, Intersex, Two-Spirit (LGBTQI2-S) UsCC Subcommittee

Clinical Mental Health Trainings for LGBTQ Youth: Four 2-day clinical trainings were conducted to educate and improve the therapeutic skills of licensed mental health clinicians who provide mental health services to LGBTQ youth. This training provided a total of twelve (12) Continuing Education Units for mental health clinicians. The trainings were offered in Service Areas 2, 4, 6, and 8. This project was implemented on October 1, 2015 and was completed on April 1, 2016.

Outcomes

A total of 130 licensed mental health clinicians were successfully trained by the end of this project. Pre and post-test surveys were administered at each of the trainings to measure knowledge about LGBTQ concepts, terminology and unique challenges and risks for this population. The results are summarized below:

- 114 pre-test and 105 post-test surveys were collected.
- Post-test results indicated that participants had an improved understanding of what defines sexual orientation. Scores improved from 41% on the pre-test to 60% on the post-test.
- Participants showed improvement on the question related to how to create a LGBTQ-affirming environment, with an increase of 19% from pre to post-test.
- There was an 8% overall increase in knowledge across the four Service Areas (2, 4, 6, and 8) from pre-test to post-test. The highest increase was in SA 8 (17%).

LGBTQI2-S Survey: A survey was distributed via email to all DMH directly operated and contracted providers' employees, which included clinical staff, managers, supervisors, and administrative supportive staff. The purpose of the survey was to: assess training needs for mental health staff serving the LGBTQI2-S population in the County of Los Angeles, help with the development of capacity building projects specific to the LGTBQI2-S community, and inform the public mental health system of training needs. The survey was anonymous, voluntary, and the data was captured using Vovici.

Outcomes

- Total number of survey participants was 1,054.
- Of those, 720 surveys were completed (334 were started, but not completed and as a result, partial data was captured).
- Raw data numbers indicate that there is a need for programs to serve the LGBTQI2-S community.
- Raw data numbers indicate that there is a need for employees in all categories to receive training on issues specific to the LGBTQI2-S community

HOMELESS OUTREACH AND MOBILE ENGAGEMENT TEAM (HOME)

Formerly known as HOET, HOME provides field-based and dedicated outreach and engagement services to the most un-served and under-served of the homeless mentally ill population in Service Area 4 and 6. In this capacity its staff function as the 'first link in the chain' to ultimately connect the homeless mentally ill individual to recovery and mental health wellness services through a collaborative effort with other care giving agencies and county entities. HOME serves predominantly adults and TAY by providing intensive case management services, linkage to health services, substance abuse, mental health, benefits establishment services, transportation, assessment for inpatient psychiatric hospitalizations, and any other services required in order to assist the chronically homeless and mentally ill across gender, cultural and linguistic diversity.

CROSSOVER YOUTH MULTI-DISCIPLINARY TEAM

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

- Review available records of referred youth related to mental health, child welfare, and Probation history. Records will include, but will not be limited to: court files, police reports, current and past mental health reports, Individualized Education Plans (IEPs), psychiatric hospital discharge summaries, and DCFS court reports. Records will be reviewed for the purpose of providing information to the other MDT members during the meetings and for writing reports.
- Consult with case-carrying Children's Social Worker and the assigned Deputy Probation Officer, as well as attorneys, children's advocates, and others on the multi-disciplinary team.
- Conduct comprehensive mental health evaluations of referred youth (when permitted within the guidelines of the multi-disciplinary team) and prepare written reports of findings and recommendations that are then presented to the delinquency judicial officer to assist them with disposition.
- Participate in multi-disciplinary team meetings to discuss findings and recommendations and appear in juvenile delinquency court hearings as requested.

See Appendix IV for a Summary of Findings for the Los Angeles County 241.1 Multidisciplinary Team.

SERVICE AREA OUTREACH & ENGAGEMENT (AS REPORTED BY THE SERVICE AREAS)

Service Area 1 - Antelope Valley

Service Area 1 (SA1) reports several successful events organized by the Service Area 1 Outreach and Engagement (O&E) team. Many of these events involved collaboration with schools, businesses and community organizations. SA 1 outreached to SAM's Club, San Joaquin Valley College, Wells Fargo banking, as well as, to the clergy providing ministries in the community. SA 1 coordinated a Health Summit, an interactive program, which brought together faith, health, and mental health community leaders to discuss topics related to the needs of the aging seniors in the community and the role faith-based institutions play in their lives. The interactive program was designed to create a meaningful peer learning environment without judgement. Through this joined outreach, DMH has created an ongoing collaboration with the Antelope Valley Health Summit and plan to participate in further joined events to better service the Antelope Valley community. The purpose of the event is to acquaint and remind the seniors, caregivers and the community at large of the insurmountable resources and health care services in the Antelope Valley. In addition to the Antelope Valley Summit, SA 1 provided outreach and engagement at the Harvest Festival, Annual Health and Senior Resource Fair, Care 1st/Back to School Resource event, Antelope Valley Re-Entry Fair and the Health & Wellness Expo (YMCA). SA 1 outreach and engagement team also collaborated in the Homeless Outreach event which addressed some medical and dental needs for approximately 200 homeless residents. Through their efforts, the SA 1 outreach and engagement team expanded and strengthened knowledge in the Antelope Valley community of MHSA resources and provided linkage and referrals to the Department of Mental Health for services.

Service Area 2 - San Fernando

Service Area 2 (SA 2) planned, organized and joined many outreach and engagement activities to educate the community on available MHSA resources and services provided at the Department of Mental Health. SA 2 developed successful community workshops and presentations that were attended by educators, consumers, community leaders, law enforcement, and family members of consumers. Some efforts were to present information on resources at events such as, but are not limited to, LGBTQ Fair, presentations to LAPD, CVS Pregnancy Center workshop, Cultural Competency Committee Presentation, Wise and Healthy Aging Presentation, LA CARE Family Resource Center presentation and distributed information at the 10th Annual Promising Practices Conference for Older Adults. SA 2 will continue to distribute information on MHSA resources and educate the communities in the San Fernando Valley area on mental health awareness.

Service Area 3 - San Gabriel

Throughout the year, the Outreach and Engagement (O & E) team from Service Area 3 (SA 3), which is comprised of the San Gabriel and Pomona Valleys, has joined with several local organizations to disseminate information by establishing resource booths (information tables) which contain a wealth of MHSA resources to assist the community access to DMH programs and services. On Saturday May 21st, 2016, the O & E team partnered with Congresswoman Grace Napolitano, Kaiser Permanente, Sunburst Youth Academy Foundation and LA Laker Metta World Peace to promote mental health awareness month

by planning and organizing an outreach event at the El Monte Airport (pictured below). The event featured special guests, performances, informational booths and free mental health resources. Metta World Peace spoke openly about his journey and struggle with mental illness and answered questions from the audience. Other events included, but not limited to, the Adelante Conference, San Gabriel Valley Youth Summit, Mental Health Commission Meeting, Faith Based Advocacy Council, Japanese American Family Health Fair, Symposium on Death Dying Grief and the Brown Memorial Temple-Mental Health 101 Training. In addition, the SA 3 outreach and engagement team participated in the 15th Annual Conference on Mental Health and Spirituality, Consortium on Asian American Mental Health Training, Viva Open Street Fair, and Supervisor Solis' Pomona Field Office Grand Opening Celebration and continues to host monthly clergy meetings and clergy roundtable to educate the faith-based community and promote mental health awareness.

Service Area 4 - Metro

Service Area 4 (SA 4) Outreach and Engagement Team reported huge strides and success in building relationships with the Korean Community. The SA 4 outreach and engagement team collaborated with Korean Clergy, in an effort to address the number of suicides in the community, language barriers and established partnerships between the clergy, community and Department of Mental Health. Mr. Edward Vidaurri, retired Mental Health District Chief for SA 4, understood that addressing the needs of the Korean speaking community required a bilingual staff member with bicultural understanding of the community. Therefore, he hired a Korean speaking staff member to work in the community and to create a professional relationship with the Korean clergy. Mr. Vidaurri focused on partnering with the Korean faith community to successfully address the barriers. Ms. Jung Ahn, LCSW, was hired to work with and develop the Korean clergy and the community's understanding of mental health and MHSA services. The Korean clergy meets bimonthly and at times draws over 100 participants. To date, SA 4 is the only service area that has developed a Korean Clergy meeting which serves as a portal for partnering with the clergy and the community to address the needs of this unserved and underserved ethnic group. The clergy meetings were developed and facilitated in English, Spanish and Korean languages. Each meeting is announced and publicized by the various media outlets in the Korean community newspapers, radio and TV stations.

In the course of her work organizing and conducting Korean Clergy Meetings, Ms. Ahn was contacted by and interviewed by "*Radio Korea"*, a local Los Angeles Korean language radio station. Her interview and the information she provided was so well received by the members in Korean community that as a result, "*Radio Korea"* asked Ms. Ahn to be a regular panelist for another talk show. This later led to the creation of a new weekly talk show, "Healing Garden", on "*Radio Korea"* (AM 1540). Ms. Ahn's talk show has been the most popular talk show in the Korean Community, as she provides resources and information to her listeners regarding mental health issues. By means of this show, Ms. Ahn has discussed mental health

issues that affect individuals and families and has included, but are not limited to, the issues of stress management, coping skills, communication skills and the stigma of mental illness. During each show, Ms. Ahn receives anywhere from 90 to 100 phone calls, e-mails, and text messages from people all over the state and nationwide. The show has been so successful that that Dr. Marvin Southard reported this accomplishment to Board of Supervisors.

As a direct result of the success of the outreach by LACDMH to SA 4 clergy, DMH has developed and is facilitating 2 Roundtable Meetings with clinicians and clergy, one in the Skid Row area and the other in the Northeast area.

Service Area 5 - West

Service Area 5 (SA 5) outreach and engagement team collaborated with various community organizations to develop successful events, meetings, and community events for underserved and underrepresented population. These events were intended to bring together various faith based organizations to share the MHSA resources available within the community for the homeless population and create an active discussion surrounding the homeless population like the Homeless Panel and the Westside Coalition Community Fair. The SA 5 outreach and engagement team also participated in the Summer Celebration to honor consumers going "From the Streets to Home." The event panelists included 5 Transition Age Youth (TAY) to Older Adult consumers. The panelists were able to share their life stories of being homeless and their journey to becoming housed/having a home. The intent of the panel was to build community based solutions to end homelessness. Service Area 5 panel consisted of a representative from a faith-based organization, Los Angeles Councilmember, Director of the Homelessness Initiative, Pacific Palisades community member who assist homeless individuals and the DMH Countywide Housing Representative. The participants included consumers, family members, support staff, City Council Representatives, and program heads of the various Mental Health Agencies. The panel participants' stories were very moving. This event demonstrated the hard work that community staff/agencies provide to aid in ending homelessness. The panelists and their direct support were honored and provided a certificate for their success. SA 5 goals for the next fiscal year is to continue outreach to churches, expand and increase clergy breakfast participants, and maintain ongoing partnership with agencies to continue in efforts to end homelessness.

Service Area 6 - South

Service Area 6 (SA 6) successfully distributed MHSA resource materials at the Homeless Connect Day: Health and Resource Fair Homeless population. Referral information was distributed regarding mental health services and MHSA resources available in the community, as well as, established network contacts with other outreach communities. SA 6 also distributed information regarding mental health services and resources in the community at the hugely popular CARE HARBOR event coordinated by LA County to promote the health and well-being of underserved populations by providing accessible, sustainable medical, dental and vision care in the community. The Empowerment Congress: Coordinated by Supervisor

Mark-Ridley-Thomas to educate, engage, and empower communities by fostering leadership, capacity building and impact public policy where SA 6 outreach and engagement team provided education, MHSA resources and referral information. In addition, the SA 6 outreach and engagement team diligently outreached to unserved and underserved community members and networked to participate in and provide resources to the Watts Health Fair, Parks After Dark, People Power Conference, and the Homeless Winter Shelter population located at the Testimonial Community Love Center in Los Angeles.

Service Area 7 - East

Service Area 7 (SA 7) have held increasingly successful and well attended meetings with clergy members and mental health Providers in Service Area 7, in order to create a networking opportunity and so that these two groups can help each other to weave spirituality into mental health practice, and assist clergy who encounter mental health problems with their parishioners. SA 7 collaborated with the community clergy to continue to grow and expand this group creating more opportunities for collaboration and helping each other to assist members of the community with both mental health and spirituality issues, in order to enhance each other's work with the community. The groups have grown from being sparsely attended to being very well attended with over 50 audience members in the last few presentations. These included presentations on Juvenile Justice, Domestic Violence, and issues facing Older Adults. In addition to the successful clergy outreach, SA 7 also joined or planned events such as the Interfaith Resource Fair, TeleCare Resource Fair, Signal Hill Senior Center, Community Partnership Meetings and the South Cali Resource Center for Disabled Individuals where the outreach and engagement team continued to provide MHSA resources and educate consumers and the community on available services.

Service Area 8 - South Bay

Service Area 8 (SA 8) organized the Consortium of Parent Partners & Parent Advocate (CAPP) Meeting. Its intended purpose is to bring local contractors, Community Workers, and Parent Partners together to provide a source of information, MHSA funded resources, support services to aid in their daily responsibilities and connect the new Parent Partners with Department of Children and Family Services Parent in Partnerships (DCFS PIP). SA 8 outreach and engagement team secured presenters who would fit the needs of DCFS PIP and joined several resource and health fairs to distribute resources on free eyeglasses, medical/dental appointments, and MHSA information on housing and other mental health services. The outreach and engagement team organized several successful events where training and presentations were provided at, to name a few, Harbor UCLA Health Fair, Regional Community Alliance and the Mental Health and Spirituality Conference. In addition, the SA 8 outreach and engagement team assisted in providing health navigation service to the unserved and underserved community to assist consumers with securing medical care to ensure underlying medical issues does not impact the consumers mental health and physical well-being.

Linkage Services

Jail Linkage & Transition (A-05)

Client Contacts: 35,773

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

Women's Community Reintegration Services and Education Center

The Women's Community Reintegration Services and Education Center (WCRSEC) was established over nine years ago with the intent to serve women with co-occurring mental health and substance use disorders being released from the Women's Lynwood Jail. During the fiscal year in review, the program has additionally provided services to women walking in from the community-at-large or referred through other County Departments co-located in the same building as WCRSEC such as the Department of Child and Family Services (DCFS) and Department of Public Supportive Services (DPSS).

Mental Health Court Program

The Mental Health Court Linkage Program has two sub-programs funded by MHSA:

1) The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) 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 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. Participation is voluntary and available to those 18 and above. Services include on-site courthouse outreach to defendants , individual service needs assessment, informing consumers and the Court of appropriate treatment options, developing diversion, alternative sentencing, and post-release plans that take into account best fit

treatment alternatives and Court stipulations, Linking consumers to treatment programs and expediting mental health referrals, advocating for the mental health needs of consumers throughout the criminal proceedings, and supporting and assisting to defendants and families in navigating the court system.

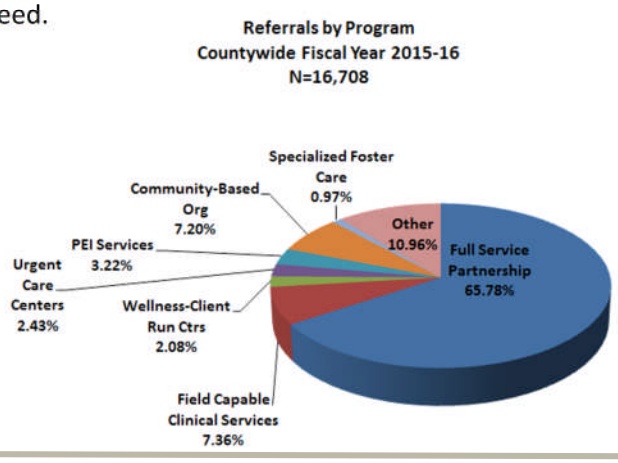
2) The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants with a mental illness including those with co-occurring substance abuse. The goal of the Community Reintegration Program (CRP) and its participating providers is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. The Community Reintegration 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.

Service Area Navigation (SN-01)

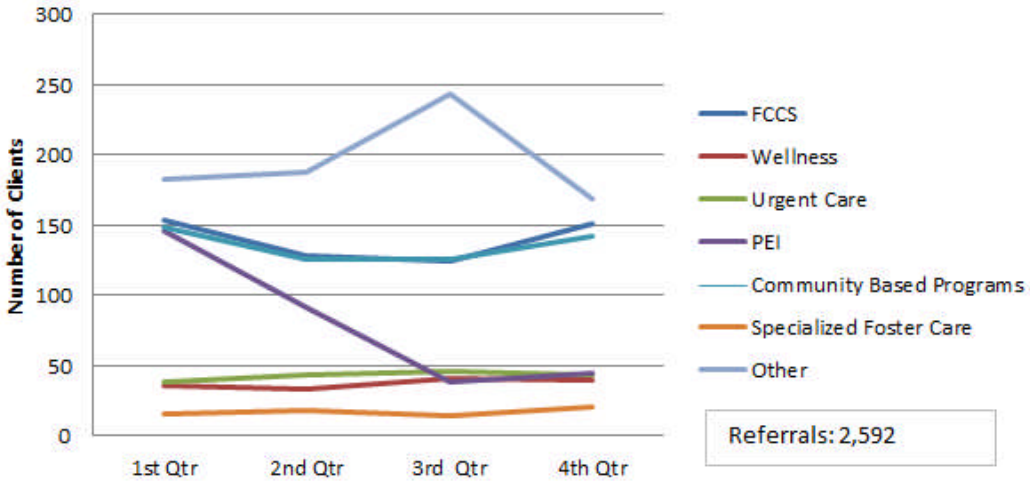
Client Contacts: 16,708

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

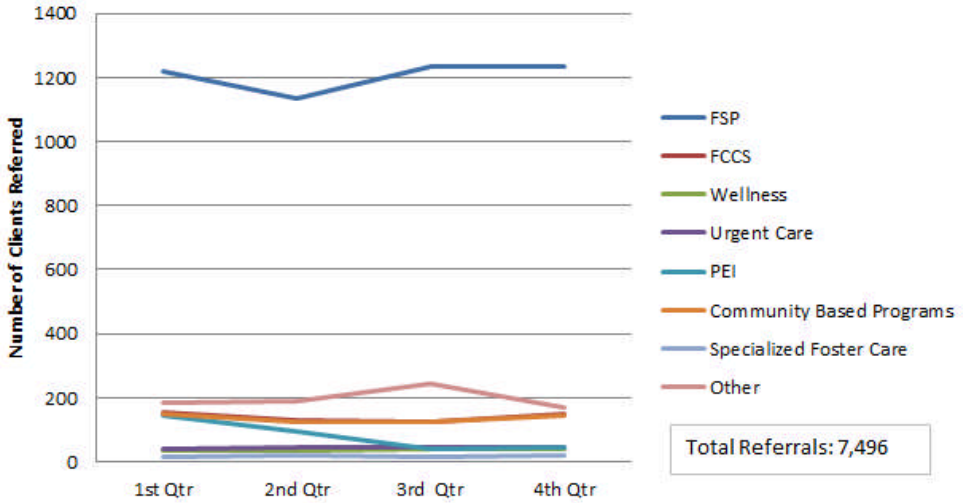
- Engaging in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith-based organizations, and self-help and advocacy groups, with the goal of increasing access to mental health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



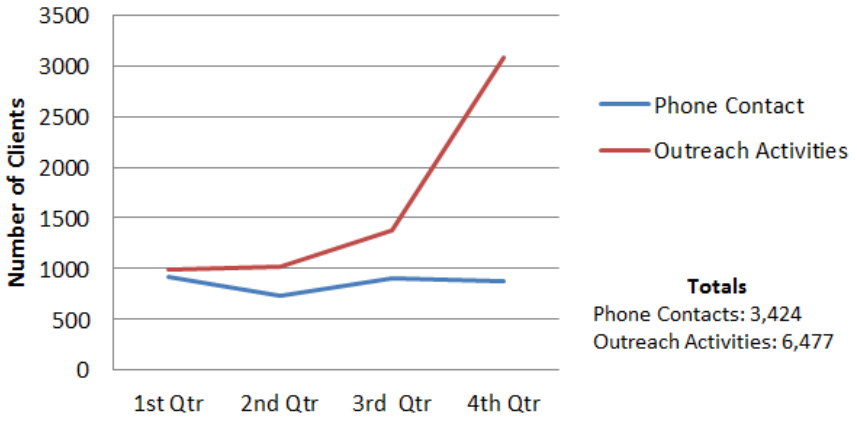
Clients Referred to Services other than FSP in FY 15-16



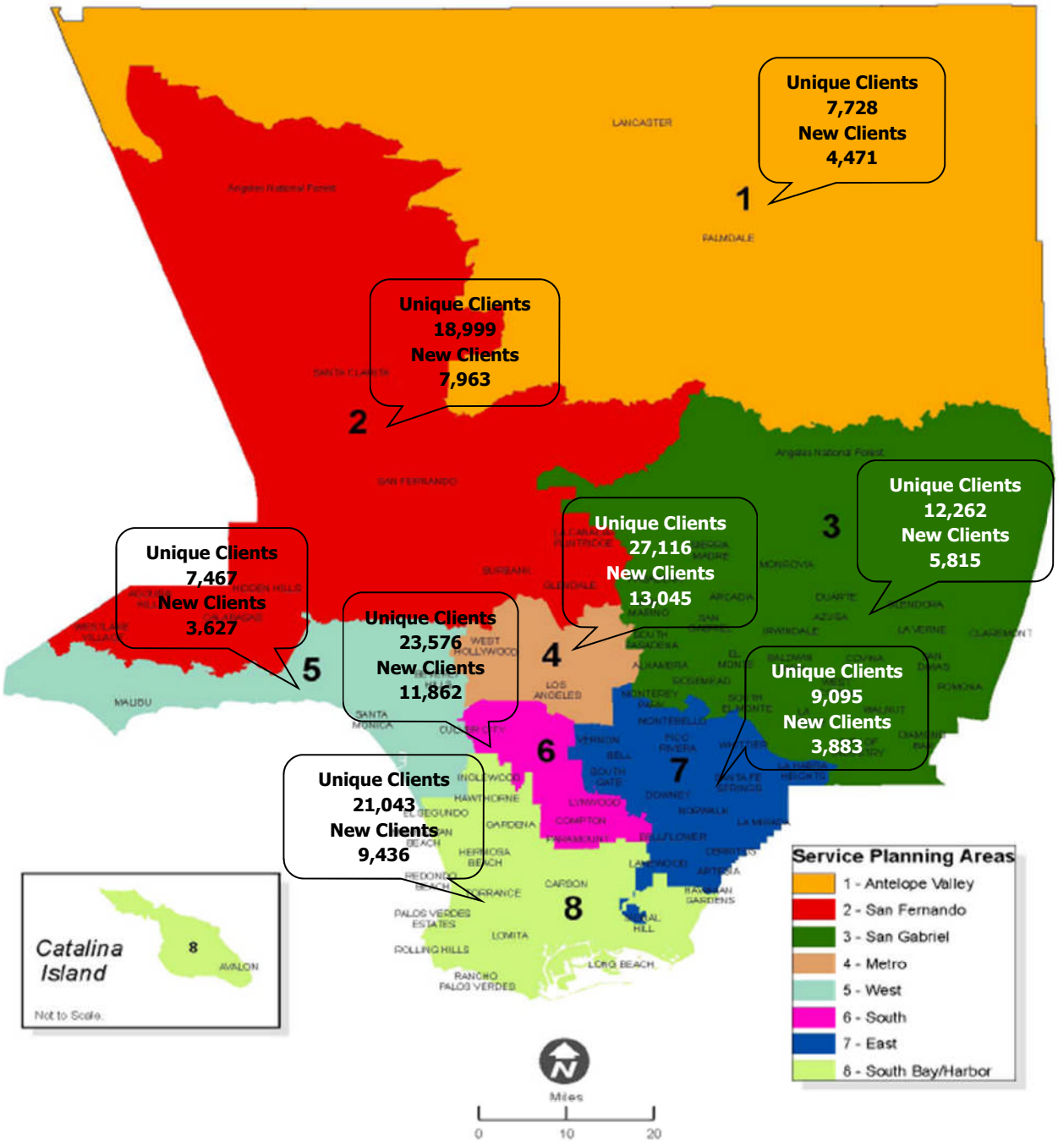
Clients Referred to Services in FY 15-16



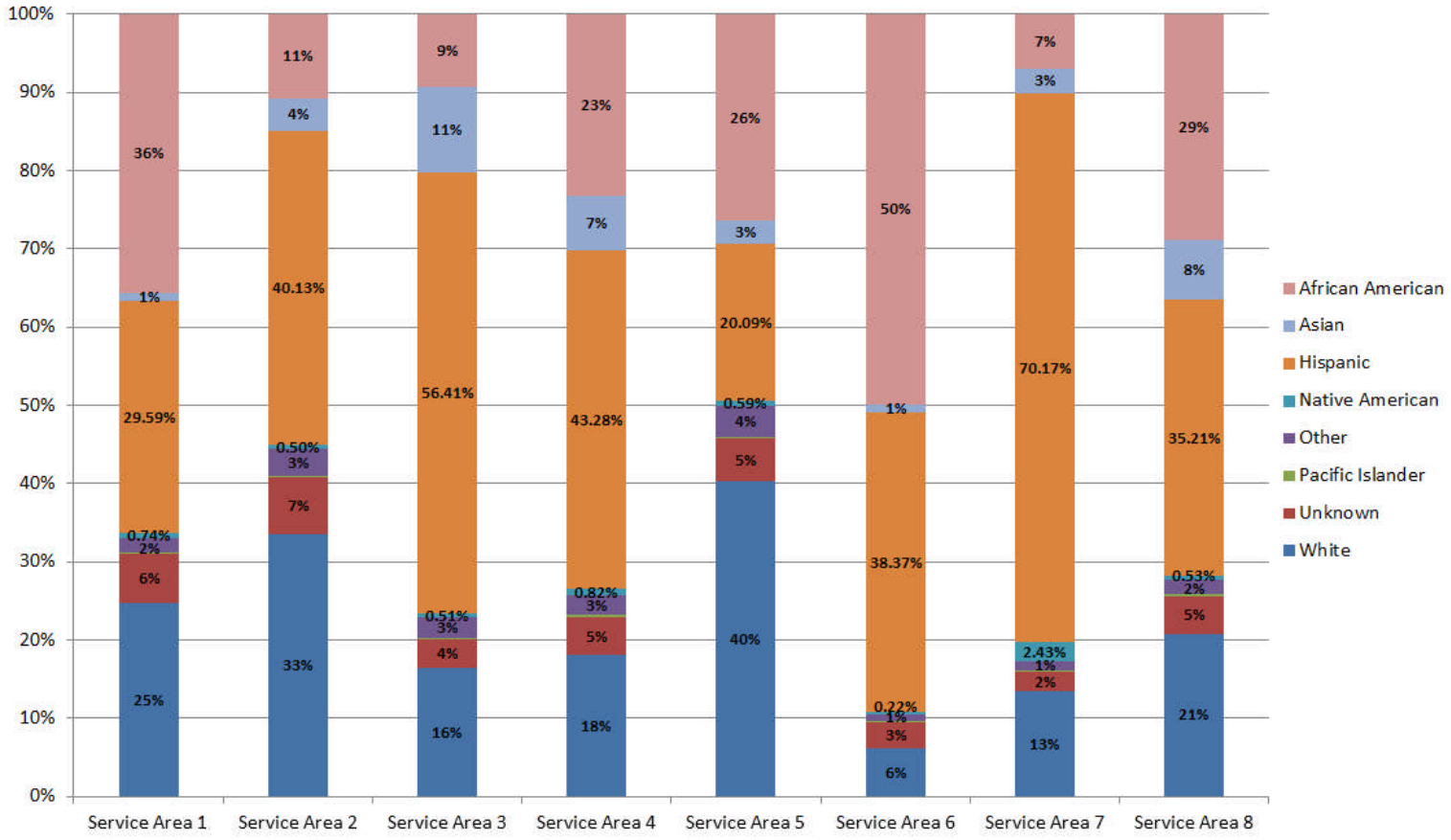
Phone Contacts and Outreach Activities in FY 15-16



Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2015-16



Ethnicity by Service Area



Service Area 1

African-American –36%
Asian – 1%
Hispanic – 30%
Native American– 0.74%
Other – 2%
Pacific Islander – 0.10%
Unknown - 6%
White - 25%

Service Area 2

African-American –11%
Asian – 4%
Hispanic – 40 %
Native American – 0.50%
Other – 3%
Pacific Islander – 0.15%
Unknown - 7%
White - 33%

Service Area 3

African-American –9%
Asian – 11%
Hispanic – 56%
Native American– 0.51%
Other – 3%
Pacific Islander – 0.11%
Unknown - 4%
White - 16%

Service Area 4

African-American –23%
Asian – 7%
Hispanic – 43%
Native American – 0.82%
Other – 3%
Pacific Islander – 0.27%
Unknown - 5%
White - 18%

Service Area 5

African-American – 26%
Asian – 3%
Hispanic – 20%
Native American – 0.59 %
Other – 4%
Pacific Islander – 0.19%
Unknown - 5%
White - 40%

Service Area 6

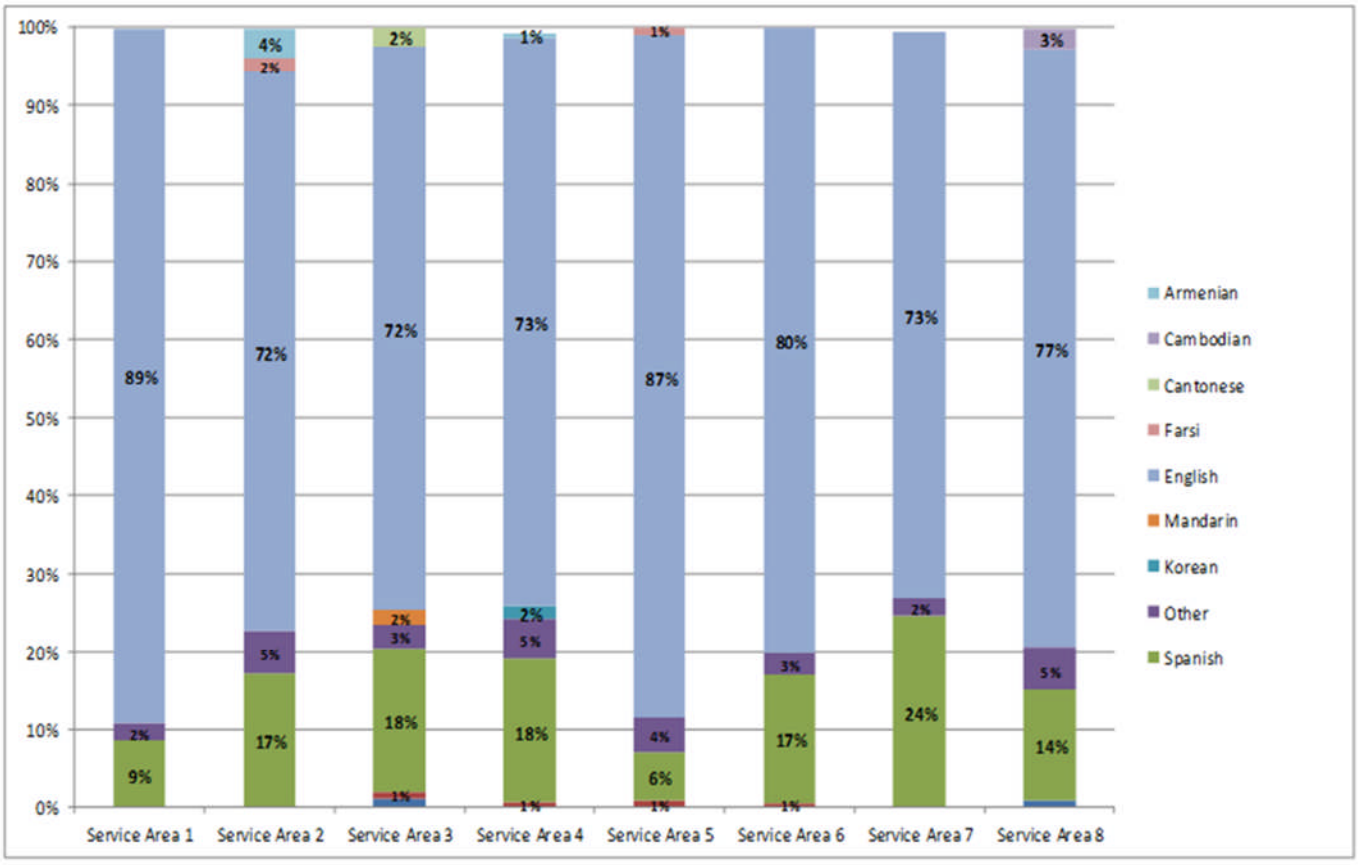
African-American –50%
Asian – 1%
Hispanic – 38%
Native American– 0.22%
Other – 1%
Pacific Islander – 0.13%
Unknown - 3%
White - 6%

Service Area 7

African-American –7%
Asian – 3%
Hispanic – 70%
Native American– 2%
Other – 1%
Pacific Islander – 0.25%
Unknown - 2%
White - 13%

Service Area 8

African-American –29%
Asian – 8%
Hispanic – 35%
Native American – 0.53%
Other – 2%
Pacific Islander – 0.40%
Unknown - 5%
White - 21%



Service Area 1
English - 89%
Spanish - 9%
Unknown/Not Reported - <0%
Other - 2%

Service Area 2
English - 72%
Spanish - 17%
Armenian - 4%
Farsi – 2%
Unknown/Not Reported - <0%
Other - 5%

Service Area 3
English - 72%
Spanish - 18%
Cantonese - 2%
Unknown/Not Reported - 1%
Other - 3%
Vietnamese - 1%
Mandarin - 2%

Service Area 4
English - 73%
Spanish - 18%
Unknown/Not Reported - 1%
Other - 5%
Korean - 2%
Armenian - 1%

Service Area 5
English -87%
Spanish - 6%
Unknown/Not Reported - 1%
Farsi - 1%
Other - 4%

Service Area 6
English - 80%
Spanish - 17%
Unknown/Not Reported - 1%
Other - 3%

Service Area 7
English - 73%
Spanish - 24%
Unknown/Not Reported - <0%
Other - 2%

Service Area 8
English - 77%
Spanish - 14%
Cambodian - 3%
Unknown/Not Reported - <0%
Other - 5%
Vietnamese - 1%
Korean - 1%

CSS Work Plan Consolidation

The original CSS plan was organized according to age group and over the course of the last 10 years has grown to 6 work plans for adults, 5 for children, 5 for Transition Age Youth (TAY), 5 for older adults and 3 cross-age group plans. Each of those 24 work plans represents a financial category for purposes of budgeting and claiming. The Department's consolidation of these 24 work plans into 6 represents an administrative simplification of the CSS Plan as well as creating greater service continuity without modifying program expectations, intentions or service capacity.

POE	FSP	Alternative Crisis Services	Recovery, Resilience & Reintegration Services (Non-FSP)	Linkage	Housing
• POE Teams	• FSP • FCCS (part of) • Family Support Services (C) • Family Crisis/Respite Care (C) • Housing FSP	• Residential & Bridging • Urgent Care Centers • IMD Step Down/Enriched Residential Services (A) • Countywide Resource Management • Mental Health-Law Enforcement Partnerships (MHSA funded)	• FCCS (part of) • Wellness/Client Run Centers (A) • TAY Drop In Centers • Probation Camp Services (T) • TAY Supported Employment • Family Wellness Resource Centers (C) • Integrated Care Programs • Crisis Resolution Services • Service Extenders (OA)	• Jail Linkage & Transition (A) • Service Area Navigation	• Housing for TAY and Adult • Housing specialists • MHSA Housing Program/Special Needs Housing Program • Housing Trust Fund • Housing support team for No Place Like Home

(A) - Adults **(C) - Children** **(T) - Transition Age Youth** **(OA) - Older Adult**

Consolidated CSS Work Plans

Community Integrated Recovery & Resiliency Services Consolidated Work Plans:

- C-05: Field Capable Clinical Services
- T-02: Drop-in Centers
- T-04: Probation Services
- T-05: Field Capable Clinical Services
- T-06: TAY Supported Employment Services
- T-07: TAY Self-Help Support Groups
- A-02: Wellness/Client-run Centers
- A-06: Field Capable Clinical Services
- A-07: Integrated Care Program
- OA-03: Field Capable Clinical Services
- OA-04: Service Extenders

FSP Consolidated Work Plan(s):

- C-01: Children Full Service Partnership
  - Wraparound
- C-02: Family Support Services
- C-04: Family Crisis Services: Respite Care
- T-01: TAY Full Service Partnership
  - Wraparound
- A-01: Adult Full Service Partnership
  - Forensic FSP
  - AOT-LA FSP
  - IMHT - FSP
- OA-01: Older Adult Full Service Partnership

Alternative Crisis Services Consolidated Work Plans:

- ACS-01: Alternative Crisis Svc
  - ACS-01a: Urgent Care Centers
  - ACS-01b: Countywide Res Management
  - ACS-01c: Res & Bridging Services
  - ACS-01d: Enriched Residential Services
- A-03: IMD Step-down facilities
- MHLE-01: Mental Health Law Enforcement Team

Housing Consolidated Work Plans:

- A-04: Adult Housing Services
- T-03: TAY Housing

Planning, Outreach and Engagement Work Plan:

- P-01:Planning, Outreach and Engagement

Linkage Consolidated Work Plans:

- A-05: Jail Transition/Linkage
- SN-01:Systems Navigators

Broadening the Scope of Full Service Partnership Programs

The Department broadened the criteria for enrollment into a FSP program by operationalizing “at risk” categories listed in the MHSA CSS regulations. Below is a summary of the criteria in the CSS regulations and how those criteria were operationalized as entry criteria for FSP:

Children

State Criteria
Individuals selected for participation in the FSP Category must meet the eligibility criteria in Welfare and Institutions Code (WIC) Section 5600.3(a) for children and youth: *WIC Section 5600.3(a):* (a)(1) Seriously emotionally disturbed children or adolescents. (2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria: (A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur: (i) The child is at risk of removal from home or has already been removed from the home. (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment. (B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder. (C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Current FSP Criteria: A child with Serious Emotional Disturbance (SED)			
Children zero to five (0-5) who: • Is at high risk of expulsion from pre-school • Is involved with or at high risk of being detained by DCFS • Has parent/caregiver with SED or severe and persistent mental illness, or who has a substance abuse disorder or co-occurring disorders	**Child/youth who:** • Has been removed or is at risk of removal from their home by DCFS • Is in transition to a less restrictive placement	**Child/youth who is experiencing the following at school:** • Suspension or expulsion • Violent behaviors • Drug possession or use • Suicidal and/or homicidal ideation	**Child/youth who:** • Is involved with probation, and is transitioning back into a less structured home/community setting, or is at risk of entering a restrictive setting

Proposed Expansion of FSP Focal Population Criteria for Children			
Children zero to five (0-5) who: • are at risk of expulsion from pre-school (e.g. past suspensions)	**Children/Youth who are unable to function in the home and/or community setting and:** • have psychotic features • have suicidal and/or homicidal ideation • have violent behaviors • have had a recent psychiatric hospitalization(s) within the last six months • have Co-Occurring Disorder (e.g. substance abuse, developmental or medical disorder) • are transitioning back to a less structured home/community setting (e.g. from Juvenile Hall and/or Group Home placement) • are at risk of becoming or who are currently homeless (e.g. eviction, couch surfing, domestic violence, parent unemployment)	**Children/Youth who:** • are at risk of or have already been removed from the home by DCFS (e.g. seven day notices or multiple placement history) • are at risk of or are currently involved with the Juvenile Justice system (e.g. contact with law enforcement and/or Juvenile Hall entries) • are at risk of or are currently a victim of Commercially Sexually Exploited Children (e.g. youth having multiple sexual partners)	**Children/Youth who are experiencing the following at school:** • truancy or sporadic attendance (e.g. tickets, School Attendance Review Board) • suspension or expulsion • failing classes

TAY, Adult and Older Adult State FSP Criteria

<table>
<tr><th>Age Group</th><th colspan="2">Criteria</th></tr>
<tr><td rowspan="2">TAY</td><td colspan="2">They are unserved or underserved and one of the following:</td></tr>
<tr><td colspan="2">• Homeless or at risk of being homeless
• Aging out of the child and youth mental health system.
• Aging out of the child welfare systems.
• Aging out of the juvenile justice system.
• Involved in the criminal justice system.
• At risk of involuntary hospitalization or institutionalization.
• Have experienced a first episode of serious mental illness.</td></tr>
<tr><td rowspan="3">Adult</td><td colspan="2">Must meet the criteria in either (1) or (2) below:</td></tr>
<tr><td>(1) Unserved and one of the following:</td><td>(2) Underserved and at risk of one of the following:</td></tr>
<tr><td>• Homeless or at risk of becoming homeless.
• Involved in the criminal justice system.
• Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.</td><td>• Homelessness.
• Involvement in the criminal justice system.
• Institutionalization.</td></tr>
<tr><td rowspan="3">Older Adult</td><td colspan="2">Must meet the criteria in either (1) or (2) below:</td></tr>
<tr><td>(1) Unserved and one of the following:</td><td>(2) Underserved and at risk of one of the following:</td></tr>
<tr><td>• Experiencing a reduction in personal and/or community functioning.
• Homeless.
• At risk of becoming homeless.
• At risk of becoming institutionalized.
• At risk of out-of-home care.
At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.</td><td>• Homelessness
• Institutionalization.
• Nursing home or out-of-home care.
• Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment.
• Involvement in the criminal justice system.</td></tr>
</table>

Current FSP Criteria and Operationalizing "At Risk" for TAY, Adult and Older Adult

TAY

<table>
<tr><th colspan="3">Current Criteria: TAY must have a Serious Emotional Disturbance (SED) and/or Severe and Persistent Mental Illness (SPMI)</th></tr>
<tr><td>Youth aging out of:
Child mental health system
Child welfare system
Juvenile justice system</td><td>Youth leaving Long-term Institutional Care:
Level 12-14 group homes
Community Treatment Facility
Institution of Mental Disease
Jail
State Hospital
Probation Camps</td><td>Youth experiencing their first psychotic break</td></tr>
<tr><td colspan="3">Co-Occurring substance abuse disorder in addition to meeting at least one of the TAY focal population criteria identified above.</td></tr>
<tr><td colspan="3">Homeless or currently at risk of homelessness
Chronically homeless</td></tr>
</table>

Operationalizing At Risk/Expansion of Focal Population Criteria
At risk of homelessness: Unstable, sporadic housing/multiple placements
Currently involved Commercial Sexual Exploitation of Children Youth (CSECY) or youth with a history of CSEC involvement

Adult

<table>
<tr><th colspan="2">Current Criteria:</th></tr>
<tr><td>Homeless
Jail
Living with family members without whose support the individual should be at imminent risk of homelessness, jail or institutionalization</td><td>Institution Type:
Institution for Mental Disease (IMD)
State Hospital
Psychiatric Emergency Services
Urgent Care Center
County Hospital
Fee for Service Hospital</td></tr>
</table>

Operationalizing At Risk/ Expansion of Focal Population Criteria		
Homelessness An adult who is unable to live to the requirements of their lease, as evidenced by the following and not limited to: • Loss of funding which will impact sustained housing • Hoarding, that will lead towards eviction • Ten day notice to vacate • Symptoms of illness which impact the ability to keep stable housing • History of destruction of property • Unable to maintain current living arrangement • Ongoing conflict with neighbors and/or landlord • Couch surfing /living in car less than 120 days • Inability to pay bills, budget, shop and cook without support	**Criminal Justice System** Factors that may contribute to an adult at risk of involvement with the criminal justice system include but are not limited to the following: • Engagement in unlawful and risky behavior • Unable to pay fees (i.e. parking tickets, jay walking tickets, court fees, etc. • Presence of warrants • Two or more contacts with law enforcement in the past 90 days • Inability to follow requirements of probation	**Psychiatric Hospitalization** Factors that may contribute to an adult at risk of psychiatric hospitalization include but are not limited to the following: • At least one encounter with an emergency outreach team, in the past 90 days • Two or more visits to a psychiatric emergency room in the past 90 days • Two or more visits to a Psychiatric Urgent Care Center in the past 90 days • Two or more visits to a Medical Emergency Room for a psychiatric disorder in the last 90 days

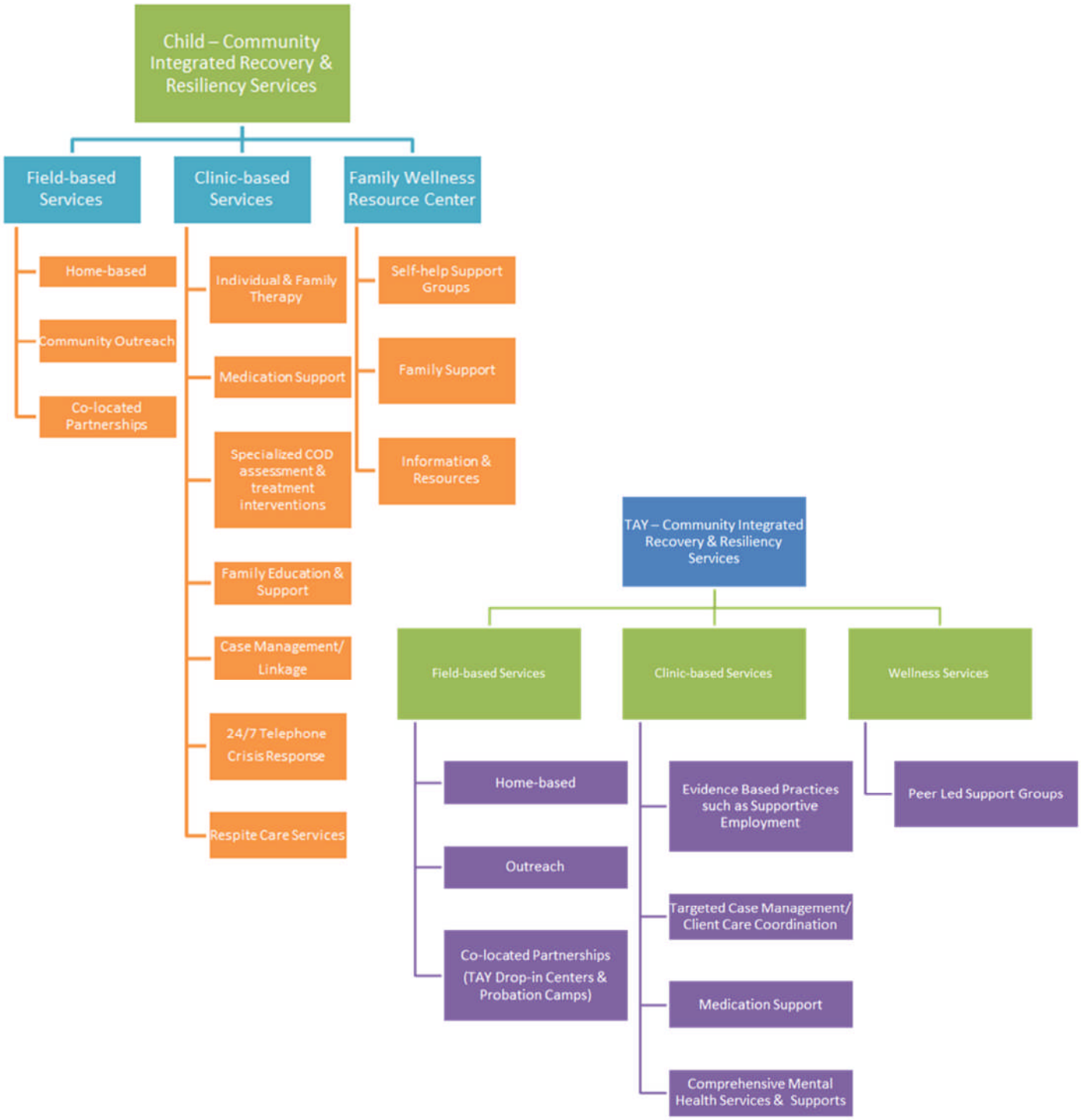
Older Adult

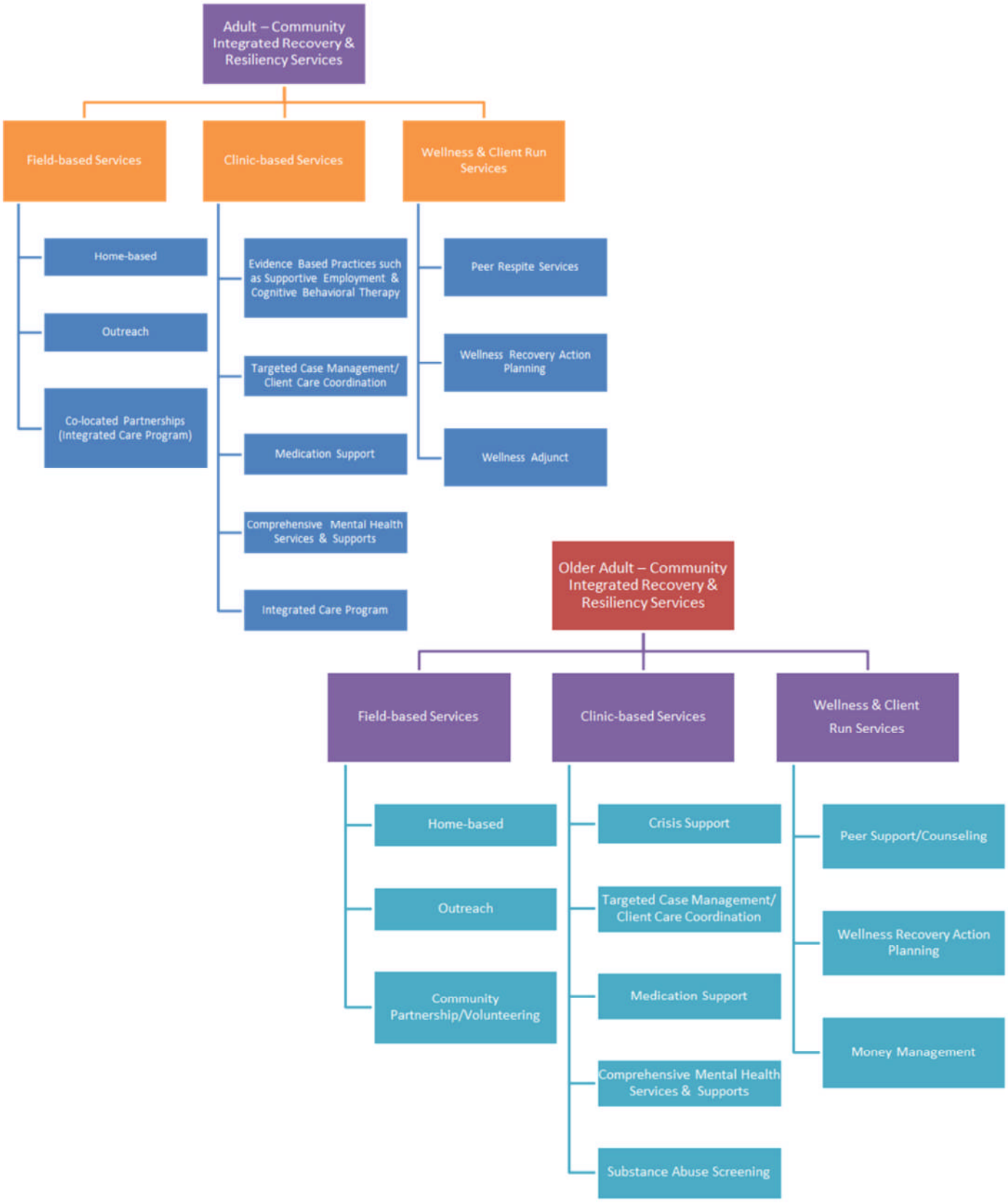
Current Criteria: Reasons for Referral of an older adult with Serious Mental Illness	
• Homelessness • Incarceration • Hospitalization • At imminent risk of homelessness • Risk of going to jail • Imminent risk for placement in a Skilled Nursing Facility (SNF) or Nursing Home • Being released from SNF/Nursing Home	• Presence of a Co-occurring disorder o Substance Abuse o Developmental Disorder o Medical Disorder o Cognitive Disorder • Client has a recurrent history or is at risk of abuse or self-neglect who are typically isolated • Serious risk of suicide (not imminent)

Operationalizing At Risk/ Expansion of Focal Population Criteria			
Hospitalization • Untreated or inappropriately treated mental health, health and/or substance use conditions • Suicidal ideation or attempts • Failure to coordinate and take both health and psychotropic medications as prescribed • Limited or no social, family and/or community support • Limited or no connection to non-emergency community services • Food and income insecurity	**Institutionalization** • Current community setting or placement does not adequately meet their physical, social, psychological, health or other needs • Lack of a support system and access to supportive services (IHSS, peer support etc.) • Multiple chronic health conditions along with a mental health condition	**Out of Home Placement** • Often involves family members and others not being comfortable providing care and/or support due to the nature or severity of physical, psychological and/or substance use conditions • Limited or no social and/or family support. • Fall risk, due to chronic health conditions and numerous medications (unsteady gait, decreased vision and difficulty ambulating on uneven surfaces)	**Incarceration** • Do not have a meaningful way in which to spend their time (volunteer, work, recreation etc.) • Limited or no income • Inadequate or no housing • Inadequate access to mental health, health and substance use services • Prior legal/incarceration history • Little or no family or social support • Absence of peer and other social supports

Beyond FSP: Community Integrated Recovery & Resiliency Services (CIRRS)

For children, TAY, adults and older adults with already established mental illnesses, an array of services will be available, comprising field-based services, clinic-based services and wellness or peer run services. Below is an overview of the service array by age group:



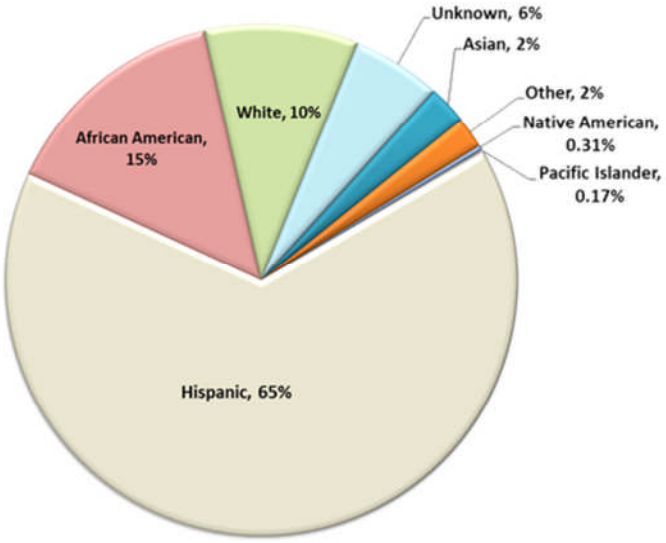

Adult – Community Integrated Recovery & Resiliency Services
Field-based Services
Clinic-based Services
Wellness & Client Run Services
Home-based
Outreach
Co-located Partnerships (Integrated Care Program)
Evidence Based Practices such as Supportive Employment & Cognitive Behavioral Therapy
Targeted Case Management/ Client Care Coordination
Medication Support
Comprehensive Mental Health Services & Supports
Integrated Care Program
Peer Respite Services
Wellness Recovery Action Planning
Wellness Adjunct
Older Adult – Community Integrated Recovery & Resiliency Services
Field-based Services
Clinic-based Services
Wellness & Client Run Services
Home-based
Outreach
Community Partnership/Volunteering
Crisis Support
Targeted Case Management/ Client Care Coordination
Medication Support
Comprehensive Mental Health Services & Supports
Substance Abuse Screening
Peer Support/Counseling
Wellness Recovery Action Planning
Money Management

Ensuring Quality and Accountability

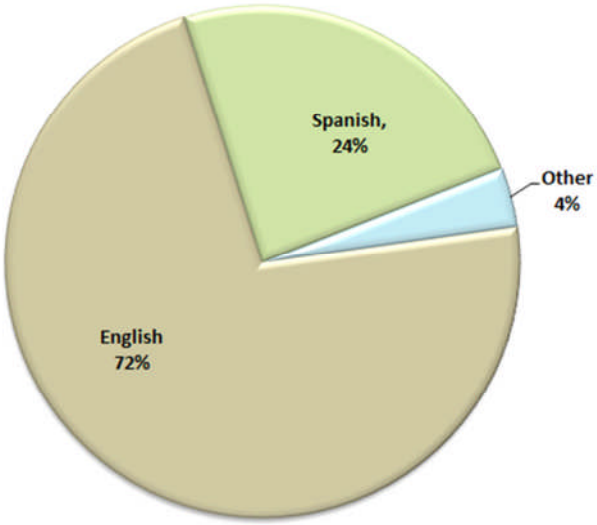
Effective July, 2017 the Department will implement a level of care approach for each age group in order to track client progress toward recovery and transition to community or natural supports. In addition, each age group will select one or more outcomes to use at designated treatment intervals to measure the effectiveness of Community Integrated Recovery and Resiliency Services. Finally, outcome benchmarks will be established as a quality improvement strategy. Work groups will be re-initiated in January, 2017 to inform this work.

The number of unique clients receiving a direct mental health service through the PEI Plan: 45,288

Ethnicity

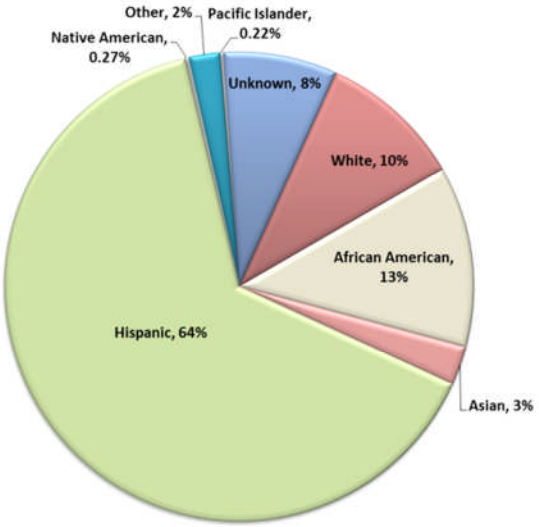


Primary Language

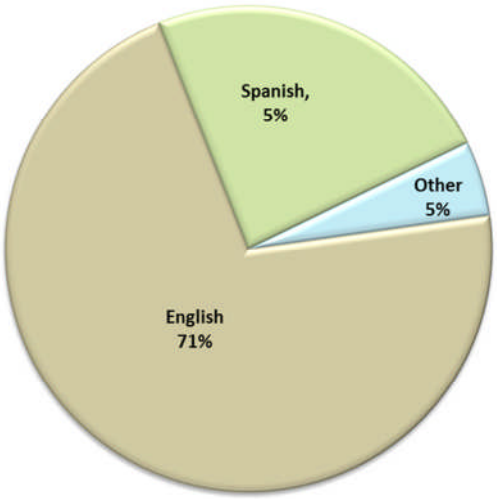


The number of new clients receiving PEI services Countywide with no previous MHSA Service: 23,864

Ethnicity



Primary Language



Suicide Prevention

PEI Early Start-Suicide Prevention: ES-1

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

LATINA YOUTH PROGRAM:

The primary goals of Pacific Clinics' School Based Services for the Latina Special Program are: To promote prevention and early intervention for youth to decrease substance use and depressive symptoms, which are major risk factors for suicide; Increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services; Increase access to services while decreasing barriers and stigma among youth in accepting mental health services; Increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion; Enhance awareness and education among school staff and community members regarding substance abuse and depression.

The agency's coordination of collaborative relationships with schools, private and public agencies, as well as other community-based organizations continue to allow it to successfully leverage many services and resources for the benefit of program participants. One of the most important aspects of the collaborative effort is the reduction of barriers and increase in access to mental health services by the community in general and children and adolescents in particular. One way in which this has been achieved is by locating the program at school sites and providing services at locations and times convenient to the program participants and their families. The services are provided at no cost to the participants and that they are provided by staff that is both culturally and linguistically competent further enhances the participants' accessibility to treatment.

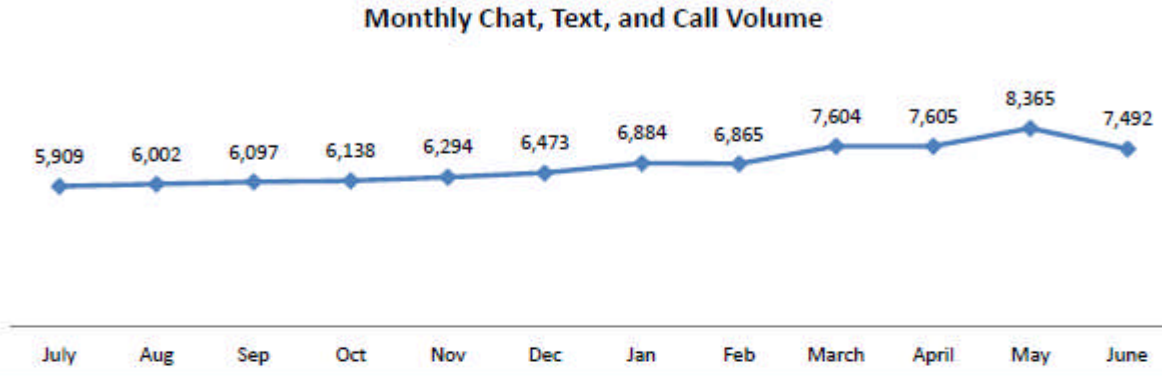
For FY 2015-16, the program provided services to 193 students who had open cases. With regard to gender, 56% were female and 46% were male. The program's staff provided crisis and urgent services as well as preventive activities such as outreach and education to 1,114 contacts. (See Appendix VI for full report)

24/7 CRISIS HOTLINE:

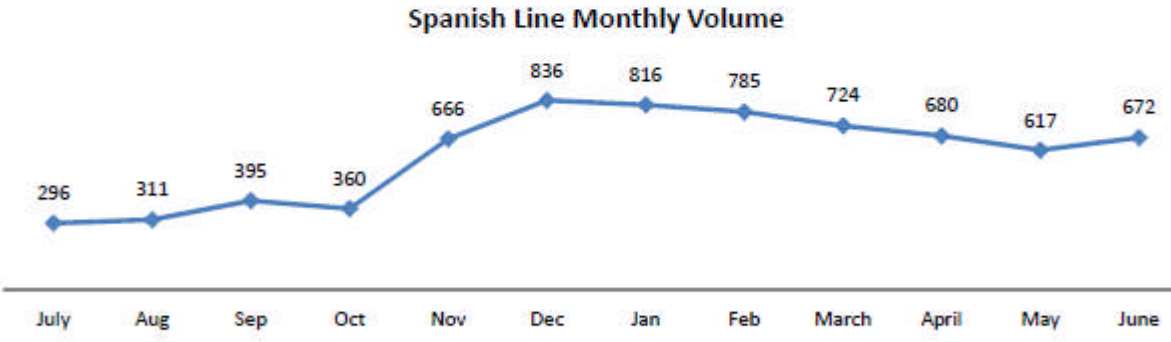
The 24/7 Suicide Prevention Crisis Line responded to a total of 81,728 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 7,158 callers. Korean and

Vietnamese language services are also available on the Crisis Hotline. Additionally, various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, and lecture, medical, and safeTALK presentations. In Los Angeles County, 5,331 persons were reached through these outreach efforts. See attached report for further information on Didi Hirsch data for FY 2015-16.

CALL ANALYSIS FOR FISCAL YEAR 2015-2016	
	Fiscal Year 15-16
TOTAL CALLS	74,088
TOTAL CHATS	7,629
TOTAL TEXTS	11
GRAND TOTALS	81,728



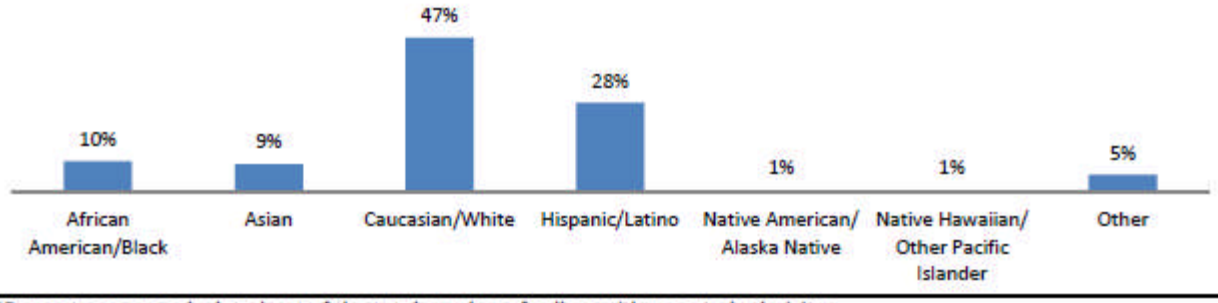
Total Calls by Language	
	Fiscal Year 15-16
Korean	27
Spanish	7,158
Vietnamese	8



Total Calls, Chats, and Texts for the Top Counties in California		
County	Fiscal Year 15-16	Percentage of State
Los Angeles	28,433	43%
Orange	7,925	12%
Riverside	3,627	6%
San Bernadino	3,618	6%
Santa Clara	2,759	4%
Ventura	1,652	3%

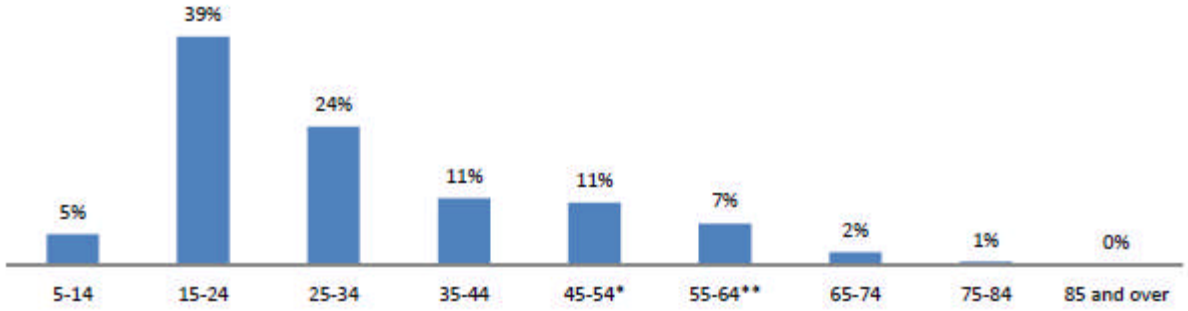
2015-2016 DEMOGRAPHICS	
Gender	
	Fiscal Year 15-16
Female	25,569
Male	21,349

Ethnicity



*Percentages are calculated out of the total number of callers with reported ethnicity.

Age Groups



*Percentages are calculated out of the total number of callers with reported age.

High Risk Categories

*The 45-54 age group has the highest suicide rate in the U.S. (based on 2010 national statistics reported by AAS).

**The suicide rate in the 55-64 age group has steadily increased in the past 10 years.

TOP CONCERNS DISCUSSED BY CALLERS (CALLER MAY IDENTIFY MORE THAN ONE)

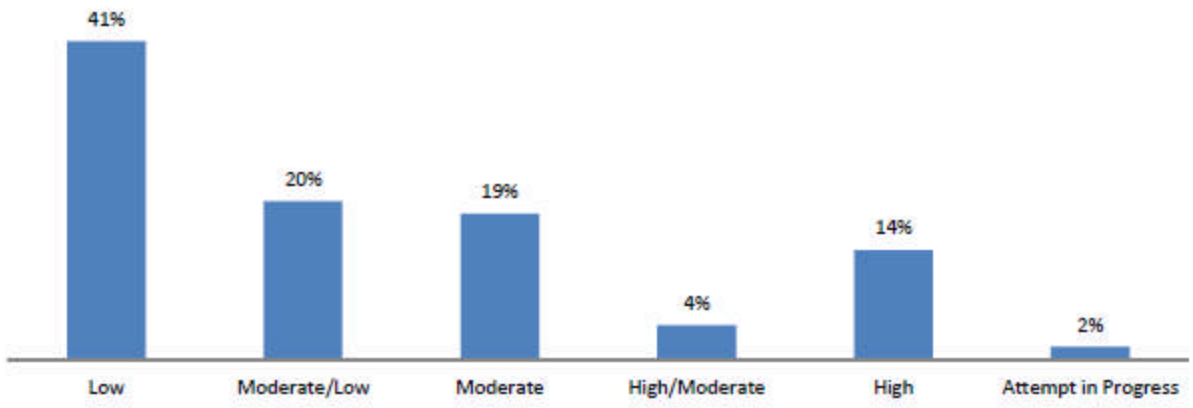
Caller Concern	Fiscal Year 15-16	Percentage
Suicidal Desire	19,355	51%
Depression	14,742	39%
Relationship/Family Issues	14,608	39%
Past Suicidal Ideation/Attempt	13,209	35%
Anxiety/Stress	11,373	30%

*Counselors listen for the reasons callers contacted the hotline, as well as other issues discussed by callers, and choose one or more categories to fit these issues.

SUICIDE RISK ASSESSMENT		
Rates of Suicide Risk Factors among Callers (callers may identify more than one)		
	Fiscal Year 15-16	Percentage
History of Psychiatric Diagnosis	13,650	44%
Prior Suicide Attempt	10,853	35%
Substance Abuse - Current or Prior	7,105	23%
Suicide Survivor	3,506	11%
Access to Gun	1,337	4%

**Presence of the above factors significantly increases an individual's risk for suicide attempts; thus, all callers presenting with crisis or suicide-related issues are assessed for these risk factors. Percentages are calculated out of the total number of calls in which suicide or crisis content was present.

SUICIDE RISK STATUS



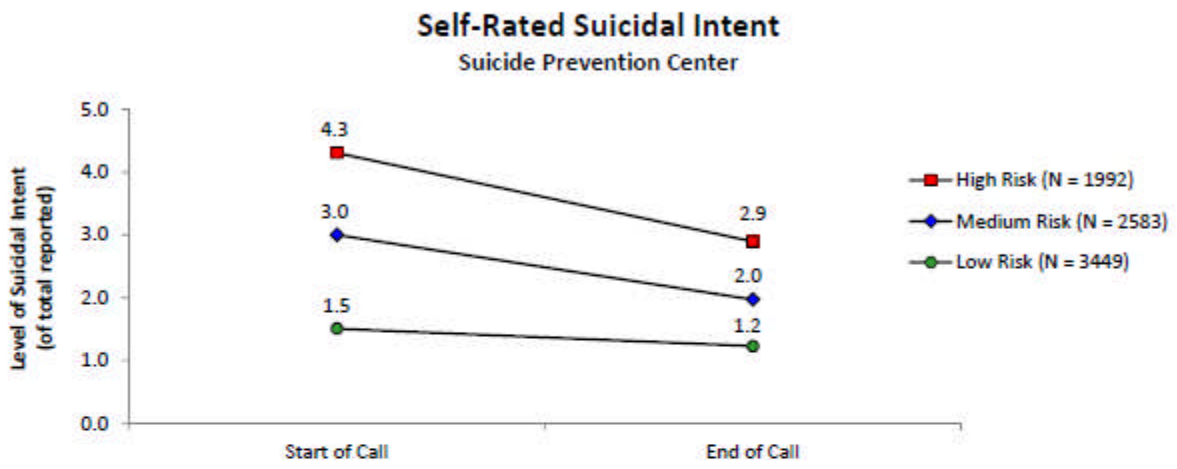
*Percentages are calculated out of the total number of callers with reported risk levels.

Risk assessment is based on the four core principles of suicide risk: Suicidal Desire, Suicidal Capability, Suicidal Intent, and Buffers/Connectedness (Joiner et al., 2007). A caller's risk level is determined by the combination of core principles present. Fore example, a caller who reports having only suicidal desire, as well as buffers, would be rated as Low Risk. A caller with suicidal desire, capability, and intent present would be rated as High Risk, regardless of the presence of buffers.

INTERVENTION OUTCOMES

Self-rated Suicidal Intent

Callers are asked to answer the question: "On a scale of 1 to 5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents 'Not likely' and 5 represents 'Extremely likely'?" Callers rate their intent both at the start and end of the call. Note: This data is on calls for which information was reported.



High or Imminent Risk	Refers to callers who rated their Suicidal Intent at 4 or 5 at the beginning of the call.
Medium Risk	Refers to callers who rated their Suicidal Intent at 3 at the beginning of the call.
Low Risk	Refers to callers who rated their Suicidal Intent at 1 or 2 at the beginning of the call.

EMERGENCY RESCUES

Emergency Rescue Type	Fiscal Year 15-16	Percentage
Third Party Rescue	1,314	45%
Self-Rescue	711	24%
SPC Initiated Rescue - Voluntary	243	8%
SPC Initiated Rescue - Involuntary	153	5%
Mandated Report	504	17%

Self-Rescue	Caller decides to go to the ER/call 911/call PMRT on his/her own (or with help from a third party).
Third Party Rescue	Only applies to third party calls; the caller will get person at risk emergency help (911/PMRT/ER).
SPC Initiated Rescue	SPC calls 911 or PMRT on caller's behalf; could be either voluntary or involuntary.
Mandated Report	Includes suspected child abuse, suspected elder/dependent adult abuse, Tarasoff.

FOLLOW UP PROGRAMS				
Please note: There have been changes to our iCarol system and these numbers represent a best estimate since training is still underway on the additional follow up fields.				
	Total YTD	Contacted	Linked	No Contact
Short-Term	69	45	20	24
Standard	854	627	274	227
Extended	75	48	30	27
Grand Total	**998**	**720**	**324**	**278**
DEFINITIONS				
Short-Term Follow-Up: Offered to callers at imminent risk who do not meet criteria for emergency rescue. The follow-up call or calls are made within 24 hours after the initial call.				
Standard Follow-Up: Offered to moderate - high risk callers. The follow-up call or calls are made 1-7 days after the initial call.				
Extended Follow-Up: Offered to callers who received standard follow-up and need continued assistance (e.g., developing a safety plan and/or connecting to resources). The follow up call or calls are made 1-8 weeks after the initial call.				
OUTREACH AND EDUCATION				
Various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, Lecture, Medical, and safeTALK presentations.				
Individuals reached through these efforts:				
County				**Fiscal Year 15-16**
LA				5,331
Orange				4,203
Total				**9,534**

PARTNERS IN SUICIDE (PSP) TEAM FOR CHILDREN, TRANSITION AGE YOUTH (TAY), ADULTS, AND OLDER ADULTS:

PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team is comprised of eight staff representing each of the four age groups, and includes six Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age appropriate services.

PSP Team members participated in a total of 202 suicide prevention events during Fiscal Year 2015-2016, outreaching to more than 5,233 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners. Highlights included the provision of 5 Applied Suicide Intervention Skills Trainings (ASIST) to 145 participants. PSP provided 58 Question, Persuade and Refer (QPR) Trainings throughout the county. 12 staff members are qualified as QPR trainers, five of whom are members of the PSP team. Recognizing and Responding to Suicide Risk (RRSR) was provided via two trainings this fiscal year, training a total of 58 participants. Assessing and Managing Suicide Risk (AMSR) was rolled out during this fiscal year. AMSR focuses on 24 core competencies required for clinicians to be successful in their work with suicidal clients and aims to build confidence and competence in assessing and managing suicide risk and reducing suicidal behaviors and completed suicides in the at-risk population of individuals who interact with mental health professionals. Four trainers from our pool of PSP team members provided six trainings and trained 110 staff including clinicians, case managers, and nurses. Two PSP members completed the Train-the-Trainer for Suicide to Hope this fiscal year. Suicide to Hope is a Recovery and Growth Workshop that provides tools to help professional caregivers and persons with experiences of suicide work together to develop achievable and significant recovery and growth goals. The plan is to roll out this training during FY 2016-17.

The PSP team also continues to coordinate and host the Los Angeles County Suicide Prevention Network which consists of quarterly meetings to increase collaboration and coordination of suicide prevention activities and includes over forty members from a wide variety of organizations.

Fifth Annual Suicide Prevention Summit "The Power of Voice: Hope, Help and Healing for College & High School Students": This Summit took place on October 27, 2015 in collaboration with California State University Northridge (CSUN). This Summit was attended by approximately 600 people, including students and faculty from CSUN.

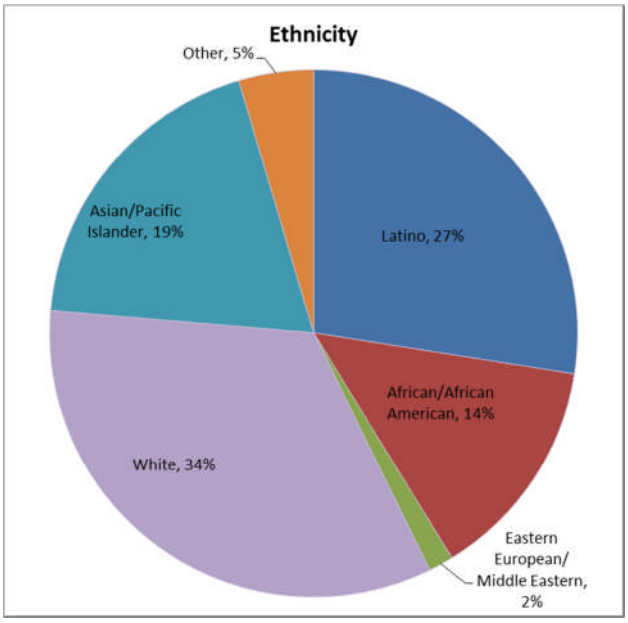
Outcomes

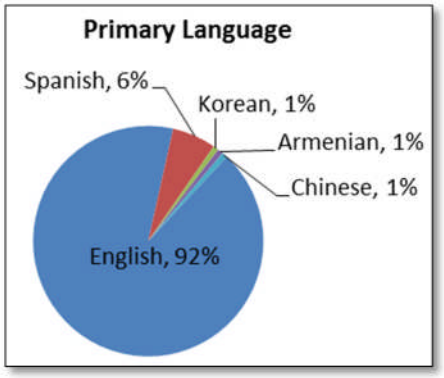
Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 15-16, changes in knowledge about suicide were measured using the Partners in Suicide Prevention (PSP) Survey and Question Persuade Refer (QPR) Survey. Participants complete the "pre" survey, either the PSP or QPR, just prior to the training to assess their baseline level knowledge about suicide prevention and then

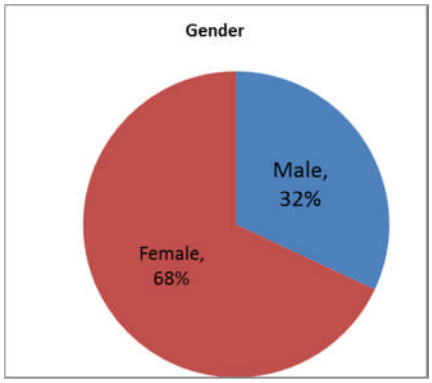
complete the "post" survey shortly after completing the training. Increases in participants' survey scores from "pre" to "post" suggest knowledge about suicide prevention has been improved.

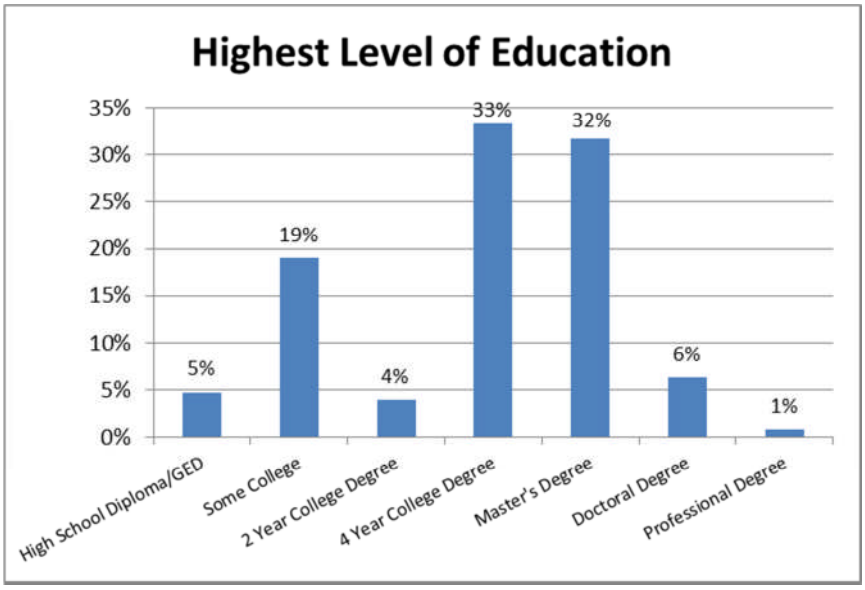
Total number of Partners in Suicide Prevention (PSP) Surveys: 443

Demographics





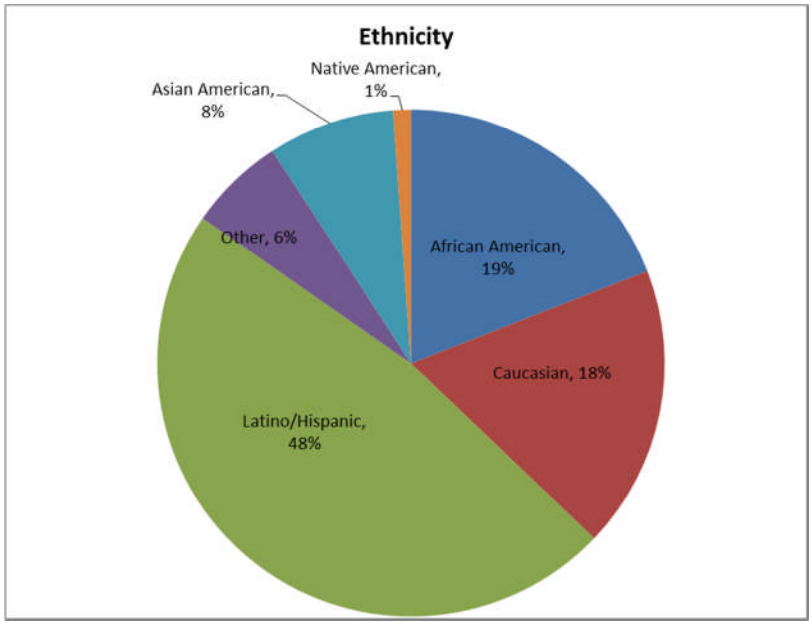


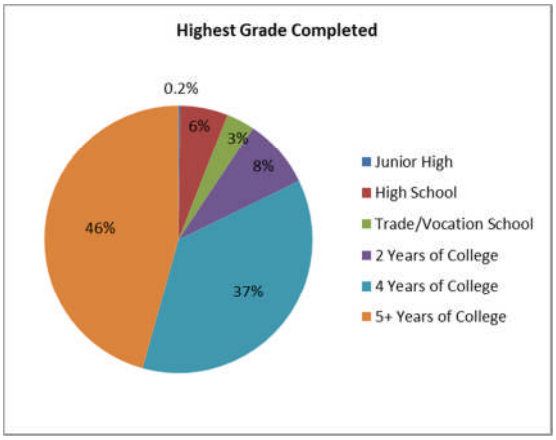


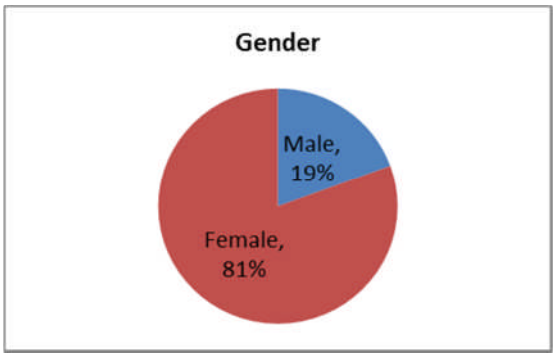
Total number of Persuade Refer (QPR) Surveys: 938

Demographics

The average age of trainees who submitted a QPR was 37 (age range 19-88). 81% were female and 19% were male.



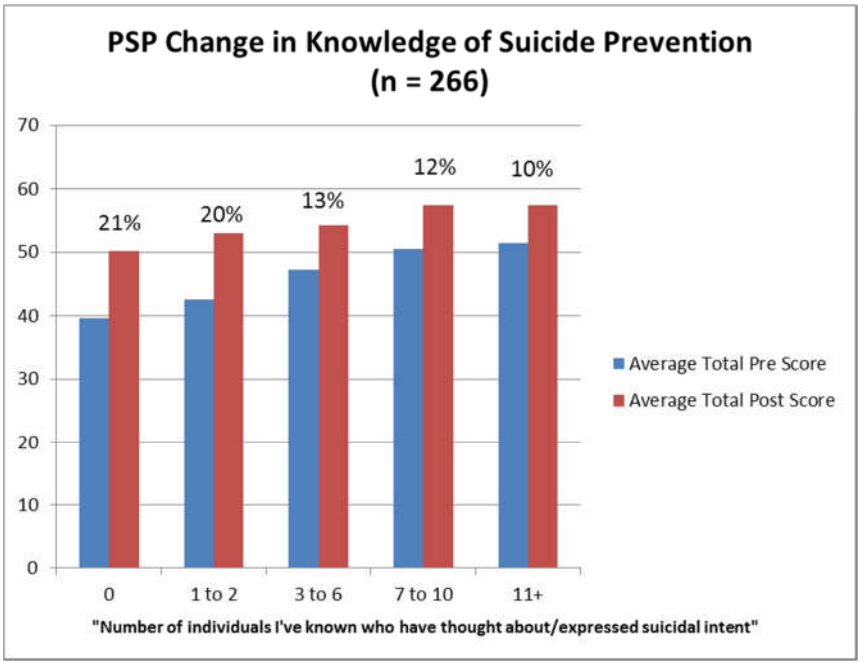


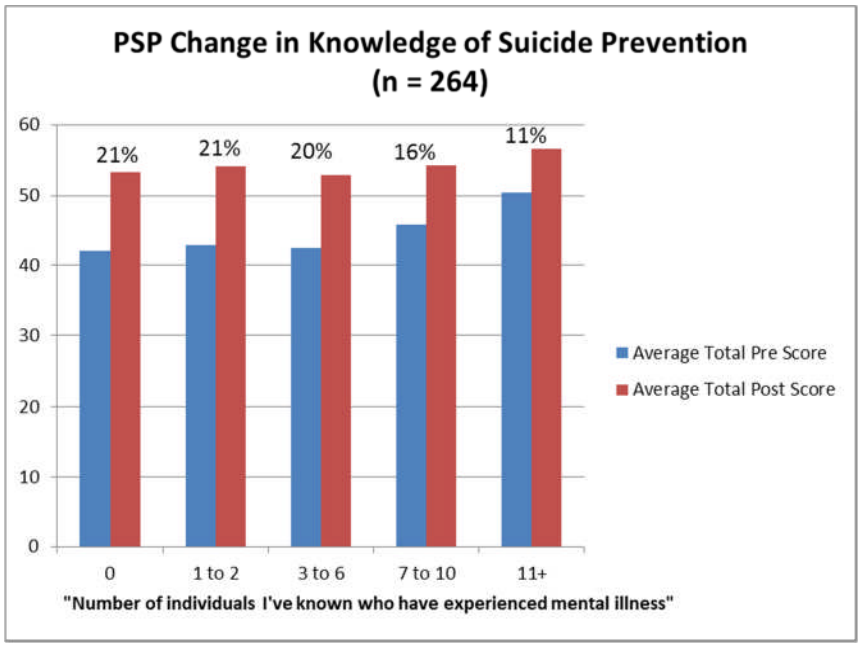


Pre and Post Differences

- Results from PSP and QPR surveys suggest participants' knowledge about suicide increased through training and education, with average increases from "pre" to post" of 14% (351) and 25% (938) respectively.
- Partners in Suicide Prevention (PSP) trainings have shown positive outcomes since inception in FY 13-14. In the previous two fiscal years participants (2,985) showed, on average, a 30% increase in knowledge about suicide prevention, as measured by the QPR (PSP only used FY 15-16).
- On the PSP, trainees who reported knowing the fewest number of individuals who have expressed suicidal intent showed the greatest increases in knowledge about suicide upon completion of the training.
- Trainees who reported not knowing anyone who has expressed suicidal intent (16) had increased their knowledge of suicide prevention by 21% and those who reported knowing 1 to 2 people (70) averaged a 20% gain.

- On the PSP, trainees who reported knowing the fewest number of individuals who have experienced mental illness showed the greatest increase in knowledge about suicide upon completion of the training.
- Trainees who reported not knowing anyone (8) who has experienced mental illness and those reported knowing 1 to 2 (22) had an average gain of 21% and those who reported knowing 3 to 6 (54) averaged a 20% gain in knowledge about suicide.





Stigma and Discrimination Reduction

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

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

EBP/PP/CDEs Implemented: **School Threat Assessment and Response Team (START):** The three (3) main objectives for START are the following: Prevention and Reduction of targeted school violence in Los Angeles County, Provision of on-going support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations and Establishment of partnerships with schools, law enforcement, and other involved community organizations.

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

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

Family-focused Strategies to Reduce Mental Health Stigma and Discrimination

The Los Angeles County Alliance for the Mentally Ill provides prevention services countywide with a focus on reducing mental health stigma seen among and discrimination experienced by consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation as well as teach communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.

During Fiscal Year 2015-2016, the Adult System of Care (ASOC) Anti-Stigma and Discrimination Team participated in 36 events in 5 service areas while outreaching to 1107

community members throughout Los Angeles County. These Countywide events provided educational presentations to faith communities and underserved/underrepresented ethnic populations and at college campuses (e.g., El Camino College, Long Beach City College). There was also collaboration with various agencies/programs including the Department of Public Social Services, San Pedro Mental Health Clinic, Peace Over Violence, Toberman Neighborhood, Lift, and Wellness Outreach Workers Program.

CHILDREN'S STIGMA AND DISCRIMINATION REDUCTION PROJECT

The project provides trainings to increase public awareness, social acceptance, and inclusion of people with mental health challenges. The Children's Anti Stigma and Discrimination project also known as A Reason to Care and Connect (ARCC) provides education to parents and to the general community through four trainings in both English and Spanish:

- It Takes a Community (ITC) is a 10-week course, developed by LA County DMH in consultation with Ruth Beaglehole specifically to reduce stigma, which includes healing and communication tools to promote mental wellness and create a world that is empathic to children.
- Educate, Equip and Support (EES) is a 13-week curriculum, developed by United Advocates for Children and Families (UACF), which is a general overview of childhood mental health disorders and strategies aimed at improving the lives of children with mental health needs and their families. It also includes grief and loss, and how to navigate the mental health, juvenile justice, special education and the child welfare systems.
- Youth Mental Health First Aid (YMHFA), created by the National Council for Behavioral Health, is 8-hour training for parents, neighbors, teachers, and the general community to help a youth (ages 12-18) who is experiencing a mental health or addictions challenge. The course introduces common mental health challenges for youth, reviews typical adolescent development, and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations.
- Anti-bullying presentations created to raise awareness of the serious problem of bullying within our youth, which includes the importance that the bully, the bullied and the bystander roles play. It also includes identifying early signs and helpful prevention and intervention strategies on dealing with the three different roles as parents, and as a community member.

During FY 2014-15, sixty (60) trainings on ITC, EES, YMHFA, and Bullying were provided to parents, children and community members countywide.

OLDER ADULTS MENTAL WELLNESS

For the majority of FY 2015-16, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of one Community Services Counselor, one social work intern, one Community Worker, one Mental Health Advocate and one Service Extender. Occasionally, other Older Adult System of Care Bureau staff provides assistance, particularly if there is more than one presentation on a given day, or if there is a need for a specific language.

The OA ASD Team participated in a total of 230 events during the fiscal year 2015-2016, outreaching to more than 3,780 Los Angeles County residents. These events included countywide educational presentations, community events and collaboration with various agencies

Highlights of OA ASD's accomplishments include:

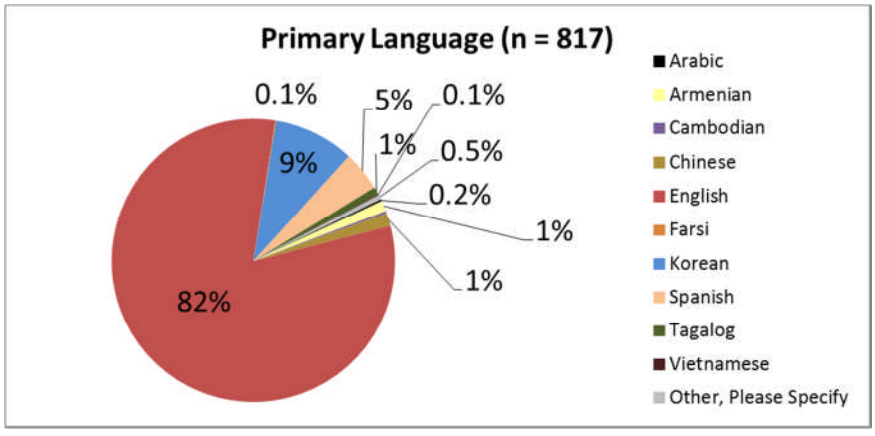
- Outreached to over 3,780 individuals in Los Angeles County
- Provided over 226 presentations for seniors throughout the county
- Participated in 4 Health Fairs throughout the county
- Increased number of workshops in Service areas of 2 and 4
- Developed and added three new presentations "Grief and Loss", "Late-Life Transitions" and "Isolation" to the Menu of topics for our Mental Wellness Series.
- Outreached to LGBT community of older adults

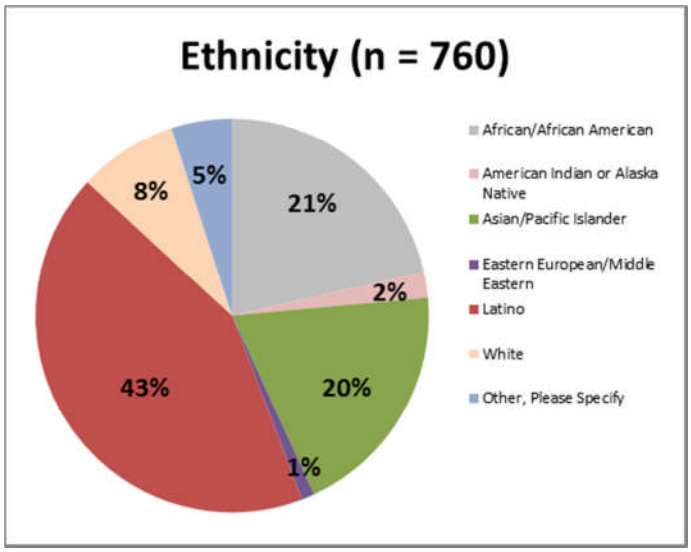
Outcomes

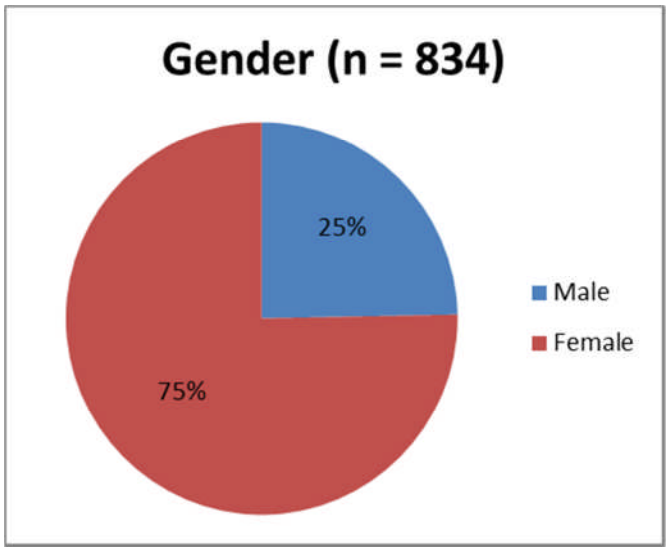
Through training and education Los Angeles County Department of Mental Health has been able to show positive results in reducing stigma and discrimination related to mental illness. Surveys were administered at the beginning and at the end of the training to measure changes in attitudes, knowledge, and/or behavior related to stigma and discrimination. Each age group (Children, Adult, and Older Adult) used a slightly modified version of a general survey that was constructed to assess these changes. Please note that the analysis for the Adult SDR surveys below reflect Mental Health First Aid (MHFA) training. The following are results from the analyzed data for FY 15-16:

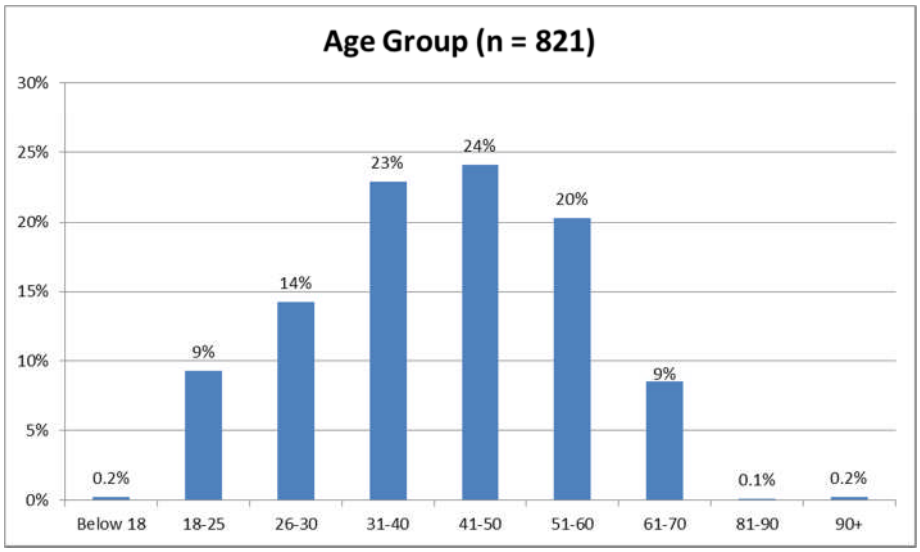
Adult Surveys = 987

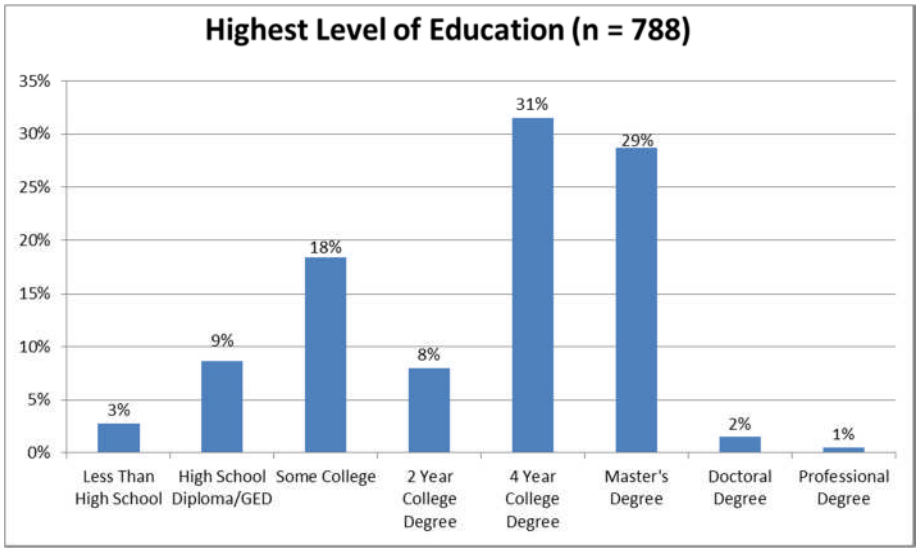
Demographics




Ethnicity (n = 760)
African/African American
American Indian or Alaska Native
Asian/Pacific Islander
Eastern European/Middle Eastern
Latino
White
Other, Please Specify
21%
2%
20%
1%
43%
8%
5%


Gender (n = 834)
Male
Female
25%
75%


Age Group (n = 821)
30%
25%
20%
15%
10%
5%
0%
0.2%
9%
14%
23%
24%
20%
9%
0.1%
0.2%
Below 18
18-25
26-30
31-40
41-50
51-60
61-70
81-90
90+

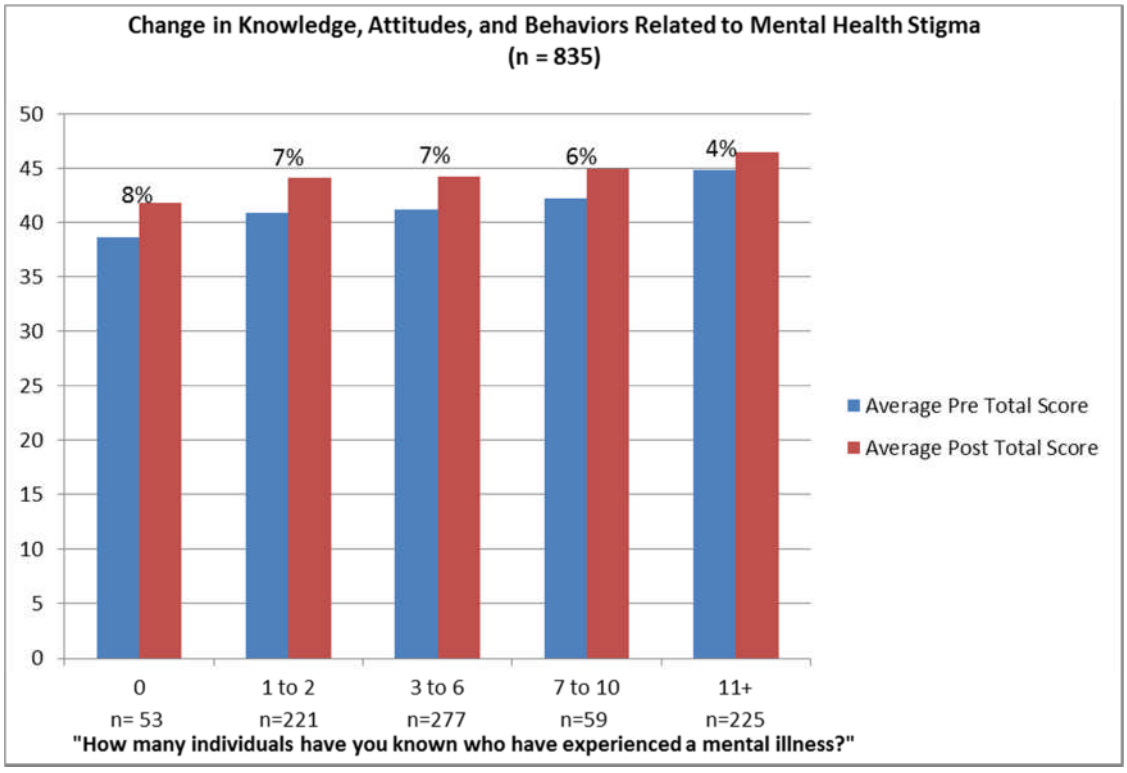

Highest Level of Education (n = 788)
35%
30%
25%
20%
15%
10%
5%
0%
3%
9%
18%
8%
31%
29%
2%
1%
Less Than High School
High School Diploma/GED
Some College
2 Year College Degree
4 Year College Degree
Master's Degree
Doctoral Degree
Professional Degree

Mental Health First Aid (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 enhance 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.

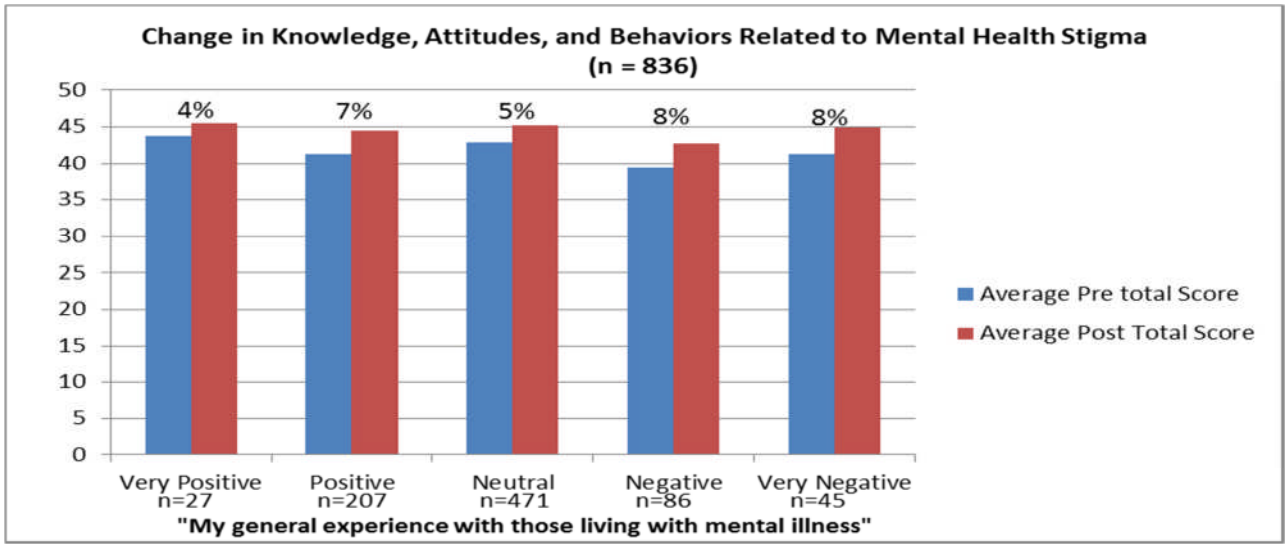
Seventy-seven percent (77%) of MHFA training participants (475) either increased their knowledge of stigma or showed no change because they were already knowledgeable on the subject matter. Prior to the training, 96% of participants' total scores were in either the Positive Attitudes category (377) or Very Positive Attitudes category (210). At "post," 98% of participants were in either the Positive Attitudes category (277) or Very Positive Attitudes category (325). This suggests the vast majority of participants had positive beliefs about people with mental illness and knowledge of the impact of stigma on those with mental illness prior to being trained and their positive beliefs knowledge were maintained or increased following training. Other points of interest included the following:

- Prior to the training, (210) participants had total scores in the Very Positive Attitudes category. At "post" the number of participants in the Very Positive Attitudes category (325) increased by 19%.
- The average total "pre" score (42), fell within the Positive Attitudes range and the average total "post" score (45), fell in the Very Positive Attitudes range.

The three groups that reported knowing the fewest individuals with mental illness showed the greatest improvement at "post" training. Trainees who reported not knowing anyone with mental illness (32) increased their knowledge of stigma by 8% and trainees who reported knowing 1 to 2 people with mental illness (152) or 3 to 6 people with mental illness (178) improved by 7%.



Prior to training, the two groups that reported having mostly negative interactions with people who experience mental illness showed the greatest increases in knowledge about the subject matter post training. Those who endorsed having “negative” experiences with individuals who experience mental illness (62) and those who endorsed having “very negative” experiences (27) improved an average of 8%.

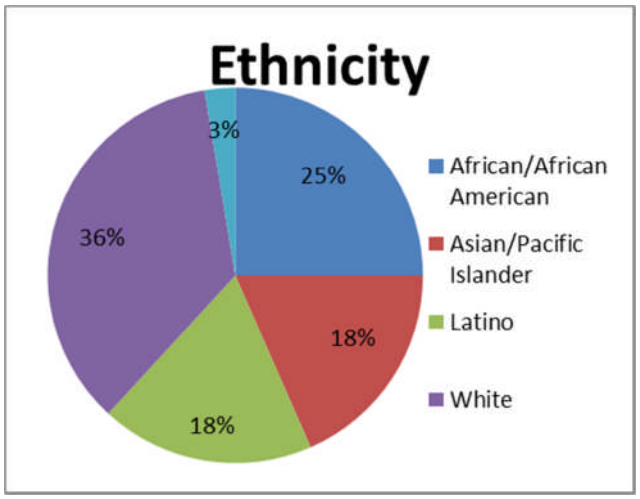


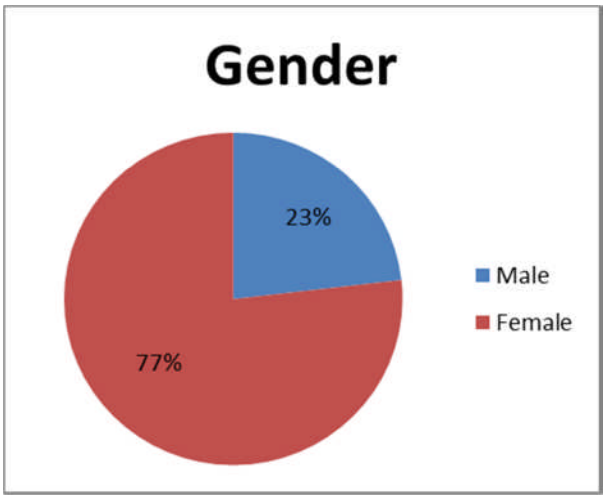
Child Surveys = ***320***

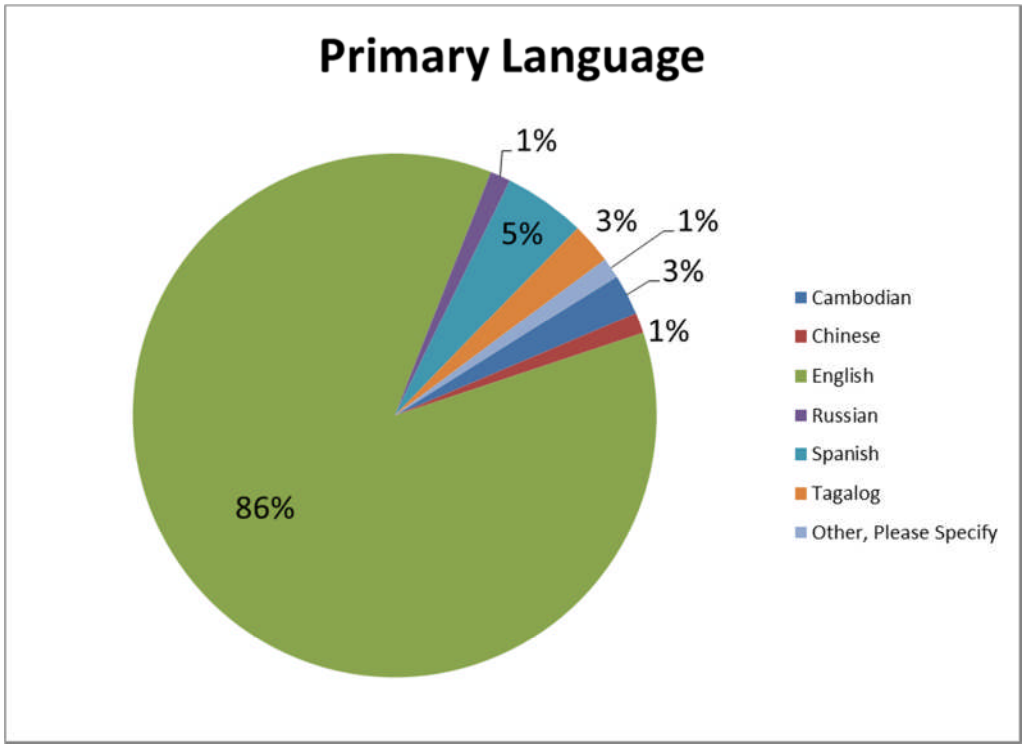
- Prior to the training, 94% of participants’ total scores were in either the Positive Attitudes category (96) or Very Positive Attitudes category (81) and at “post” training 94% of participants were in either the Positive Attitudes category (87) or Very Positive Attitudes category (95). This suggests, prior to training, the great majority of participants had positive beliefs about people with mental illness and a great deal of knowledge about the impact of stigma on the lives of people with mental illness and their positive beliefs and knowledge were maintained or increased following training.
- Prior to training, 41% of participants had total scores in the Very Positive Attitudes category (81). At “post” 49% of participants had total scores in this category (95), for an increase of 8%.

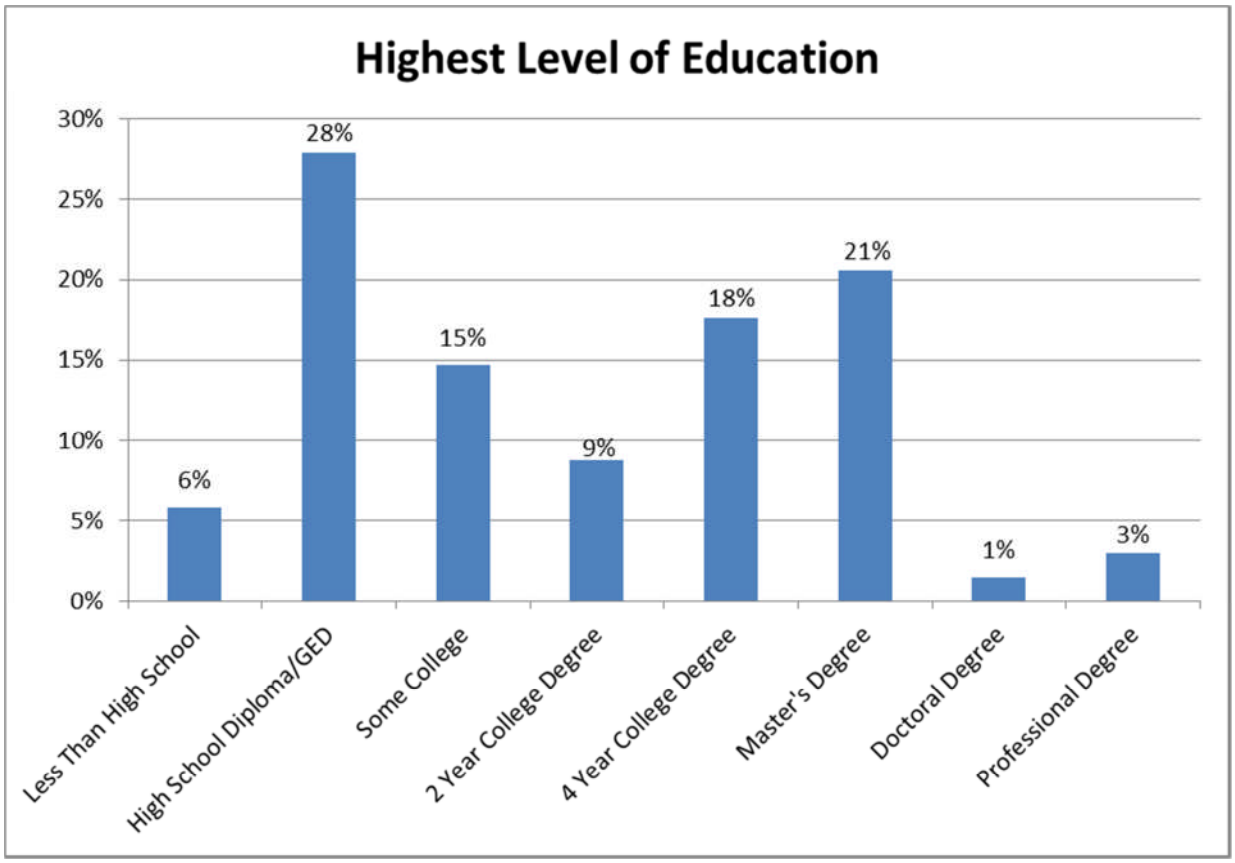
*Older Adult Surveys = **195***

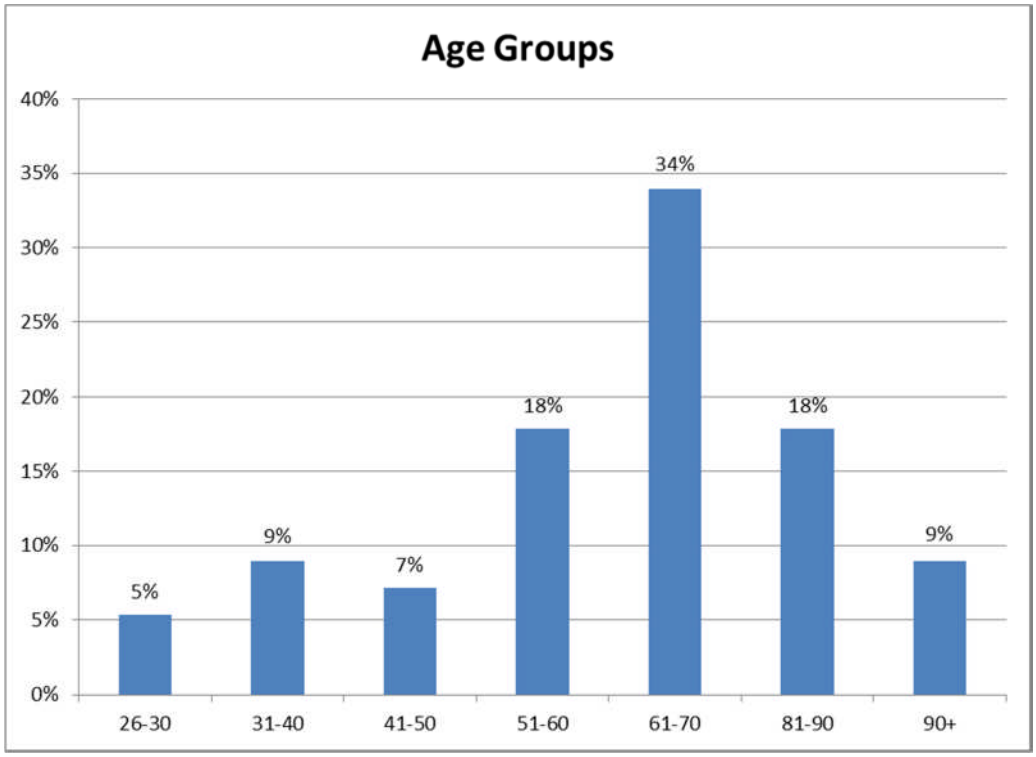
Demographics



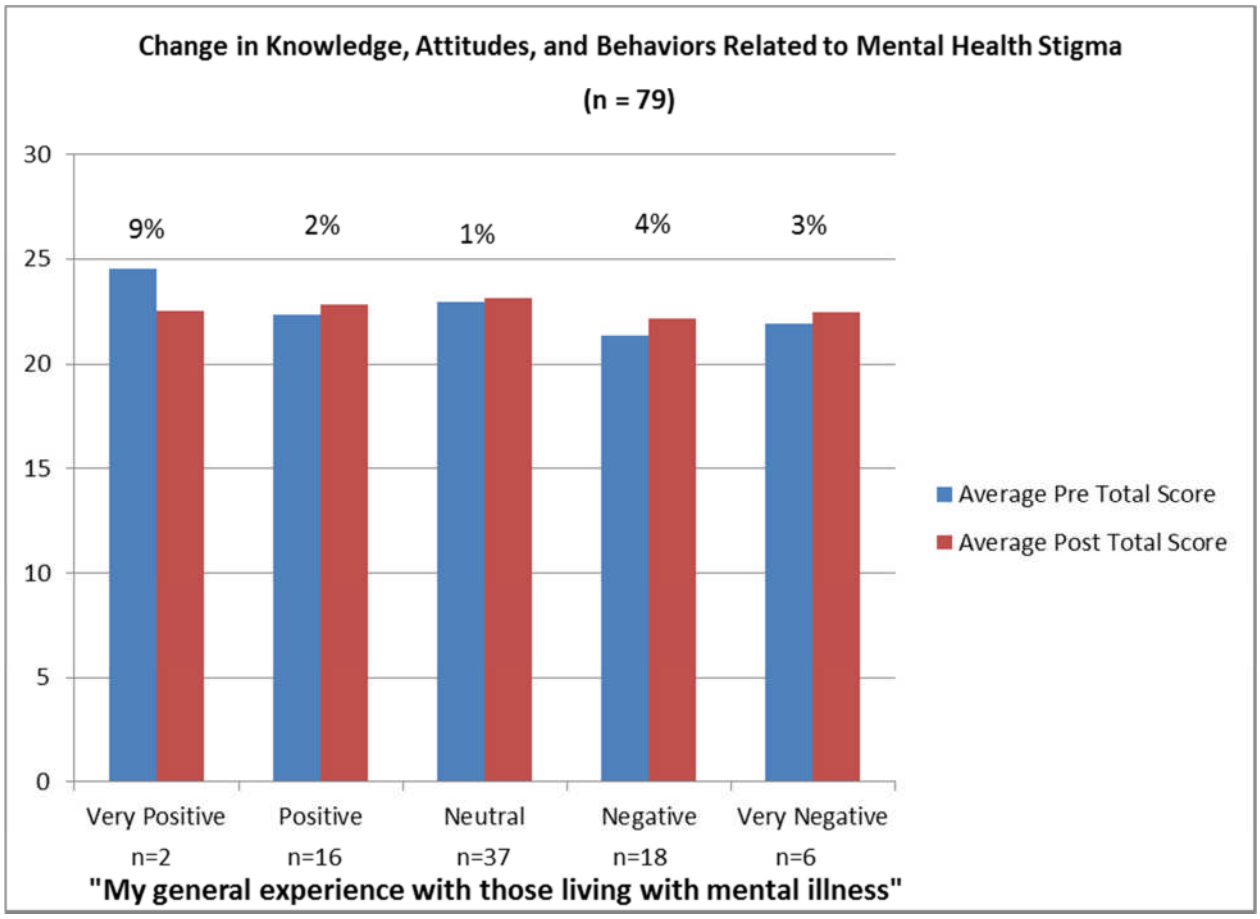





Highest Level of Education
30%
25%
20%
15%
10%
5%
0%
6%
28%
15%
9%
18%
21%
1%
3%
Less Than High School
High School Diploma/GED
Some College
2 Year College Degree
4 Year College Degree
Master's Degree
Doctoral Degree
Professional Degree


Age Groups
40%
35%
30%
25%
20%
15%
10%
5%
0%
5%
9%
7%
18%
34%
18%
9%
26-30
31-40
41-50
51-60
61-70
81-90
90+

- Prior to the training, the average total "pre" score (22) fell in the Positive Attitudes range and 85% of participants' "pre" scores were in the Positive Attitudes category (69), suggesting that the great majority of participants had positive beliefs about people with mental illness prior to training. At "post" training, 91% of participants' scores were in the Positive Attitudes category (74), an increase of 6%. The 6% increase is greater than the 1% increase seen in FY14-15.
- The average score decreased by 9% for those who, prior to the training, reported generally having very positive experiences with those who have had a mental illness. This decrease is likely an anomaly because there were only two (2) trainees in the category, with an average "pre" score, (25), that was already very high. Those who, prior to training, reported that they tend to have negative interactions with people who experience mental illness showed the greatest increases in knowledge about mental illness and understanding of how stigma affects people who have mental illness, "post" training. Trainees who endorsed having generally negative experiences (29) showed an increase of 4% and those who endorsed having generally very negative experiences (16) increased by 3%.



PROFILES OF HOPE PROJECT

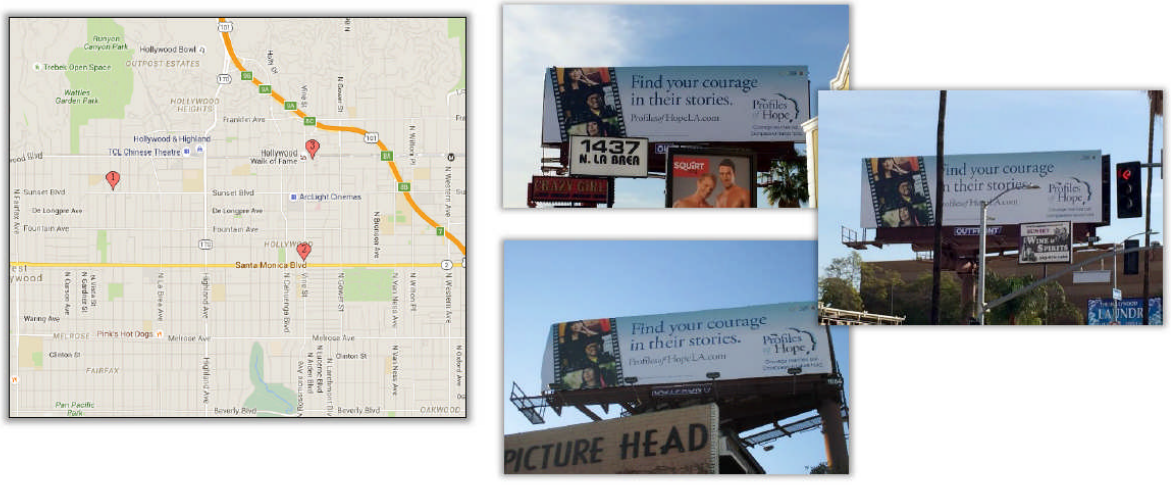
Profiles of Hope's main objective is to build County-wide awareness for the range of support services the Los Angeles County Department of Mental Health has to offer. It uses a multi-media mix to reach people at multiple touch points as they go about their daily activities, for optimal message impact and leverages our broadcast media partnerships for custom station integrations and high profile event extensions that would allow us to feature the video assets. It uses targeted media to heighten visibility and awareness among key groups and amplifies outreach via social media, specifically YouTube (video).

The following is a media overview and overall performance for 2016:

- KTLA partnership
  - Profiles of Hope 30-second PSAs, co-branded promotional spots of the Live on Green event and presence at the Spirit Pavilion at the event with viewing of 10-minute video
- •In-cinema
  - 30-second PSAs on-screen and in lobbies at select locations.
- •High profile radio stations
  - 3 top-ranking general market radio stations, 30-second PSAs and live integrations and Profiles of Hope 10-minute video featured at signature radio station events in LA county
- •Outdoor
  - 3 premium bulletins at key locations in Hollywood
- Print
  - 3 full-page 4 color ads in LA Weekly and 4 dedicated email blasts
- Social Media
  - 10 minute and 30 second POH videos promoted on Facebook and YouTube

3 High Profile Bulletins in Hollywood area

– Bulletins ran for one month each between February and March



Early Intervention

The Department's Prevention and Early Intervention program consists of 13 programs that, together, provide prevention services targeted to those at risk for developing a mental illness as well as those at risk for suicide, student mental health assessment and intervention for those at risk for suicide or violence, a robust set of stigma and discrimination reduction activities and campaign entitled *Profiles of Hope* and an array of early intervention evidence-based, promising and community-defined evidence practices for individuals across the age spectrum experiencing early symptoms of a mental illness.

Each evidence-based, promising or community-defined evidence practice has a set of expectations established by the Department and informed by the practice developers that defines the training and/or certification necessary to deliver the practice, practice parameters and outcome measures associated with each practice. Each practice has a practice lead within the Department that oversees the training for the practice, ensures practice fidelity according to the Department's standards and participates in the Department's technical assistance site visits where outcome data, utilization and other measures of fidelity are reviewed with providers. In addition, the Department's PEI administration holds quarterly provider meetings where the practice leads provide updates.

In order to submit an evidence-based, promising or community defined practice for consideration to be practiced in PEI programs, an application must be completed and submitted to the Department's PEI Evidence-Based Practice Committee, comprised of representatives of the 4 age groups, the MHSA Implementation and Outcomes Division, a children's mental health services expert consultant and chaired by the Department's Children's Medical Director and the Program Manager III overseeing PEI Administration. In addition, experts in the field familiar with peer reviewed literature are used to review applications and inform decisions.

In consultation with practice developers and local stakeholders, the Department established a general outcome measure for children and for adults and a focus of treatment specific measure for practices that treat trauma, depression, anxiety, situational crises, parenting and family difficulties, conduct or disruptive disorders, emotion regulation, The general and focus of treatment specific measures are collected at the beginning of a PEI practice and at the end of the practice. The outcomes for each practice presented in this Annual Update are from individuals who completed a practice and completed both the beginning and end of treatment measures.

Outcome measures are selected through an initial review of measures in use for particular age groups related to particular foci of treatment. The results of the literature review are then presented to a joint provider-Department committee and a decision is made on which measures will be used to assess outcomes. Factors that are considered are the cost of measure, the length of the measure, the languages the measures come in and whether the developer allows for translation to additional languages (for measures completed by clients), and more recently, whether the measure is able to be used within electronic health records. The outcome measures associated with each practice are listed in Appendix V.

School Based Services: PEI-1

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

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Multidimensional Family Therapy
4. Promoting Alternative Thinking Strategies
5. Strengthening Families

Family Education & Support Services: PEI-2

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

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

At Risk Family Services: PEI-3

The At Risk Family Services Project provides training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements. It builds skills for families with difficult, out of control or substance abusing children who may face the juvenile

justice involvement and provides support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

Trauma Recovery Services: PEI-4

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

EBP/PP/CDEs Implemented:

1. Child-Parent Psychotherapy
2. Crisis Oriented Recovery Services
3. Dialectal Behavioral Therapy*
4. Depression Treatment Quality Improvement*
5. Group Cognitive Behavioral Therapy for Major Depression
6. Individual Cognitive Behavioral Therapy*
7. Parent-Child Interaction Therapy
8. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
9. Seeking Safety
10. System Navigators for Veterans
11. Trauma Focused Cognitive Behavioral Therapy

Program was added to the PEI Plan after 2009

Primary Care & Behavioral Health: PEI-5

The Primary Care and Behavioral Health Project develops mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. The goal of the project is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Behavioral health professionals skilled in consultation and primary care liaison will be integrated within the primary care system. By offering assistance in identifying emotional and behavioral issues at a clinic setting, the stigma associated with seeking out mental health services will be minimized.

EBP/PP/CDEs Implemented:

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

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

The Early Support and Care for Transition-Age Youth Project (1) builds resiliency, increase protective factors, and promote positive social behavior among TAY; (2) addresses depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project.

EBP/PP/CDEs Implemented:

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

Juvenile Justice Services: PEI-7

The Juvenile Justice Services Project builds resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system. It also promotes coping and life skills to youths in the juvenile justice system to minimize recidivism and identifies mental health issues as early as possible in order to provide early intervention services. Services are to be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites.

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Functional Family Therapy

4. Group Cognitive Behavioral Therapy for Major Depression
5. Loving Intervention for Family Enrichment
6. Multidimensional Family Therapy
7. Multisystemic Therapy
8. Trauma Focused Cognitive Behavioral Therapy

Early Care & Support for Older Adults: PEI-8

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

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

Improving Access for Underserved Populations: PEI-9

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

EBP/PP/CDEs Implemented:

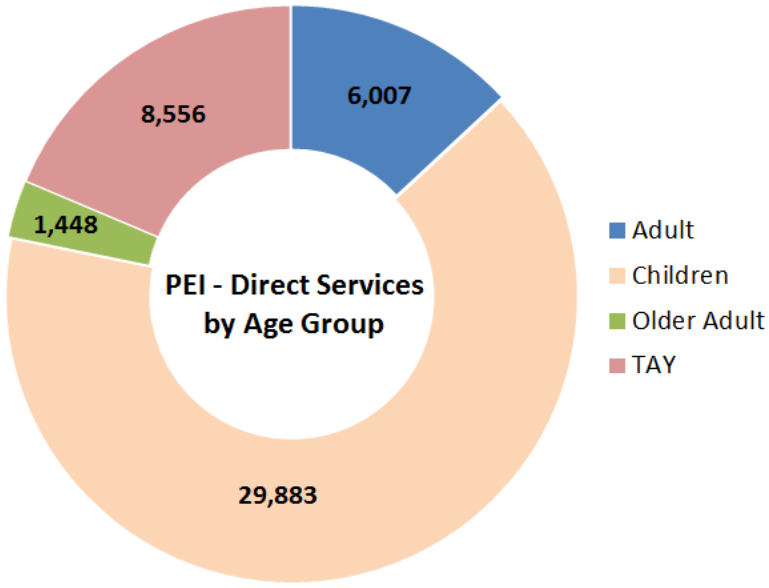
1. Group Cognitive Behavioral Therapy for Major Depression
2. Nurse-Family Partnership
3. Prolonged Exposure Therapy for Posttraumatic Stress Disorder
4. Trauma Focused Cognitive Behavioral Therapy

American Indian Project: PEI-10

The American Indian Project (1) builds resiliency and increase protective factors among children, youth and their families; (2) addresses stressful forces in children/youth lives, teaching coping skills, and diverting suicide attempts; (3) and identifies as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.

EBP/PP/CDEs Implemented: American Indian Life Skills

Evidenced Based Practices (EBPs): Number of Clients Served by Age Group for Fiscal Year 2015-16



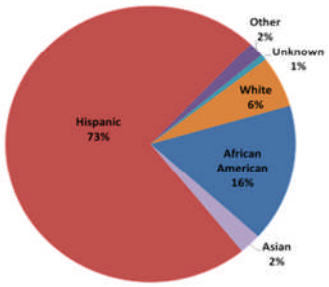
Evidenced Based Practices (EBPs): Number of Clients Served by EBP for Fiscal Year 2015-16

Aggression Replacement Training (ART)

Unique Clients 570

Percentage by Gender

Male	72%
Female	28%

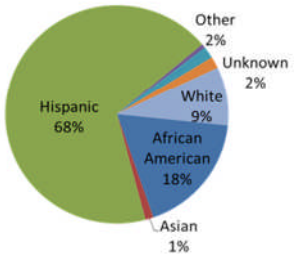


Center for the Assessment and Prevention of Prodromal States (CAPPS)

Unique Clients 172

Percentage by Gender

Male	55%
Female	45%

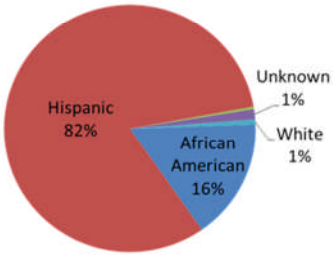


Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)

Unique Clients 303

Percentage by Gender

Male	57%
Female	43%

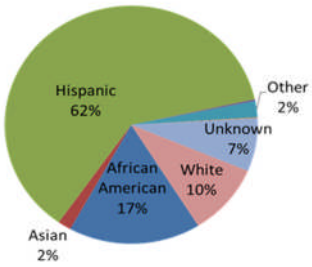


Child Parent Psychotherapy (CPP)

Unique Clients 1,816

Percentage by Gender

Male	55%
Female	45%

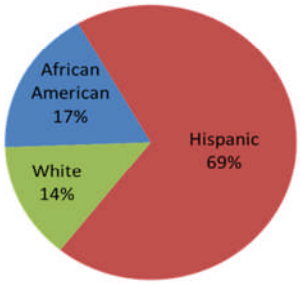


Brief Strategic Family Therapy (BSFT)

Unique Clients 49

Percentage by Gender

Male	41%
Female	59%

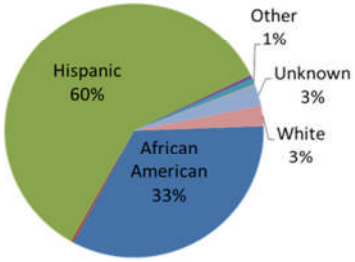


Crisis Oriented Recovery Services (CORS)

Unique Clients 1,242

Percentage by Gender

Male	53%
Female	47%

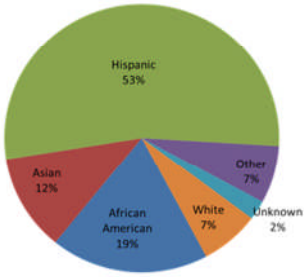


Caring for Our Families (CFOF)

Unique Clients 43

Percentage by Gender

Male	49%
Female	51%

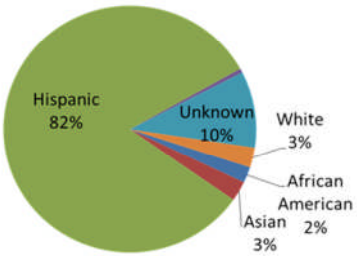


Depression Treatment Quality Improvement (DTQI)

Unique Clients 191

Percentage by Gender

Male	37%
Female	63%



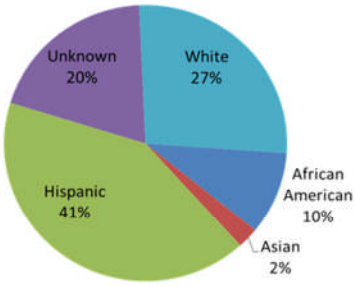
Dialectical Behavioral Therapy (DBT)

Unique Clients 41

Percentage by Gender

Male 22%

Female 78%



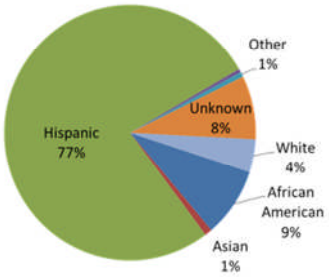
Incredible Years (IY)

Unique Clients 646

Percentage by Gender

Male 67%

Female 33%



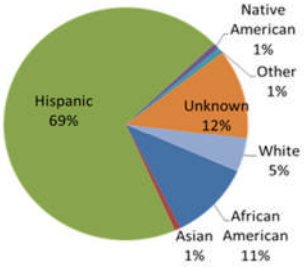
Families OverComing Under Stress (FOCUS)

Unique Clients 128

Percentage by Gender

Male 55%

Female 45%



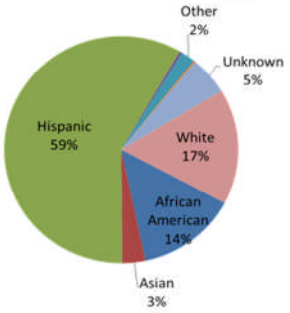
Individual Cognitive Behavioral Therapy

Unique Clients 3,224

Percentage by Gender

Male 34%

Female 66%



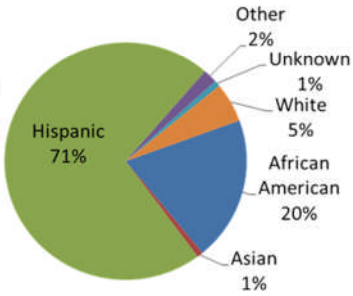
Functional Family Therapy (FFT)

Unique Clients 372

Percentage by Gender

Male 63%

Female 37%



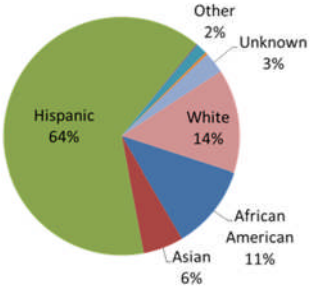
Interpersonal Psychotherapy for Depression (IPT)

Unique Clients 1,412

Percentage by Gender

Male 29%

Female 71%



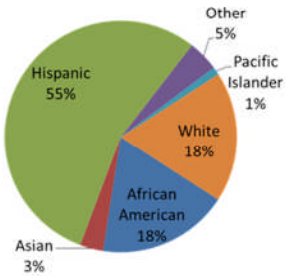
Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)

Unique Clients 93

Percentage by Gender

Male 33%

Female 67%



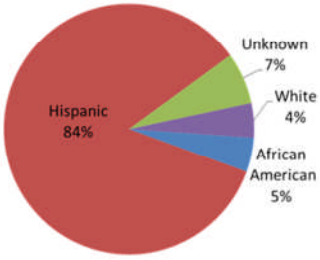
Loving Intervention Family Enrichment (LIFE)

Unique Clients 90

Percentage by Gender

Male 52%

Female 48%

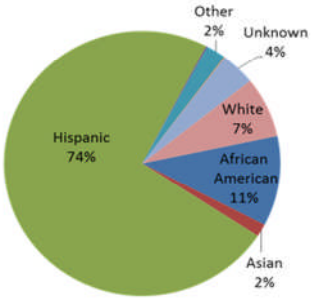


Managing and Adapting Practice (MAP)

Unique Clients 16,061

Percentage by Gender

Male	56%
Female	44%

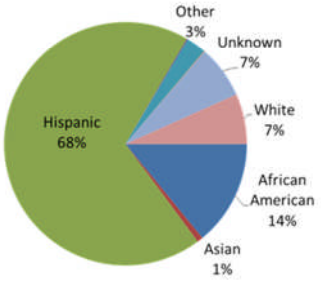


Parent – Child Interaction Therapy (PCIT)

Unique Clients 1,293

Percentage by Gender

Male	66%
Female	34%

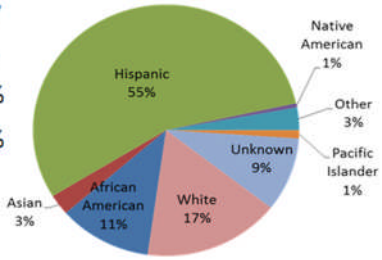


Mental Health Integration Program (MHIP)

Unique Clients 757

Percentage by Gender

Male	35%
Female	65%

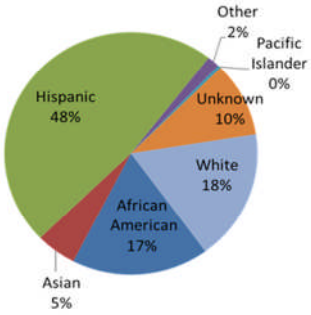


Partnerships with Law Enforcement and First Responders

Unique Clients 251

Percentage by Gender

Male	47%
Female	53%

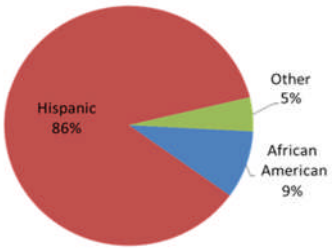


Multisystemic Therapy (MST)

Unique Clients 22

Percentage by Gender

Male	86%
Female	14%

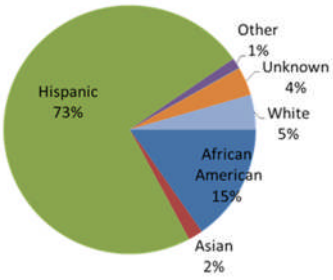


Positive Parenting Program (Triple-P)

Unique Clients 1,921

Percentage by Gender

Male	67%
Female	33%

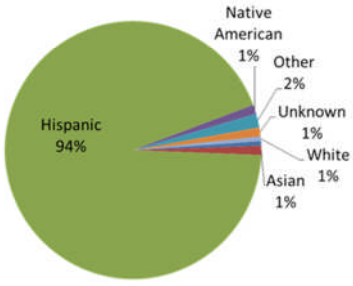


Pacific Clinic's Latina Youth Program

Unique Clients 175

Percentage by Gender

Male	46%
Female	54%

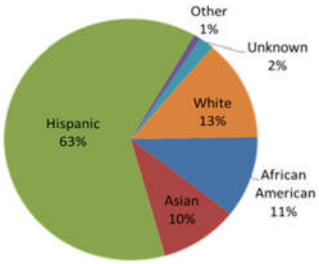


Problem Solving Therapy (PST)

Unique Clients 110

Percentage by Gender

Male	20%
Female	80%

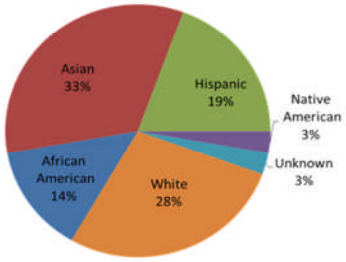


Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

Unique Clients 36

Percentage by Gender

Male	44%
Female	56%

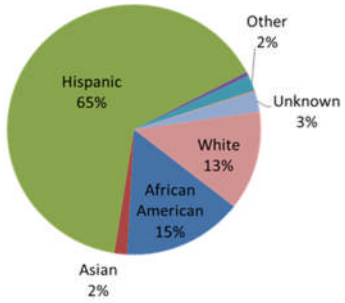


Seeking Safety (SS)

Unique Clients 4,703

Percentage by Gender

Male	45%
Female	55%

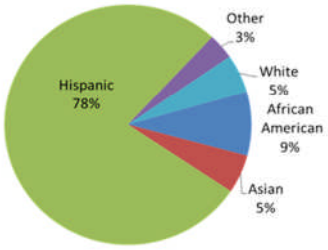


Promoting Alternative THinking Strategies (PATHS)

Unique Clients 58

Percentage by Gender

Male	69%
Female	31%

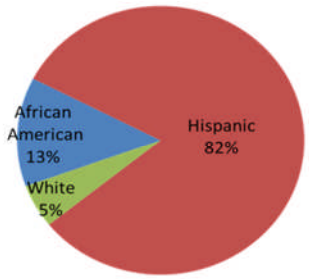


Strengthening Families Program (SFP)

Unique Clients 38

Percentage by Gender

Male	74%
Female	26%

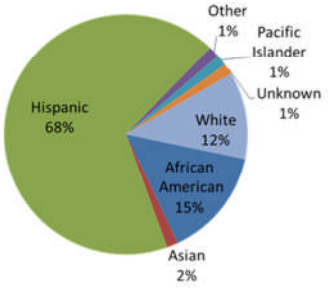


Reflective Parenting Program (RPP)

Unique Clients 68

Percentage by Gender

Male	53%
Female	47%

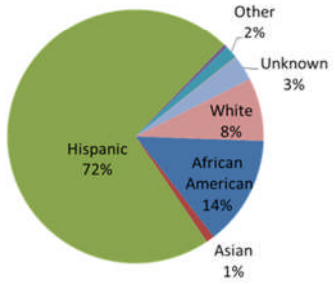


Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)

Unique Clients 6,621

Percentage by Gender

Male	45%
Female	55%

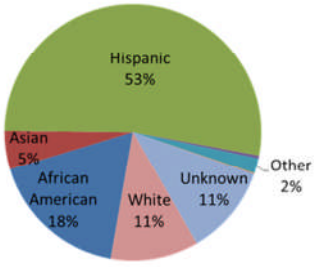


School Threat Assessment Response Team (START)

Unique Clients 1,724

Percentage by Gender

Male	45%
Female	55%

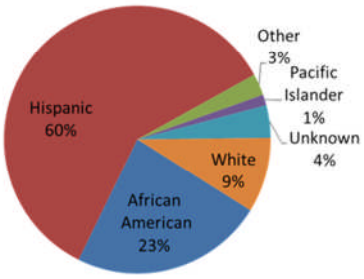


UCLA Ties Transition Model

Unique Clients 77

Percentage by Gender

Male	56%
Female	44%



PEI Practices Implemented

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
1	**Aggression Replacement Training (ART)**	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	Children (ages 5-12) – Skill streaming Only Children (ages 12-15) TAY (ages16-17)	Prevention & Early Intervention	PEI-1 PEI-6 PEI-7
2	**Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)**	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	Children (ages 4-15) TAY (ages 16-17)	Early Intervention	PEI-5
3	**American Indian Life Skills Program (AILSP)**	AILSP is designed to build life skills and increase suicide prevention skills for American Indian high school students. It is designed to promote self-esteem, identify emotions and stress, increase communication and problem solving skills, and recognize and eliminate self-destructive behavior (including substance use). AILSP provides American Indian children and TAY information on suicide and suicide intervention training and helps them set personal and community goals.	Children (ages 14-15) TAY (ages 16-18)	Prevention	PEI-10
4	**Brief Strategic Family Therapy (BSFT)**	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	Children (ages 10-15) TAY (ages 16-18)	Prevention & Early Intervention	PEI-3
5	**Caring for Our Families (CFOF)**	Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	Children (ages 5-11)	Prevention & Early Intervention	PEI-2 PEI-3

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
6	**Center for the Assessment and Prevention of Prodromal States (CAPPS)**	The focus of this CAPPS PEI Demonstration Pilot will be to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.	TAY	Prevention & Early Intervention	PEI-6
7	**Child-Parent Psychotherapy (CPP)**	CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.	Young Children (ages 0-6)	Early Intervention	PEI-3 PEI-4
8	**Cognitive Behavioral Intervention for Trauma in School (CBITS)**	CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure.	Children (ages 10-15) TAY	Prevention & Early Intervention	PEI-1 PEI-7
9	**Crisis Oriented Recovery Services (CORS)**	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.	Children TAY Adults Older Adults	Early Intervention	PEI-4 PEI-8
10	**Depression Treatment Quality Improvement (DTQI)**	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	Children TAY Adults Older Adults	Prevention & Early Intervention	PEI-4
11	**Dialectical Behavior Therapy (DBT)**	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	Children (ages 12-15) TAY (ages16-20)	Early Intervention	PEI-5 PEI-6

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
12	**Early Start Suicide Prevention - 24/7 Crisis Hotline**	Didi Hirsch provides 24/7 crisis Hotline services in English, Spanish, and Korean. Support services are provided to attempters and/or those bereaved by a suicide, as well as consultation to law enforcement and first responders. This practice builds community capacity by offering evidence-based training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models.	Children TAY Adults Older Adults	Prevention	ES-1
13	**Early Start Suicide Prevention – Latina Youth Program**	Pacific Clinics provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to schools regarding suicide risk factors among teens. It also provides education and support services in the community about warning signs and risk factors for suicide among youth. The program has expanded to include male as well as female youth, 14 to 25 years of age, who are identified as being “at risk” for suicide.	Children TAY Adults Older Adults	Prevention	ES-1
14	**Early Start Suicide Prevention – Web-based Training for School Personnel on Suicide Prevention**	The Los Angeles County Office of Education (LACOE), Center for Distance and Online Learning (CDOL) was contracted to design, develop, and maintain a website dedicated to provide critical online information and materials on suicide prevention, intervention, and postvention for school personnel, parents, and students in all 80 K-12 school districts in Los Angeles County. Launched in January 2011, the website has been widely publicized throughout the County, State (through the Office of Suicide Prevention), and at national conferences and meetings of various suicide prevention networks/organizations (including a recent Webinar on “Responding after a Suicide: Best Practices for Schools,” sponsored by the Suicide Prevention Resource Center).	Children TAY Adults Older Adults	Prevention	ES-1
15	**Early Start Suicide Prevention – Partners in Suicide (PSP) Team**	PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The Team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age-appropriate services. PSP team members participate in suicide prevention events including countywide educational trainings, suicide prevention community events, and collaboration with various agencies and partners.	Children TAY Adults Older Adults	Prevention	ES-1
16	**Early Start School Mental Health – School Threat Assessment Response Team (START)**	The START program developed 21 teams composed of a law enforcement officer and a DMH clinician who partner with educational institutions (K-12 through higher education) school-based mental health programs, substance abuse programs, and other social service providers in the community to prevent school violence. Staff conducts school threat assessments and provides intervention and case management services to those who meet criteria for the START program.	Children TAY Adults Older Adults	Prevention	ES-2

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
17	**Early Start School Mental Health – Service Area 6 School Mental Health Demonstration Program**	The School Mental Health PEI Demonstration Pilot (SMHPEI Demonstration Pilot) will provide school-based mental health outreach and education, on-site school crisis intervention, a peer support network, and early screening.	Children TAY	Prevention	ES-2
18	**Early Start Stigma and Discrimination – Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination**	The Los Angeles County Alliance for the Mentally Ill is implementing "Family-focused Strategies to Reduce Mental Health Stigma and Discrimination" for consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation, as well as teaching communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services.	Adults Older Adults	Stigma & Discrimination Reduction	ES-3
19	**Early Start Stigma and Discrimination – Children's Stigma and Discrimination Reduction Project**	The project provides education to parents and the community through two distinct curricula. A 10-week course developed specifically to reduce stigma includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. A 12-week curriculum, developed by United Advocates for Children and Families on childhood mental illnesses which includes topics such as grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS.	Adults Older Adults	Stigma & Discrimination Reduction	ES-3
20	**Early Start Stigma and Discrimination – Older Adults Mental Wellness**	The Older Adult Anti-Stigma and Discrimination Team (OA ASD) outreaches to residents through countywide educational presentations, community events, and collaboration with various agencies. OA ASD increases awareness on mental well-being for older adults throughout Los Angeles County, particularly among underserved and underrepresented communities. Presentations are available in 5 different languages: English, Spanish, Korean, Chinese and Farsi.	Older Adults	Stigma & Discrimination Reduction	ES-3
21	**Early Start Stigma and Discrimination – Profiles of Hope Project**	The Profiles of Hope and accompanying Public Service Announcements (PSAs) aim to show that anyone can be subject to the stigma a mental illness has traditionally carried, and change their minds about how they support and view others with a diagnosis of mental illness. "Profiles of Hope," a 60-minute film, promotes an anti-stigma message for those diagnosed with mental illness and has been broadcast on local television stations along with the PSAs.	TAY Adults Older Adults	Stigma & Discrimination Reduction	ES-3

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
22	**Early Start Stigma and Discrimination – Videos**	Six high-profile personalities, experienced and passionate advocates in promoting hope, wellness and recovery, donated their time and talent to create 10-15 minute anti-stigma and discrimination videos that are aired on various television stations, including: Latina boxing champion Mia St. John; CSI-Las Vegas actor and musician Robert David Hall; actress and author Mariette Hartley; psychiatrist in recovery Clayton Chau, M.D., Ph.D.; Veteran General Hospital actor Maurice Bernard; and US Vets CEO Steve Peck, M.S.W.	TAY Adults Older Adults	Stigma & Discrimination Reduction	ES-3
23	**Families Over Coming Under Stress (FOCUS)**	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	Children TAY Adults	Prevention & Early Intervention	ES-3
24	**Functional Family Therapy (FFT)**	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	Children (ages 11-15) TAY (ages16-18)	Early Intervention	PEI-4 PEI-9
25	**Group Cognitive Behavioral Therapy for Major Depression (Group CBT)**	Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.	TAY (ages 18-25) Adults Older Adults	Early Intervention	PEI-3 PEI-4 PEI-6 PEI-7 PEI-8
26	**Incredible Years (IY)**	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.	Young Children (ages 2-5) Children (ages 6-12)	Prevention & Early Intervention	PEI-2 PEI-3 PEI-5

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
27	**Individual Cognitive Behavioral Therapy (Ind. CBT)**	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.	TAY (18-25) Adults Older Adults Directly Operated Clinics only	Early Intervention	PEI-3 PEI-4 PEI-5 PEI-6 PEI-7
28	**Interpersonal Psychotherapy for Depression (IPT)**	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	Children (ages 9-15) TAY Adults Older Adults	Early Intervention	PEI-6 PEI-8
29	**Loving Intervention Family Enrichment Program (LIFE)**	An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	Children (ages 10-18)	Early Intervention	PEI-7
30	**Make Parenting a Pleasure (MPAP)**	MPAP is a group-based parent training program designed for parents and caregivers of children from birth to eight years of age. The program addresses the stress, isolation, and lack of adequate parenting information and social support that many parents experience. MPAP begins by recognizing the importance of parents as individuals, and builds on family strengths and helps parents develop strong support networks. The curriculum focuses first on the need for self-care and personal empowerment, and then moves from an adult focus to a parent/child/family emphasis.	Children (ages 0-8) TAY Adults Older Adults	Prevention	PEI-2 PEI-3 PEI-6
31	**Managing and Adapting Practice (MAP)**	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	Young Children Children TAY (ages 16-21)	Early Intervention	PEI-1 PEI-2 PEI-3 PEI-4

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
32	**Mental Health First Aid (MHFA)**	MHFA is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. An interactive 8-hour course, MHFA presents an overview of mental illness and substance use disorders and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Participants learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.	TAY Adults Older Adults	Stigma & Discrimination Reduction	PEI-2 PEI-9
33	**Mental Health Integration Program (MHIP) formerly known as IMPACT**	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.	Adults	Prevention & Early Intervention	PEI-5 PEI-8
34	**Mindful Parenting Groups (MP)**	MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	Young Children (ages 0-3)	Early Intervention	PEI-3
35	**Multidimensional Family Therapy (MDFT)**	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	Children (ages 12-15) TAY (ages 16-18)	Early Intervention	PEI-1 PEI-6 PEI-7
36	**Multisystemic Therapy (MST)**	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	Children (ages 12-15)TAY (ages 16-17)	Early Intervention	PEI-7

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
37	**Nurse Family Partnership (NFP)**	Registered nurses conduct home visits to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits may continue until the baby is two years old. Provided in conjunction with the L.A. County Department of Public Health.	Young Children (ages 0-2)	Prevention & Early Intervention	PEI-2 PEI-9
38	**Olweus Bullying Prevention Program (OBPP)**	OBPP is designed to promote the reduction and prevention of bullying behavior and victimization problems for children. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers, and students with the classroom, the school as a whole, and the community. School staff has the primary responsibility for introducing and implementing the program.	Children (ages 6-15)	Prevention	PEI-1
39	**Parent-Child Interaction Therapy (PCIT)**	PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	Young Children (ages 2-7)	Stigma & Discrimination Reduction	PEI-3 PEI-4
40	**Problem Solving Therapy (PST)**	PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	Older Adults	Early Intervention	PEI-8
41	**Program to Encourage Active Rewarding Lives for Seniors (PEARLS)**	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	Older Adults	Prevention & Early Intervention	PEI-8 PEI-9

PROGRAM NAME		DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
42	**Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)**	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only	Early Intervention	PEI-4 PEI-7 PEI-9
43	**Promoting Alternative Thinking Strategies (PATHS)**	PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	Children (ages 5-12)	Prevention & Early Intervention	PEI-1
44	**Reflective Parenting Program (RPP)**	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	Young Children (ages 2-5) Children (ages 6-12)	Early Intervention	PEI-3
45	**Seeking Safety (SS)**	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	Children (ages 13-15) TAY Adults Older Adults	Early Intervention	PEI-4 PEI-6
46	**Strengthening Families (SF)**	SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	Children (ages 3-15) TAY (ages 16-18)	Prevention & Early Intervention	PEI-1

	PROGRAM NAME	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)	PREVENTION AND/OR EARLY INTERVENTION	PEI PROJECT(S)
47	**Trauma Focused Cognitive Behavioral Therapy (TF-CBT)**	An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.), for children and TAY receiving these services.	Young Children Children TAY (ages16-18)	Early Intervention	PEI-4 PEI-6 PEI-7 PEI-9
48	**Trauma Focused CBT (TF-CBT): "Honoring Children, Mending the Circle"**	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. Traditional aspects of healing with American Indians and Alaskan natives from their world view are included.	Children	Early Intervention	PEI-10
49	**Triple P Positive Parenting Program (Triple P)**	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.	Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)	Prevention & Early Intervention	PEI-2 PEI-3 PEI-5
50	**UCLA Ties Transition Model (UCLA TTM)**	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).	Young Children (0-5) Children (ages 6-12)	Early Intervention	PEI-3
51	**Veterans System Navigators**	Military veterans engage veterans and their families in order to identify and link them to support and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Navigators also engage in joint planning efforts with community partners, including veterans groups, veterans administration, community-based organizations, other County Departments, schools, faith-based organizations, etc. with the goal of increasing access to mental health services and strengthening the network of services available to veterans. Provided in conjunction with the L.A. County Department of Military and Veterans Affairs.	TAY Adults Older Adults	Prevention	PEI-4

The table below lists practice and outcome information for PEI outcomes practices (Data as of 9/22/2016):

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Aggression Replacement Training (ART)	67.39%	3,263	41.2% (n=1,161)	58.8% (n=1,657)	YOQ Total Score (n=363)	25.42%	ECBI Intensity Scale (n=352)	9.84%
					YOQ-SR Total Score (n=473)	12.96%	ECBI Problem Scale (n=352)	21.43%
ART Skillstreaming		288	52.9% (n=92)	47.1% (n=82)	YOQ Total Score (n=22)	27.63%	ECBI Intensity Scale (n=18)	N<20
					YOQ-SR Total Score (n=6)	N<20	ECBI Problem Scale (n=18)	N<20
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)	82.10%	1,013	48% (n=343)	52.0% (n=371)	YOQ Total Score (n=240)	48.21%	PTSD-RI Child/ Adolescent Severity Score (n=208)	53.85%
							PTSD-RI-5 Child/Adol. Severity Score (n=5)	N<20
					YOQ-SR Total Score (n=95)	42.55%	PTSD-RI Parent Severity Score (n=211)	50.00%
							PTSD-RI-5 Parent Severity Score (n=6)	N<20
Brief Strategic Family Therapy (BSFT)	62.01%	153	62% (n=72)	37.9% (n=44)	YOQ Total Score (n=47)	47.92%	RBPC Anxiety-Withdrawal Raw Score (n=42)	66.67%
							RBPC Attention Problems-Immaturity Raw Score (n=42)	54.55%
							RBPC Conduct Disorder Raw Score (n=42)	46.15%
					YOQ-SR Total Score (n=26)	44.19%	RBPC Motor Tension Excess Raw Score (n=42)	50.00%
							RBPC Psychotic Behavior Raw Score (n=42)	0.00%
							RBPC Socialized Aggression Raw Score (n=42)	50.00%

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Caring for Our Families (CFOF)	68.45%	728	67.8% (n=353)	32.2% (n=168)	YOQ Total Score (n=132)	23.08%	ECBI Problem Scale (n=59)	30.77%
							ECBI Intensity Scale (n=59)	20.17%
Center for the Assessment & Prevention of Prodromal States (CAPPS)	55.68%	149	46.7% (n=49)	53.3% (n=56)	OQ Total Score (n=9)	N<20	SOPS Disorganized Symptoms (D) Total Score (n=31)	60%
					YOQ Total Score (n=20)	26.56%	SOPS General Symptoms (G)Total Score (n=31)	57.14%
							SOPS Negative Symptoms (N) Total Score (n=31)	54.55%
					YOQ-SR Total Score (n=27)	35.94%	SOPS Positive Symptoms (P) Total Score (n=31)	64.29%
							SOPS Total of All Scores (n=31)	55.26%
Child-Parent Psychotherapy (CPP)	63.62%	4,017	47% (n=1,437)	53% (n=1,621)	YOQ Total Score (n=351)	56.00%	TYCYC PTS Total Score (n=525)	19.05%
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	93.86%	107	65% (n=57)	35.2% (n=31)	YOQ Total Score (n=32)	28.57%	PTSD-RI Child/ Adolescent Severity Score (n=33)	28.00%
					YOQ-SR Total Score (n=21)	18.42%	PTSD-RI Parent Severity Score (n=21)	23.53%
Crisis Oriented Recovery Services (CORS)	32.00%	3,178	60% (n=1,254)	40.1% (n=838)	OQ Total Score (n=173)	20.55%	No specific outcome measure required for this practice	
					YOQ Total Score (n=689)	27.27%		
					YOQ-SR Total Score (n=307)	28.57%		
Dialectical Behavior Therapy (DBT)	31.61%	61	29.4% (n=5)	70.6% (n=12)	OQ Total Score (n=4)	N<20	DERS Total Score (n=4)	N<20

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Depression Treatment Quality Improvement (DTQI)	94.85%	996	61.3% (n=573)	38.7% (n=361)	OQ Total Score (n=4)	N<20	PHQ-9 Total Score (n=323)	62.50%
					YOQ Total Score (n=309)	45.10%		
					YOQ-SR Total Score (n=301)	47.17%		
Families Overcoming Under Stress (FOCUS)	50.74%	171	73.2% (n=104)	26.8% (n=38)	YOQ Total Score (n=60)	40.91%	FAD Affective Involvement (n=13)	N<20
							FAD Affective Responsiveness (n=13)	N<20
							FAD Behavioral Control (n=13)	N<20
					YOQ-SR Total Score (n=20)	43.24	FAD Communication (n=13)	N<20
							FAD General Functioning (n=13)	N<20
							FAD Problem Solving (n=13)	N<20
							FAD Roles (n=13)	N<20
Functional Family Therapy (FFT)	62.85%	1,556	65.1% (n=827)	34.9% (n=444)	YOQ Total Score (n=678)	29.31%	No specific outcome measure required for this practice	
					YOQ-SR Total Score (n=603)	27.08%		
Group Cognitive Behavioral Therapy for Major Depression (Group CBT)	88.30%	998	43.2% (n=307)	56.8% (n=403)	OQ Total Score (n=195)	22.35%	PHQ-9 Total Score (n=218)	42.86%
Incredible Years (IY)	72.65%	2,034	64.5% (n=1,114)	35.5% (n=613)	YOQ Total Score (n=815)	27.78%	ECBI Intensity Scale (n=723)	18.11%
							ECBI Problem Scale (n=723)	35.29%

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Individual Cognitive Behavioral Therapy (Ind CBT)-Anxiety	64.54%	848	40.8% (n=180)	59.2% (n=261)	OQ Total Score (n=112)	36.23%	GAD-7 Total Score (n=111)	54.55%
					YOQ Total Score (n=7)	N<20		
					YOQ-SR Total Score (n=16)	N<20		
Individual Cognitive Behavioral Therapy (Ind CBT)-Depression		2,533	40% (n=554)	60% (n=832)	OQ Total Score (n=341)	34.62%	PHQ-9 Total Score (n=383)	53.85%
					YOQ Total Score (n=14)	N<20		
					YOQ-SR Total Score (n=41)	42.86%		
Individual Cognitive Behavioral Therapy (Ind CBT)-Trauma		353	48.3% (n=87)	51.7% (n=93)	OQ Total Score (n=54)	40.91%	PTSD-RI Adult Severity Score (n=15)	N<20
					YOQ Total Score (n=6)	N<20	PCL-5 Total Score (n=3)	N<20
					YOQ-SR Total Score (n=7)	N<20	PTSD-RI Child/ Adolescent Severity Score (n=15)	N<20
							PTSD-RI-5 Child/Adol. Severity Score (n=0)	N<20
							PTSD-RI Parent Severity Score (n=5)	N<20
							PTSD-RI-5 Parent Severity Score (n=0)	N<20
Interpersonal Psychotherapy for Depression (IPT)	71.14%	4,026	52.7% (n=1,551)	47.3% (n=1,392)	OQ Total Score (n=602)	28.77%	PHQ-9 Total Score (n=996)	54.55%
					YOQ Total Score (n=265)	48.15%		
					YOQ-SR Total Score (n=387)	46.43%		

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Loving Intervention Family Enrichment Program (LIFE)	99.08%	331	63.5% (n=193)	36.5% (n=111)	YOQ Total Score (n=124)	33.33%	ECBI Intensity Scale (n=104)	20.18%
					YOQ-SR Total Score (n=88)	20.75%	ECBI Problem Scale (n=104)	43.75%
Managing and Adapting Practice (MAP)	52.66%	27,168	55.2% (n=9,260)	44.8% (n=7,515)	YOQ Total Score (n=3,745)	41.51%	ECBI Intensity Scale (n=1,446)	24.62%
							ECBI Problem Scale (n=1,446)	43.75%
							PHQ-9 Total Score (n=939)	55.56%
							RCADS- Total Anxiety (n=917)	42.86%
					YOQ-SR Total Score (n=1,710)	40.82%	RCADS-P Total Anxiety (n=858)	40.00%
							PTSD-RI Child/ Adolescent Severity Score (n=85)	53.13%
							PTSD-RI-5 Child/Adol. Severity Score (n=16)	N<20
					OQ Total Score (n=25)	32.35%	PTSD-RI Parent Severity Score (n=86)	43.48%
							PTSD-RI-5 Parent Severity Score (n=10)	N<20
							PCL-5 Total Score (n=1)	N<20
Mental Health Integration Program (MHIP) - Anxiety	116.00%	1,502	39% (n=510)	61% (n=789)	No General Measure Required for this Practice		GAD-7 Total Score (n=467)	50.00%
Mental Health Integration Program (MHIP) - Depression		4,756	35% (n=1,437)	65% (n=2,713)			PHQ-9 Total Score (n=1,333)	53.00%
Mental Health Integration Program (MHIP) - Trauma		297	29% (n=79)	71% (n=191)			PCL-C Total Score (n=62)	27.00%
Mindful Parenting (MP)	PEI OMA was updated to allow data entry for the practice as of 5/27/2015. To date there is not enough data entered to analyze.							

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Multidimensional Family Therapy (MDFT)	64.84%	64	86.2% (n=25)	13.8% (n=4)	YOQ Total Score (n=18)	N<20	RBPC Anxiety-Withdrawal Raw Score (n=5)	N<20
							RBPC Attention Problems-Immaturity Raw Score (n=5)	N<20
							RBPC Conduct Disorder Raw Score (n=5)	N<20
					YOQ-SR Total Score (n=20)	21.05%	RBPC Motor Tension Excess Raw Score (n=5)	N<20
							RBPC Psychotic Behavior Raw Score (n=5)	N<20
							RBPC Socialized Aggression Raw Score (n=5)	N<20
Multisystemic Therapy (MST)	40.61%	126	71.7% (n=71)	28.3% (n=28)	YOQ Total Score (n=47)	47.62%	Specific outcome measure data for practice is not entered in PEI OMA	
					YOQ-SR Total Score (n=41)	38.78%		
Nurse-Family Partnership (NFP)	Outcome data is not reported in PEI OMA							
Parent-Child Interaction Therapy (PCIT)	58.33%	1,946	43% (n=579)	57.1% (n=770)	YOQ Total Score (n=280)	57.14%	ECBI Intensity Scale (n=444)	37.59%
							ECBI Problem Scale (n=444)	63.16%
Problem-Solving Therapy (PST)	61.65%	346	60% (n=168)	40.2% (n=113)	OQ Total Score (n=95)	28.36%	PHQ-9 Total Score (n=119)	45.45%
Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)	76.38%	152	50% (n=63)	50% (n=63)	OQ Total Score (n=27)	25.00%	PHQ-9 Total Score (n=43)	45.45%
Prolonged Exposure Therapy for Post-Traumatic Stress Disorder (PE-PTSD)	37.82%	45	52.6% (n=10)	47.4% (n=9)	OQ Total Score (n=8)	N<20	PDS Symptom Severity Score (n=9)	N<20

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Promoting Alternate Thinking Strategies (PATHS)	51.15%	730	34.4% (n=174)	65.6% (n=332)	YOQ Total Score (n=36)	37.04%	ECBI Intensity Scale (n=36)	19.83%
					YOQ-SR Total Score (n=1)	N<20	ECBI Problem Scale (n=36)	33.33%
Reflective Parenting Program (RPP)	64.71%	165	75.2% (n=100)	24.8% (n=33)	YOQ Total Score (n=48)	10.20%	ECBI Intensity Scale (n=66)	9.02%
					YOQ-SR Total Score (n=4)	N<20	ECBI Problem Scale (n=66)	14.29%
Seeking Safety (SS)	62.71%	15,756	40% (n=4,724)	60% (n=7,093)	OQ Total Score (n=691)	31.17%	PTSD-RI Adult Severity Score (n=426)	30.56%
							PCL-5 Total Severity Score (n=7)	N<20
					YOQ Total Score (n=857)	34.48%	PTSD-RI Parent Severity Score (n=664)	36.84%
							PTSD-RI-5 Parent Severity Score (n=18)	N<20
					YOQ-SR Total Score (n=1,733)	32.08%	PTSD-RI Child/ Adolescent Severity Score (n=1,395)	31.82%
							PTSD-RI-5 Child/Adol. Severity Score (n=28)	29.03%

Evidence-Based Practice	Outcomes, Starting July 2011 through September 22, 2016							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Strengthening Families (SF)	37.11%	236	88% (n=74)	12% (n=10)	YOQ Total Score (n=41)	32.14%	RBPC Anxiety-Withdrawal Raw Score (n=15)	N<20
							RBPC Attention Problems-Immaturity Raw Score (n=15)	N<20
							RBPC Conduct Disorder Raw Score (n=15)	N<20
					YOQ-SR Total Score (n=29)	26.92%	RBPC Motor Tension Excess Raw Score (n=15)	N<20
							RBPC Psychotic Behavior Raw Score (n=15)	N<20
							RBPC Socialized Aggression Raw Score (n=15)	N<20
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	45.73**	13,873	55.6% (n=4,682)	44.4% (n=3,738)	YOQ Total Score (n=1,783)	48.98%	PTSD-RI Parent Severity Score (n=1,408)	50.00%
							PTSD-RI-5 Parent Severity Score (n=106)	56%
					YOQ-SR Total Score (n=688)	48.00%	PTSD-RI Child/ Adolescent Severity Score (n=1,434)	51.85%
							PTSD-RI-5 Child/Adol. Severity Score (n=117)	50%
Triple P- Positive Parenting Program (Triple P)	42.31**	4,176	57.6% (n=1,323)	42.4% (n=975)	YOQ Total Score (n=754)	41.67%	ECBI Intensity Scale (n=758)	27.14%
					YOQ-SR Total Score (n=56)	30.23%	ECBI Problem Scale (n=758)	50.00%
UCLA Ties Transition Model (UCLA TTM)	86.63%	166	48% (n=59)	52% (n=64)	YOQ Total Score (n=6)	N<20	ECBI Intensity Scale (n=7)	N<20
							ECBI Problem Scale (n=7)	N<20

* CORS data collection was delayed until mid 2013 so compliance rate might be understated.
**MAP, TF-CBT, and Triple P compliance rates do not include data for inactive treatment cycles reported to CiMH at the time of the data transition to DMH.
Data reported on here only includes information contained in our DMH PEI OMA system.
MHIP does not collect a "post" measure. Pre/Post changes reported are determined from first questionnaire with scores to last questionnaire with scores.

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

The MHSA Implementation and Outcomes Division provides regular training on the use of outcome measures for PEI and use of the PEI OMA web-based application in the form of in-person training as well as webinars and written guides. For more information on PEI outcome user support, use the following link www.dmhoma.pbworks.com.

LACDMH's MHSA Implementation and Outcomes Division have developed opportunities for providers to utilize outcome data to enhance their services and to better understand PEI outcome reports.

Prevention Programs

Three (3) programs were identified to prevent and minimize the impact of mental health issues for consumers and their families. Each prevention program provides one (1) or more types of services including: case management and/or individual services; workshops or seminars (one-time only services); and group sessions (multiple session services).

1. Making Parenting a Pleasure (MPAP) is a promising practice, group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic backgrounds. Age group is parents of children (ages 0-8 years).

2. The Outreach and Education Pilot (OEP) for TAY At-Risk of or involved with the Juvenile Justice System or on Probation, At-Risk for School Failure, and At-Risk of Substance Abuse focuses on assisting youth who are at jeopardy of general delinquency, school failure, involvement with law enforcement agencies, as well as abusing or at risk of alcohol and drugs (whether illegal or legal). This OEP for At-Risk TAY At-Risk provides focuses on mental health promotion and prevention services to youth age to prevent recidivism and behaviors that bring them into contact with the juvenile justice system.

3. The Outreach and Education Pilot (OEP) for Underserved Populations focuses on assisting racial/ethnic minorities and underserved communities in Los Angeles County. This OEP provides community-based outreach, educational workshops, case management, individual counseling, and group sessions delivered by and for targeted communities. Services can occur in culturally appropriate settings, which can range from community events to faith-based organizations, as well as other community-based organizations, primary care settings, community centers, and schools. Such activities are intended to help identify situations in which educational programs may lessen the impact or prevent more serious mental health issues from occurring. Serves all ages.

Eighteen Community-Based Organizations, including Faith-Based Organizations and School Districts were funded to provide the three PEI Prevention Programs.

PEI COMMUNITY-BASED PREVENTION PROGRAMS			
NAME OF AGENCY		SUPERVISORIAL DISTRICT	PEI PROGRAM
1.	Avalon Carver Community Center	2	MPAP
2.	Child Alliance, Inc.	2	MPAP
3.	Children and Families, Inc.	4	MPAP
4.	El Rancho Unified School District	1	MPAP
5.	His Sheltering Arms	2	MPAP
6.	Lennox School District	2	MPAP
7.	Westside Children's Center	2	MPAP

PEI COMMUNITY-BASED PREVENTION PROGRAMS			
	NAME OF AGENCY	SUPERVISORIAL DISTRICT	PEI PROGRAM
8.	CASA of Los Angeles	1	OEP At-Risk TAY
9.	Helping Other People Excel (HOPE)	2	OEP At-Risk TAY
10.	Paving the Way Foundation	5	OEP At-Risk TAY
11.	United Job Creation Council	2	OEP At-Risk TAY
12.	ABC Unified School District	4	OEP Underserved
13.	Catholic Charities of Los Angeles, Inc.	1	OEP Underserved
14.	Coalition to Abolish Slavery & Trafficking (CAST)	3	OEP Underserved
15.	Refiners Fire Fellowship United Church of Christ	4	OEP Underserved
16.	St. Barnabas Senior Center of Los Angeles	1	OEP Underserved
17.	World Mission University	2	OEP Underserved
18.	Young Nak Outreach & Transformation	1	OEP Underserved

NUMBER OF PARTICIPANTS SERVED, RACE/ETHNICITY, AND OUTCOMES		
Number of Clients Served:		
MPAP	559	
OEP At-Risk TAY	565	
OEP Underserved	8,581	
Total	9,705	
Race/Ethnicity of Clients Served: (*Participants may check multiple categories)*		
African/African American	429	
Asian/Pacific Islander	2,297	
Hispanic/ Latino	1,970	
Eastern European/Middle Eastern	22	
Native American/American Indian	11	
White/Other	257	
Not Reported/Unknown	326	
Outcomes - Number of Pre/Post Surveys Submitted:		
MPAP	720	
OEP At-Risk TAY	57	
OEP Underserved	4,663	
Total	5,440	
Number of Participants and Percentage increase Reporting Increase in Knowledge about Mental Health Promotion/Prevention and Skills:		
MPAP	630	87.5%

NUMBER OF PARTICIPANTS SERVED, RACE/ETHNICITY, AND OUTCOMES		
OEP At-Risk TAY	40	70.2%
OEP Underserved	3,673	78.8%
Total	4343	79..8%

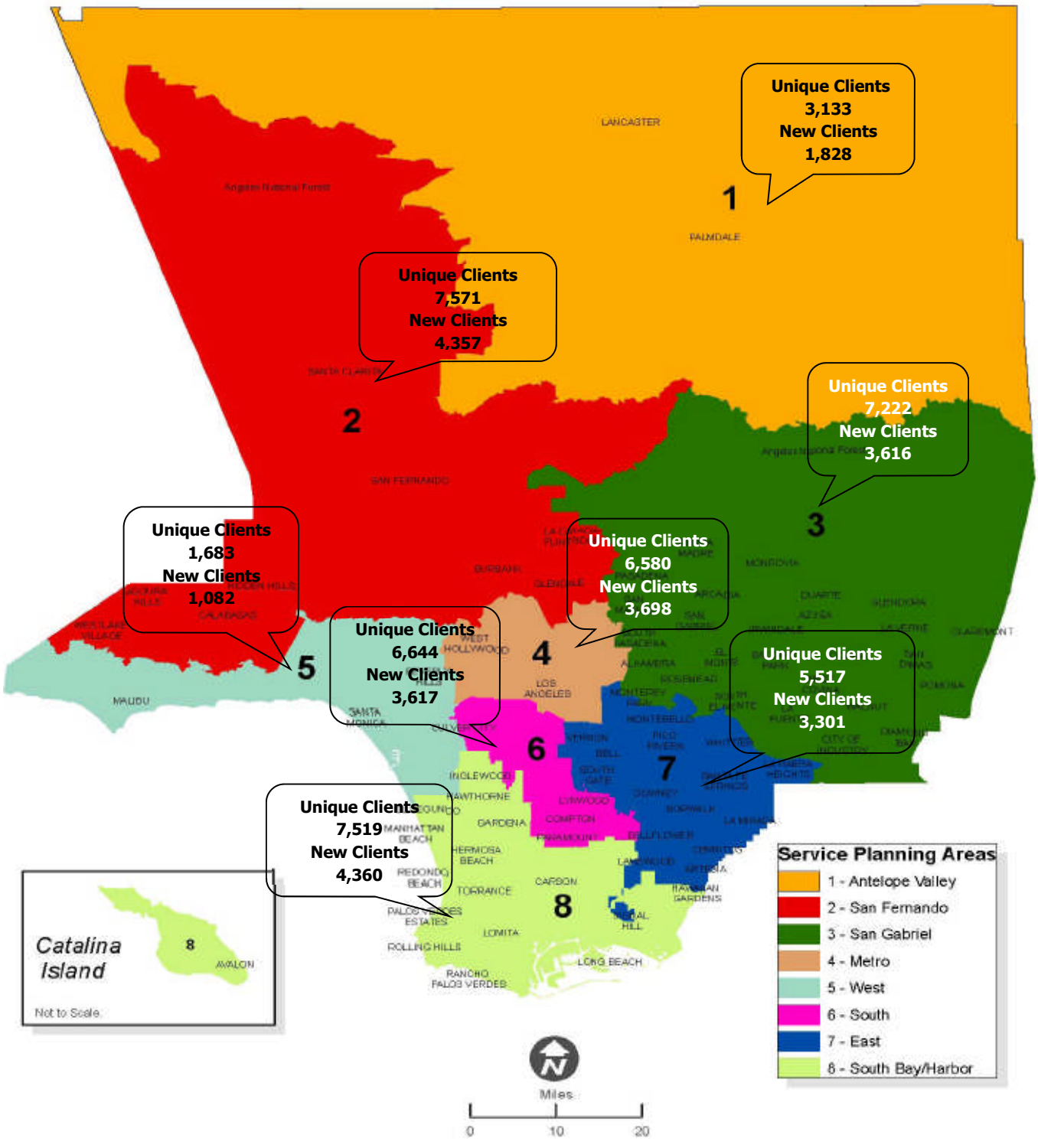
Outreach for Increasing Recognition of Early Signs of Mental Illness

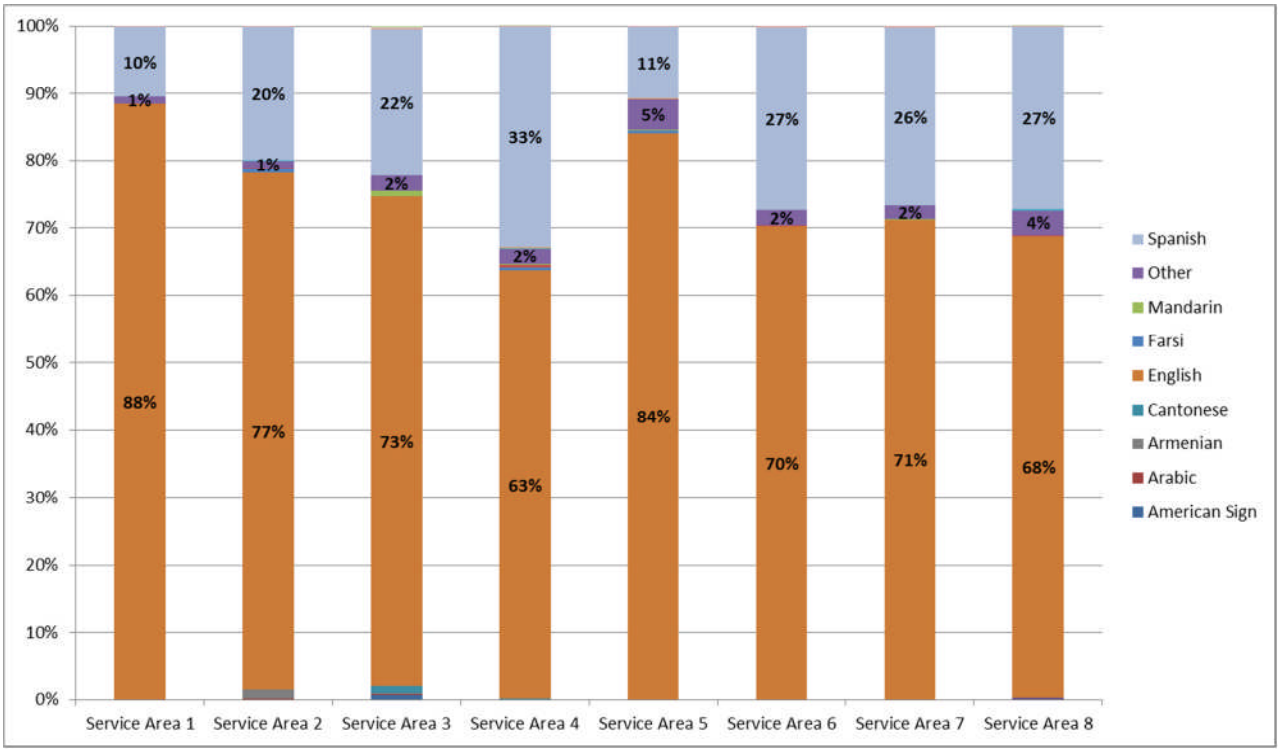
The Department funds this function through CSS, specifically through Planning, Outreach and Engagement and through the work of Promotores/Community Mental Health Workers.

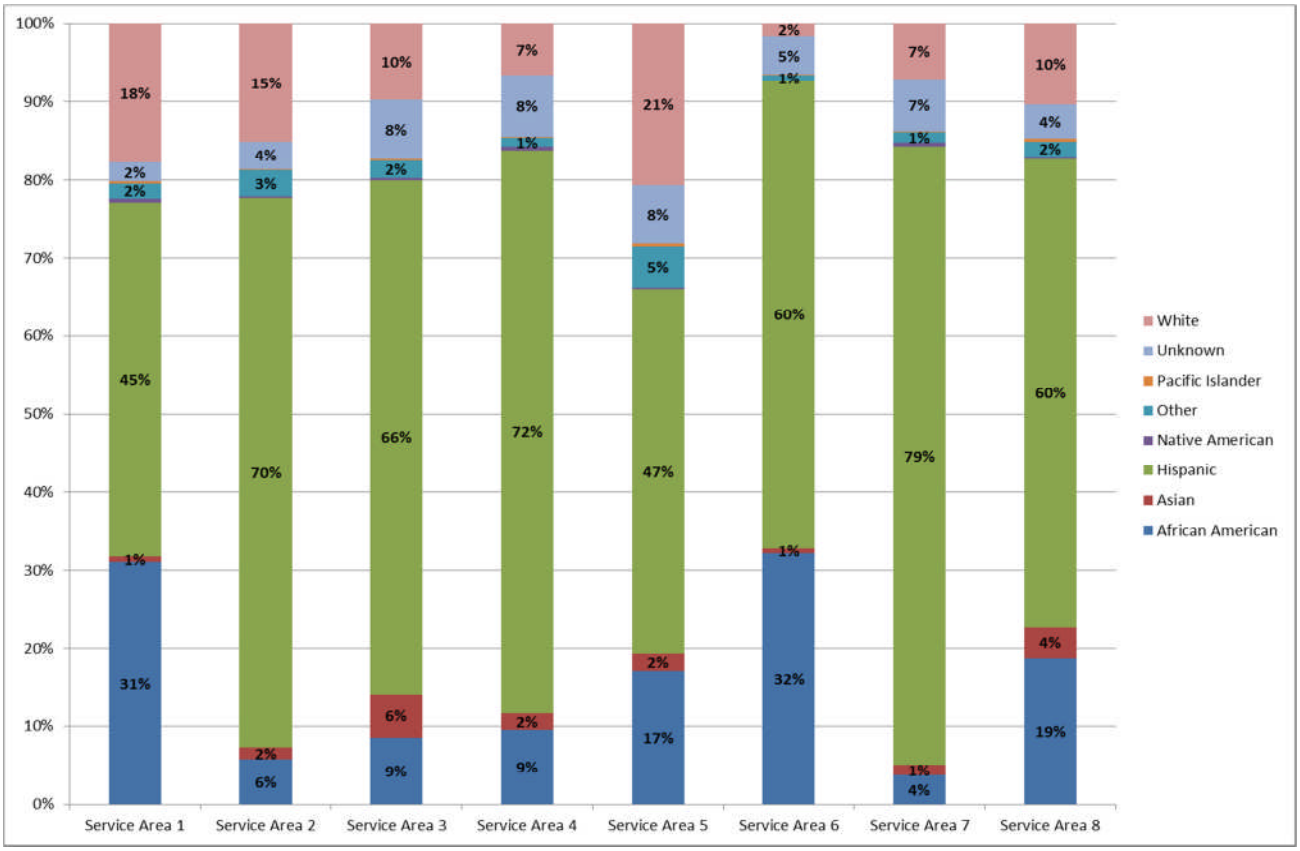
Access and Linkage to Treatment for Individuals with Serious Mental Illness/Serious Emotional Disturbance Seeking Services through PEI

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 Los Angeles County and cannot be reported on.

Los Angeles County Number of Clients served Through PEI by Service Areas Fiscal Year 2015-16




100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Service Area 1
Service Area 2
Service Area 3
Service Area 4
Service Area 5
Service Area 6
Service Area 7
Service Area 8
10%
1%
88%
20%
1%
77%
22%
2%
73%
33%
2%
63%
11%
5%
84%
27%
2%
70%
26%
2%
71%
27%
4%
68%
Spanish
Other
Mandarin
Farsi
English
Cantonese
Armenian
Arabic
American Sign


100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Service Area 1
Service Area 2
Service Area 3
Service Area 4
Service Area 5
Service Area 6
Service Area 7
Service Area 8
18%
2%
2%
45%
1%
31%
15%
4%
3%
70%
2%
6%
10%
8%
2%
66%
6%
9%
7%
8%
1%
72%
2%
9%
21%
8%
5%
47%
2%
17%
2%
5%
1%
60%
1%
32%
7%
7%
1%
79%
1%
4%
10%
4%
2%
60%
4%
19%
White
Unknown
Pacific Islander
Other
Native American
Hispanic
Asian
African American

Prevention and Early Intervention Program Consolidation

The original PEI plan identified 13 programs with overlapping evidence-based, promising and community-defined evidence practices associated with each of the 13 programs. This consolidation of 13 programs into 7 represents a one-to-one correspondence between practices and the programs that counties are required to report on, increasing reporting accuracy.

The PEI Three-Year Plan for Fiscal Years (FY) 2017-18 to 2019-20 was developed through a stakeholder process that consisted of four age groups (children, TAY, adults, and older adults) as well as a countywide special population workgroup. Stakeholders representing consumers, parents, family members, mental health provider, educational and social service providers and DMH staff, participated in the planning process that occurred in fall 2016. (Work group sign in sheets available upon request.) As a result of this planning process, the following programs were developed and selected:

- 7 PEI Plan Programs
- Total 79 L.A. DMH PEI programs/projects
- 32 Prevention Programs
- 38 Early Intervention Programs
- 16 Evidence-Based Programs
- 13 Promising Practices
- 9 Community-Defined Evidence Practices

An overview of the PEI Plan is presented on the next page, and more extensive descriptions of the PEI 3-year Plan follow.

Summary (*Indicates programs are new additions to the PEI Plan. See Appendix VIII for a list of abbreviations.)

PEI - 01 Suicide Prevention	PEI - 02 Stigma and Discrimination Reduction	PEI - 03 Strengthening Family Functioning	PEI - 04 Trauma Recovery Services
1. 24/7 Crisis Hotline 2. ASIST Training 3. AMSR Training 4. Latina Youth Program 5. Partners in Suicide (PSP)Team for Children, TAY, Adults, and Older Adults 6. QPR Training 7. RRSR Training	1. Children's Stigma and Discrimination Reduction Project 2. Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination 3. Mental Health First Aid (MHFA) 4. Mental Health Promoters/Promotores Program 5. Older Adults Mental Health Wellness Project 6. Profiles of Hope Project	1. AAFEN 2. AF-CBT 3. BSFT 4. CFOF 5. FC 6. IY 7. LIFE 8. MPAP 15. MP 16. PCIT 17. RPP* 18. Triple P (Prevention and Early Intervention Services)* 19. Second Step* 20. UCLA Ties Transition Model	1. CPP CBITS 3. PE-PTSD 4. SS 5. TF-CBT 6. TF-CBT - Honoring Children, Mending the Circle (American Indians)

PEI – 05 Individuals and Families Under Stress	PEI – 06 At-Risk Youth	PEI - 07 Vulnerable Communities
20. CORS 21. DTQI 22. DBT 23. FOCUS 24. Group CBT 25. Group IPT (Maternal Depression)* 26. Heathy IDEAS* 27. Ind. CBT 28. IPT 29. MAP 30. MHIP 31. Mindful Schools* 32. NFP 33. PST 34. PEARLS 35. PATHS 36. SCALE 37. Senior Reach* 38. The Mothers and Babies, Mamas y Bebes*	17. ART 18. American Indian Life Skills (AILS) 19. Boys and Girls Club Project: LEARN* 20. CAPPS 21. Coordinated Specialty Care Model for Early Psychosis (CSC-EP)* 22. Early Identification and Prevention of Psychosis Outreach (PIER Model)* 23. FFT 24. MDFT 25. MST 26. OBPP 27. Positive Action* 28. Safe School Ambassadors* 29. START* 30. SFP 31. TAY Drop-In Center Targeted Outreach & Engagement Strategies 32. Why Try? Program*	7. Commercial Sexual Exploitation of Children and Youth (CSECY) Training 8. Domestic Violence and Intimate Partner Violence Services* 9. Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex and 2-Spirit (LGBTQI2-S) TAY Prevention Services* 10. PEI Supportive Housing Services* 11. Veterans Community Colleges Outreach and Case Management Services* 12. Veterans Mental Health Services (peer support, female veterans, suicide prevention)* 9. Veterans Service Navigators

Cross-Cutting Programs and Strategies

The Department has several PEI Prevention programs and strategies as well as EBP/CDEs that serve the Vulnerable Communities and other At-Risk Populations which include services from two or more of the seven (7) PEI Programs listed above.

	Cross-Cutting Programs and Strategies	PEI Program Numbers.	Ages Served
1.	Building Resilience for Vulnerable Children and Families	3, 4, 5, 6, 7	All Ages
2.	Commercially Sexually Exploited Children and Youth (CSECY) Programs	3, 4, 5, 6, 7,	Children & TAY
3.	Co-concurrent Physical Disabilities and Mental Health Concerns (Blind/Visually Impaired and Deaf/Hearing Impaired)	3, 4, 5, 6	All Ages
4.	County Department of Health Services (DHS)-DMH Co-Located Programs	3, 4, 5	Adults & Older Adults
5.	Domestic and Intimate Partner Violence	3, 4, 5, 6, 7	Children & TAY
6.	Early Education, Headstart and Preschool Programs:	3, 4, 5, 6, 7	Children & TAY
7.	Federally Qualified Health Center (FQHC) Programs	3, 4, 5	Adults & Older Adults
8.	Juvenile Justice After Care Program	4, 5, 6	Children & TAY
9.	School-Based and School-Linked Programs:	3, 4, 5, 6, 7,	Children & TAY
10.	Training for Community, Consumers, and Providers	All	All Ages
11.	Unaccompanied Minors:	3, 4, 5, 6, 7	Children & TAY

PEI-01. 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.

PROGRAM NAME	TYPE	AGES SERVED
1. **24/7 Crisis Hotline** The 24/7 Crisis Hotline services and support services to attempters and/or those bereaved by a suicide. Services are offered in English as well as Spanish; people in crisis can also receive Korean and Vietnamese language services most evenings and assistance consultation to law enforcement and first responders. There are multiple daily scheduled Warm Line coverage in Los Angeles County, and in order to minimize coverage gaps, the Warmline coverage will be expanded. The program has built community capacity by offering training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models to various staff to recognize and respond appropriately to suicide.	SP	All Ages
2. **Applied Suicide Intervention Skills (ASIST) Training** ASIST is intended to help participants become ready, willing and able to provide suicide first aid to persons at risk of dying by suicide. ASIST instructs clergy, first responders, teachers, and others holding jobs in which they are likely to come in contact with people at risk for suicide how to recognize risk factors, intervene, and link those at risk with appropriate resources.	SP	TAY, Adults & Older Adults
3. **Assessing and Managing Suicide Risk (AMSR) Training** AMSR is a one-day training workshop for behavioral health professionals that are designed to help participants provide safer suicide care. Health care providers face many challenges when working with patients and clients at risk for suicide.	SP	TAY, Adults & Older Adults
4. **Latina Youth Program** Pacific Clinics provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to schools regarding suicide risk factors among teens. The primary goals of the Latina Youth Program are to 1) Promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide; 2) Increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services; 3) Increase access to services while decreasing barriers and stigma among youth in accepting mental health services; 4) Increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion; and 5) Enhance awareness and education among school staff and community members regarding substance abuse and depression.	SP	All Ages
5. **Partners in Suicide (PSP) Team for Children, Transition Age Youth , Adults, and Older Adults** PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team is comprised of staff representing each of the four age groups, and includes Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence-	SP	TAY, Adults & Older Adults -

PROGRAM NAME	TYPE	AGES SERVED
based practices, and provides linkage and referrals to age appropriate services. Team members conduct countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners.		
6. **Question, Persuade and Refer (QPR) Training** QPR Training for Suicide Prevention is an educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. Gatekeepers individuals who are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers). The process follows three steps: (1) Question the individual's desire or intent regarding suicide, (2) Persuade the person to seek and accept help, and (3) Refer the person to appropriate resources. Trainees receive a *QPR* booklet and wallet card as a review and resource tool that includes local referral resources.	SP	TAY, Adults & Older Adults
7. **Recognizing and Responding to Suicide Risk (RRSR) Training** Recognizing and Responding to Suicide Risk (RRSR) is a training, offered for the first time this fiscal year. Seven (7) staff completed the Train-the-Trainer program and provided five (5) trainings during this fiscal year. RRSR is an interrelated series of learning events based on a set of 24 core competencies that comprehensively define the knowledge, skill and attitudes required for effective clinical risk assessment and treatment of individuals at risk for suicide.	SP	TAY, Adults & Older Adults

PEI-02. Stigma and Discrimination Reduction

The purpose of the Stigma and Discrimination Reduction Program 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.

PROGRAM NAME	TYPE	AGES SERVED
1. **Children's Stigma and Discrimination Reduction Project** The project provides education to parents and to the community through two distinct curricula. The first is a 10-week course, developed specifically to reduce stigma, includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. The second is a 12-week course, developed by United Advocates for Children and Families, is an education course on childhood mental illnesses, and includes grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS.	SDR	TAY, Adults & Older Adults
2. **Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination** a. Adult System of Care Anti-Stigma and Discrimination Team	SDR	All Ages

PROGRAM NAME	TYPE	AGES SERVED
b. Mental Health 101: NAMI Mental Health 101 is a presentation program designed for the general audiences with special attention centered on the uniqueness of multi-cultural communities including African American, LGBTQ, Latino, Asian & Pacific Islander, and Native Americans. c. Family to Family (English, Spanish and Korean): an EBP that delivers education, increases participants coping skills and empowers family members to become advocates for mental health. Family-to-Family is a 12 -week course for family members/partners/friends of those with mental illness to facilitate a better understanding of mental illness and treatment. The class offers preventative measures for caregiver burnout and early stress signs for caregivers to seek help. d. Ending the Silence (language of trained speaker): an in-school presentation designed to teach middle school and high school students about the signs and symptoms of mental illness, how to recognize early warning signs and the importance of acknowledging need for help. e. Basics (English and Spanish): 10 week course aimed at parents/caregivers of children and adolescents with symptoms or diagnosis of mental illness to build similar skills as the Family to Family for adult family. f. Parents and Teachers as Allies: an in-service presentation designed for teachers and school personnel to raise awareness about mental illness. g. Provider Education: offers in-service training to line staff, emergency room staff, and other health care personnel to expand compassion for the individuals and families living with mental health conditions and to promote collaboration with mental health agencies. h. NAMI in the Lobby: an outreach effort within psychiatric hospitals, outpatient clinics, mental health urgent care centers, and community colleges about NAMI programs and resources as an effort to reduce the average number of years it takes a family to find the resources in NAMI from 7 years. i. In Our Own Voice: presentations designed for the general public to promote awareness of mental illness and the possibility of recovery. These presentations are given by mental health consumers who have been trained and coached on telling their story of mental illness and recovery in a specific format. The presentations put a face on the lived experience of mental illness and recovery. j. Family Voice: similar presentations for the general public to promote awareness of mental illness and the family involvement in recovery process, as told by family members. k. Basics: a 6 week course offered by 10 NAMI Affiliate locations 2 times annually per Affiliate.		
3. **Mental Health First Aid (MHFA)** MHFA is a public education program that helps parents, first responders, faith leaders, and other people identify, understand, and respond to signs of mental illnesses and substance use conditions. The training is intended to build skills for individuals need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. MHFA teaches individuals to recognize the signs and symptoms of common mental illnesses and substance use disorders; de-escalate crisis situations safely; and initiate timely referral to mental health and substance use treatment resources available in the community. The Department both conducts MHFA training as well as train individuals as MHFA trainers.	SDR	TAY, Adults & Older Adults
4. **Mental Health Promoters/Promotores Program** The program represents a promising approach to mental illness and disease prevention	SDR	TAY, Adults &

PROGRAM NAME	TYPE	AGES SERVED
as it increases knowledge about mental illness, increases awareness about available mental health services, and promotes early use of mental health services. The program includes the use of community health workers who are not certified health care professionals, but have been trained to promote health or provide preventive healthcare services within their community, including educational and awareness building activities. The Promotores/Promoters are from and familiar with the cultural needs/dynamics of the communities that they serve and they can speak the language of the community, which results in a greater impact. The Latino Promotoras program is being expanded to other service areas in Los Angeles County. Pilot projects will be initiated to determine the effectiveness of the Mental Health Promotors model in several underserved communities. During the first stage the Promoters model will be implemented for the following communities: African (Somali), Armenian, Asian/Pacific Islander (Filipino), and Native American communities, and thereafter other underserved communities as well.		Older Adults
5. **Older Adults Mental Health Wellness Project** The Older Adult Anti-Stigma and Discrimination team conducts countywide educational presentation, community events and collaboration with various agencies. They provide workshops for seniors through the county and participate in health fairs, as well as provide MHFA training for non-clinical staff, volunteers, and people in the community.	SDR	TAY, Adults & Older Adults
6. **Profiles of Hope Project** The Project has developed a set of 10-minute and 30-minute inspirational stories that spotlight high-profile individuals who candidly share how they overcame stigma and various obstacles to live successful and productive lives. The series was initiated as a vehicle in which to foster dialog and discussion on the issues related to mental health and recovery. The series is designed to help promote widespread tolerance and acceptance of those diagnosed with mental illnesses and/or addiction.	SDR	All Ages

PEI-03. Strengthening Family Functioning

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

PROGRAM NAME	TYPE	AGES SERVED
1. **Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)** AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	EI PP	Children (5-15) TAY (16-17)
2. **Asian American Family Enrichment Network (AAFEN)** The AAFEN Program serves Asian immigrant parents and primary caregivers with inadequate parenting skills to effectively control and nurture their teenage children, who experience reduced family attachment, social functioning, as well as increased family conflict. The AAFEN Program aims at increasing the emotional and behavioral self-efficacy of the Asian parents/caregivers and enhancing the safety and healthy development of Asian immigrant youths. In particular, the AAFEN Program is designed to promote such protective factors as the stability of the Asian immigrant families, the confidence and competence of the Asian immigrant parents and/or primary caregivers in carrying out responsive and effective bicultural parenting and family management skills, and positive family bonding and relationship.	P CDE	Ages 12-18
3. **Brief Strategic Family Therapy (BSFT)** This 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.	EI EBP	Ages 10-16
4. **Caring for Our Families (CFOF)** Adapted from the "Family Connections" model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	EI CDE	Children (5-11)

PROGRAM NAME	TYPE	AGES SERVED
5. **Family Connections (FC)** 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.	EI PP	Children 0-17 TAY (16-17)
6. **Incredible Years (IY)** The IY intervention 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	EI EBP	Children (0-12)
7. **Loving Intervention Family Enrichment Program (LIFE)** An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	EI CDE	Children (4-15) TAY (16-19)
8. **Making Parenting a Pleasure (MPAP)** MPAP is a group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic backgrounds. Age group is parents of children (ages 0-8 years).	P PP	Children (0-8)
9. **Mindful Parenting Groups (MP)** MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	EI	Children (0-3)
10. **Parent-Child Interaction Therapy (PCIT)** PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	EI EBP	Young Children (2-7)

PROGRAM NAME	TYPE	AGES SERVED
11. **Reflective Parenting Program (RPP)** RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	EI	Children (0-12)
12. **Positive Parenting Program (Triple P)** Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through the Los Angeles County Library Family Café Places, community-based organizations, Headstart, childcare providers, preschools and other early education programs. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.	EI EBP	Ages 0-18
13. **Second Step** A classroom-based program, this practice teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information- processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision making process when emotionally aroused in developmentally and age-appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.	P PP	Children (4-14)
14. **UCLA Ties Transition Model** 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).	EI PP	Children (0-8)

PEI-04. Trauma Recovery Services

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

PROGRAM NAME	TYPE	AGES SERVED
1. **Child-Parent Psychotherapy (CPP)** 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. The practice is intended for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma. CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach.	EI EBP	Children (0-6)
2. **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** This CDE aims to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure. The practice serves children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of 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.	EI CDE	Children (10-18)
3. **Prolonged Exposure –Post Traumatic Stress Disorder (PE)** 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.	EI EBP	Ages 18 +
4. **Seeking Safety (SS)** This 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.	EI PP	Ages 13+
5. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** TF-CBT is intended to reduce symptoms of depression and psychological trauma for children and TAY, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.). Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams.	EI EBP	Children (3-18)
6. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle** This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.	EI EBP	Children (3-18)

PEI-5. Individuals and Families Under Stress

The purpose of the Individuals and Families Under Stress Project is to build competencies, capacity and resiliency in parents, family members and other caregivers by teaching a variety of strategies. The project utilizes universal and selective prevention intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on individual, parental, family, and caregiver skill-building through a variety of training, education, individual, group parent, and family interaction methods.

PROGRAM NAME	TYPE	AGES SERVED
1. **Crisis Oriented Recovery Services (CORS)** This short-term intervention is 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.	EI	Ages 3 +
2. **Depression Treatment Quality Improvement (DTQI)** 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.	EI EBP	Ages 12-20
3. **Dialectical Behavioral Therapy (DBT)** 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.	EI EBP	Ages 18 +
4. **Families OverComing Under Stress (FOCUS)** Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole, with hopes of building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	EI EBP	Ages 5 + Couples & Families
5. **Group Cognitive Behavioral Therapy (CBT)** Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line	EI EBP	Ages 18 +

	PROGRAM NAME	TYPE	AGES SERVED
	with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.		
6.	**Group Individual Psychotherapy (Group IPT)** Group IPT is most effective when the group members all have a similar diagnosis or problem area, such as depression, cancer, or PTSD. Groups designed to prevent postpartum depression or depression during pregnancy, or groups for high-risk adolescents would also be highly suitable for treatment with IPT. The similarity in treatment focus fosters rapid development of group cohesion and support. Both are fostered within the group as quickly as possible; later sessions are designed to generalize these skills to the client's family and community, where they can apply them to interpersonal relationships to identify and develop the support they need during crises, and to resolve interpersonal conflicts or manage difficult transitions or losses.	EI PP	Ages 15 +
7.	**Heathy IDEAS (Identifying Depression, Empowering Activities for Seniors)** This is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. *Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation. Behavioral activation is a brief, structured approach to help clients reduce depressive symptoms through increased involvement in meaningful activities, which are pleasurable or reduce stress.	P	Older Adults 60+
8.	**Individual Cognitive Behavioral Therapy (Ind CBT)** This practice is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.	EI EBP	Ages 16 +
9.	**Individual Psychotherapy (IPT)** IPT is a short-term therapy (8-20 weeks) 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.	EI EBP	Ages 12 +
10.	**Managing and Adapting Practice (MAP)** MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment,	EI	Ages 0-21

PROGRAM NAME	TYPE	AGES SERVED
namely, anxiety, depression, disruptive behavior, and trauma.		
11. **Mental Health Integration Program (MHIP)** MHIP delivers specialty mental health services to Tier 2 PEI participants with mild to moderate mental health symptoms that 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 of symptoms.	EI	Ages 18 +
12. **Mindful Schools** This is a school-based pilot project that will provide mindfulness training and technical assistance for students, school staff and parents in school settings ranging from Headstart programs, preschools and K to 12 schools. The program results include improved attention, emotional regulation, less reactivity, improved behavior in schools, social skills, stress reduction, reduced anxiety, improved well-being, and better behavior in schools. For teachers the program focuses on reduced stress and burnout.	P	Children (0-15), TAY & Adults
13. **Nurse Family Partnership (NFP)** This EBP provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. Clients are able to participate in the program for two-and-a-half years and the program is voluntary.	P EBP	Children (0-2), TAY & Adults
14. **Problem Solving Therapy (PST)** PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	EI PP	Older Adults 60+
15. **Program to Encourage Active Rewarding Lives for Seniors (PEARLS)** PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	EI EBP	Older Adults 60+
16. **Providing Alternative Thinking Strategies (PATHS)** A school-based preventive intervention for children in elementary school, this 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.	EI EBP	Children (5-12)
17. **School, Community, and Law Enforcement (SCALE) Program** This CDE intervention is designed for Asian immigrant adolescents and their families at risk to school failure and or juvenile justice involvement. Behavioral problems addressed include school truancy, academic failure, association with	P CDE	Ages 12-18

PROGRAM NAME	TYPE	AGES SERVED
gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers). Core components include holistic family needs assessment, individualized life skills mentoring and counseling, family case management service linkage, community education and consultation.		
18. **Senior Reach** Senior Reach is an innovative evidence-based program that provides behavioral health, case management, and wellness services to older adults age 60+ and older, who are isolated, frail and in need of support. Senior Reach focuses on identifying and engaging this high-risk target population via a population-based health intervention model. The program provides counseling and wellness services and trains individuals in the community to identify and refer seniors in need. Services will be provided by community and faith-based organizations, non-traditional mental health providers, and the County Community and Senior Services.	P PP	Older Adults 60 +
19. **The Mothers and Babies Course, Mamas y Bebes** Developed in both Spanish and English, prenatal intervention is designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The explicit goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program consists of a 12-week mood management course and four booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas.	EI PP	Ages 13 +

PEI-06. At Risk Youth

The At-Risk Youth Project focuses on TAY to (1) build resiliency, increase protective factors, and promote positive social behavior; (2) address depressive disorders among TAY, especially those from dysfunctional backgrounds; and (3) identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project.

PROGRAM NAME	TYPE	AGES SERVED
1. **Aggression Replacement Training (ART)** ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	EI PP	Children (5-15) TAY (16-17)
2. **American Indian Life Skills (AILS)** This program serves American Indian children and youth in an urban environment. The program incorporates a school-based, culturally tailored curriculum for suicide	P PP	Children (14-15) TAY

	PROGRAM NAME	TYPE	AGES SERVED
	prevention among American Indian youth. The intended outcomes are a reduction in feelings of hopelessness and improvement in suicide prevention skills for American Indian youth at risk of depression or suicide countywide. The program reaches out to children/families that lack information and access to resources, including culturally-relevant healthcare. Another vulnerable group includes youth and TAY suffering from child abuse, families with domestic violence, and families impacted by substance use.		(15-19)
3.	**Boys and Girls Club Project LEARN** This program involves enhancing the educational performance and well-being of low income youth who are at-risk of school failure and involvement with the juvenile justice system. After school program services are offered at Boys and Girls Clubs through teams of local BGCA staff, school staff, parents, and students. In addition to assistance with academic problems, activities focusing on conflict resolution, social and behavioral skills, anxiety and coping skills will be available.	P PP	Children (7-15) TAY (16-18)
4.	**Center for the Assessment and Prevention of Prodromal States (CAPPS)** A "first break program", CAPPS is a family focused treatment program serving TAY and their families at high risk for developing psychosis or in danger of experiencing their first psychotic break (prodromal phase). Treatment includes psycho-education, skill building, and problem solving.	EI	TAY (16-25)
5.	**Coordinated Specialty Care Model for Early Psychosis (CSC-EP)** CSC-EP is a team-based, multi-element approach to treating early psychosis. CSC-EP serves youth experiencing the symptoms of early psychosis including: onset of psychotic symptoms in the past year, subthreshold symptoms of psychosis, and recent deterioration in youth with a parent/sibling with a psychotic disorder. This collaborative, recovery based treatment approach involves clients and treatment team members as active participants. The program includes various treatment components that focus on reducing and managing symptoms and distress and improving individuals' ability to achieve success in independent roles. Services include comprehensive clinical assessment, medication management, case management, individual and family psychoeducation and support groups including multifamily therapy, and peer and family advocate support. CSC-EP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with early psychosis. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.	EI	Children (12-15) TAY (16-25)
6.	**Early Identification and Prevention of Psychosis Outreach** Based on the Portland Identification and Early Referral (PIER) model, this outreach model relies heavily on community outreach and empowering community and family members to help detect early signs of serious mental illness in TAY. The PIER model was designed with a sole focus on clients in the prodromal phases and uses a three-pronged approach of community outreach, assessment and treatment to reduce symptoms, improve function, and decrease relapse. Outreach efforts are aimed at establishing and maintaining a community network of "early identifiers." Key activities involve community mapping and establishment of a steering council of key community members. The program develops and delivers outreach messages to target audiences (educational, medical and mental health professionals, community groups, media, youth and parent groups, multicultural communities), with a focus on outreach to schools, mental health clinicians and primary care physicians. Outreach efforts are continuously monitored and evaluated.	P Pilot	TAY (16-25)

	PROGRAM NAME	TYPE	AGES SERVED
7.	**Functional Family Therapy (FFT)** FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	EI EBP	Children (10-15) TAY (16-18)
8.	**Multidimensional Family Therapy (MDFT)** MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	EI EBP	Children (12-15) TAY (16-18)
9.	**Multisystemic Therapy (MST)** MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	EI EBP	Children (12-15) TAY (16-17)
10.	**Olweus Bullying Prevention Program** The Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop. Goals of the program include: reducing existing bullying problems among students, achieving better peer relations at school, and preventing the development of new bullying problems. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community.	P PP	Children (5-15) TAY (16-18)
11.	**Positive Action** Positive Action is an integrated and comprehensive curriculum-based program that is designed to improve academic achievement, school attendance, and problem behaviors such as substance use, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior. It is also designed to improve parent–child bonding, family cohesion, and family conflict. Cheaper for schools to sustain and materials are free online.	P PP	Children (12-15) TAY (16-18)
12.	**Safe Schools Ambassadors** The Safe School Ambassadors (SSA) program is a bystander education program that aims to reduce emotional and physical bullying and enhance school climate in elementary, middle, and high schools. The program recruits and trains socially influential student leaders from diverse cliques and interest groups within a school to act as "Ambassadors" against bullying. A Train-the Trainer program facilitates sustainability of the program in schools.	P	Children (5-15) TAY (16-18)
13.	**School Threat Assessment and Response Team (START)** The three (3) main objectives for START are: 1) Prevention and reduction of targeted	P	All Ages

PROGRAM NAME	TYPE	AGES SERVED
school violence in Los Angeles County; 2) Provision of ongoing support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations; and 3) Establishment of partnerships with schools, law enforcement, and other involved community organizations. START has responded to thousands of incidents where law enforcement officials, school authorities and other individuals had concerns about potential violence in elementary schools, middle schools, high schools, and college campuses. START conducts threat assessments and develops interventions which include intensive case management strategies.		
14. **Strengthening Families Program (SFP)** SFP 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.	EI EBP	Children (3-15) TAY (16)
15. **TAY Drop-In Center Targeted Outreach & Engagement Strategies** a. Peer Lead Support groups are held at the TAY MHSA Permanent Supportive Housing units to promote coping and life skills to minimize the need for emergency and/or ongoing intensive mental health services. The groups are efforts to build self-sufficiency, promote a sense of community and ultimately prevent TAY from losing their housing. b. The Painted Brain is a culturally relevant early intervention strategy for TAY transitioning out of justice or other institutional settings. The program increases social connectedness and engagement in mental health treatment through utilizing art, music, media and poetry.	P	TAY (16-25)
16. **Why Try Program** The Why Try Program is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning. It utilizes a series of ten visual analogies that teach important life skills (e.g., decisions have consequences; dealing with peer pressure; obeying laws and rules; plugging in to support systems).	P PP	Children (7-15) TAY (16-18)

PEI 07. Vulnerable Communities

The Vulnerable Communities Program is intended to build resilience and increase protective factors among vulnerable individuals in Los Angeles County. Services will be designed to 1) identify as early as possible individuals who are a risk for emotional and mental problems; 2) conduct outreach, education, and training; 3) promote mental wellness; and (4) provide culturally and linguistically appropriate early mental health intervention services.

PROGRAM NAME	TYPE	AGES SERVED
1. **Commercial Sexual Exploitation of Children and Youth (CSECY) Training** Training will be conducted to increase awareness and outreach to children and youth at risk of or involved in commercial sexual exploitation. Target audience include community groups, social service organizations, schools, and mental health providers. The workshops include topics on clinical identification and screening strategies used in assessing children and youth for possible sexual exploitation; a review of complex trauma as it applies to CSECY; clinical interventions or promising practices that are trauma-focused; special issues related to sexual exploitation such as LGBTQ, substance abuse and gender differences; and impact of race, culture and gender on treatment considerations for CSECY.	P	TAY, Adults & Older Adults
2. **Domestic Violence and Intimate Partner Violence Services** This is a community-based outreach and engagement, educational prevention program to reduce and/or eliminate **domestic abuse, spousal abuse, battering, family violence,** and **intimate partner violence,** patterns and behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family. Educational awareness for at risk individuals, group and peer support meetings, and educational training for service providers working with victims will be initiated.	P	TAY & Adults
3. **Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and 2-Spirit (LGBTQI2) Services** The goal of the LGBTQI2 services is to increase recognition of early signs of mental illness, increase community awareness, and increase access to community-based programs for LGBTQI2 TAY. Services include 1) Outreach and engagement to LGBTQ12 TAY; 2) Peer support groups; 3) Development of a Toolkit to support mental health providers and community-based organizations in developing the capacity to increase access; 4) Referrals and linkage services to mental health and other service providers; 5) Development of community partnerships with educational, health, law enforcement, faith-based, and other organizations; 5) Development of a training curriculum to educate the community and providers about LGBTQ12 TAY issues; and 6) training of mental health providers on reaching out to and working with LGBTQ12 TAY including approaches such as LGBT Affirmative Therapy.	P	TAY
4. **PEI Supportive Housing Services** The goal of this model is to provide PEI services to the residents of Permanent Supportive Housing (PSH) that targets the risk factors with the goal of increasing the protective factors. The model includes a PEI Lead that will coordinate the services along with a team of clinical staff in each Service Area (SA). The SA PEI team will assess the needs for PEI interventions and supportive services in each of the PSH developments based on the population living there, identify appropriate PEI strategies	P	All Ages

PROGRAM NAME	TYPE	AGES SERVED
and providers and/or provide the PEI services directly. Services will be provided onsite whenever possible, including mentoring/coaching, school help, life skills, and renting skills.		
5. **Veterans Community Colleges Outreach and Case Management Services** Services will be provided by veterans to veterans attending Community Colleges in Los Angeles. The overall goals of the program are to: 1) increase access, coordinate care, and enhance the capacity of multiple organizations to work together in order to achieve better outcomes for military personnel and their families; 2) provide a newly trained cadre of case managers and faculty capable of helping military personnel and their families manage the pressures of combat-related stressors and post-war adjustments; and 3) develop peer support and training/employment opportunities for veterans. The collaboration with the colleges will focus on intensive case management as well as access to employment, housing and mental health resources to veterans who are suffering from PTSD and other emotional issues resulting from combat duty.	P	TAY & Adults
6. **Veterans Mental Health Services** A range of services to Veterans countywide will be expanded and initiated, including services emphasizing peer support, female veterans' services, and suicide prevention, and retreats. Collaboration with and coordination of services public and private existing veterans service organizations both in the development and implementation of services will occur, with grants with community-based and faith-based organizations working with veterans. Supportive housing services for Veterans, their partners, children, caregivers, and other family members will be available onsite at Veteran Permanent Housing units.	P	TAY, Adults & Older Adults
7. **Veterans Service Navigators** In collaboration with the County Department of Military and Veterans Affairs, this program utilizes military veterans to engage veterans and their families in order to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff follows up with the veterans and their families to ensure that they have successfully linked up and received the help they need. The Navigators engage in joint planning efforts with community partners, including veterans groups, veterans administration, community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.	P	TAY, Adults & Older Adults

Innovation 1:

The final Innovation 1 model, the Integrated Peer Run Program completed its 3 year course on June 30, 2016. On March 10, 2016, the System Leadership Team Budget workgroup recommended continued funding of the Peer Run Respite Care Program (PRRCH) through CSS funding (Wellness/Client Run work plan) effective July 1, 2016. The SLT approved that recommendation on April 20, 2016. A full write up of the Peer Run Model and its outcomes was contained in the Annual Update for Fiscal Year 2016-17

.

Innovation 2:

During Fiscal Year 2015-16, the Statement of Work and Request for Services solicitation was drafted for Innovation 2, entitled Trauma Resilient Communities through Community Capacity Building. Department lead staff continued to engage communities in prioritizing their needs and in identifying organizations who may be interested in servicing as lead agencies, ensuring they complete the paperwork necessary to successful get on the Department's MHSA Master Agreement List for Innovation. The Request for Services solicitation is expected to be issued in February, 2017. DMH leadership has met with First Five leadership, administrators from the Los Angeles County Department of Public Health and with key experts in the trauma field to ensure that this project is consistent and aligned with other existing local trauma initiatives.

Concurrently, DMH drafted a Request for Services solicitation for the evaluation of Innovation 2 that it expects to be issued in January, 2017.

Workforce Education and Training

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

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

1 *111 staff trained through the Recover Oriented Practice (formerly known as Public Mental Health Workforce Immersion)*

During FY 2015-16, 111 individual staff members of the public mental health workforce attended the Public Mental Health Workforce Immersion into MHSA.

2 *104 Stipends were awarded to 2nd Year MSW and MFT Student*

These stipends were awarded in exchange for a one year commitment to work in a hard-to-fill area of the County. Priority is given to individuals representing un- or under-served populations and/or speaking a threshold language.

3 *33 individuals completed the Health Navigator Skill Development Program*

94% of participants self-identified as representing underserved communities, and 55% spoke a threshold language.

4 *69 individuals received ongoing career advisement in order to further their careers in the public mental health system*

All 69 participants in this program are currently employed in the public mental health system.

5 *19 mental health consumers completed the Advance Peer Advocate Training*

These individuals with lived experience are interested in

6 *185 staff members participated in the interpreter training program*

Interpreters and clinicians trained to effectively use interpreters.

**Not unique number as some individuals participated in more than one training component*

7 *All 8 Service Areas of the County are now operating a faith-based Roundtable Group.*

These faith–based Roundtables permit clergy from various religions to sit with mental health professionals and develop solutions for congregants that may be displaying symptoms of mental illness.

8 *55 participants completed the Intensive MH Recovery Specialist Training Program*

These participants were trained to work in the public mental health system as mental health rehabilitation specialists.

9 *202 supervisors completed the Recovery Oriented Supervision Training*

These supervisors are currently employed in the mental health system and are trained to effectively implement recovery oriented supervision.

10 *Licensure Examination Preparation*

During FY 2015-16, 245 MSWs, MFT Interns, and Psychologists were registered in the Licensure Examination Preparation Program.

working as mental health peer advocates.

1-Workforce Education and Training (WET) Coordination

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

2 -WET County of Los Angeles Oversight Committee

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

3 -Transformation Academy without Walls

Public Mental Health Workforce Immersion into MHSA (Recovery Oriented Practices)

Since FY 2007-08, this program offers public mental health staff (i.e., clerical, clinical staff to program administrators) a three day immersion program on the tenets of MHSA. The training incorporates the MHSA experience including consumers sharing their recovery journey. Upon completion, staff is expected to acquire an understanding of the recovery oriented approach and to also incorporate such concepts into practice in their work. The delivered curriculum also addresses the integration of mental health, health and co-occurring disorders.

During FY 2015-16, 111 individual staff members of the public mental health workforce attended this training; 55% represented an un- or under- served population, while 32% spoke a second language.

Licensure Preparation Program (LPP)

This program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapists, and psychologists. All accepted participants must be employed in the public mental health system and have completed the required clinical hours to take the mandatory Part I, and thereafter Part II of the respective licensure board examinations.

The number of participants for each specific exam during FY 2015-16 is as follows:

FISCAL YEAR 2015-2016					
EXAM	**REGISTERED**	**THRESHOLD LANGUAGE (NOT ENGLISH)**	**UREP**	**PASS**	**FAIL**
MSW - Part I	86	33	67	48	6
MSW - Part II	41	23	29	11	1
MFT - Part I	64	16	39	19	0
MFT - Part II	13	12	6	3	3
Psych - Part I	30	5	18	9	1
Psych - Part II	11	3	8	4	0
TOTALS	**245**	**92**	**167**	**94**	**11**

Licensure Preparation Program (LPP) – The Licensure Preparation Program will continue with no changes for FY 2016-2017.

Health Navigator Skill Development Program

In preparation for Health Care Reform, this program trains individuals (Peer Advocates, Community Workers and Medical Case Workers) on knowledge and skills needed to assist consumers navigate and likewise advocate for themselves in both the public health and mental health systems. This 52 hour course uniquely incorporates a seven hour orientation for participants' supervisors and is intended to support the participants' navigator role. During FY 2014-15, 33 participants completed the training, with 100% identifying with un- or under- served populations and 54% speaking a threshold language. All 33 participants are certified as Health Navigators.

Health Navigator Skill Development Program – This program will continue with no significant changes during FY 2016-17.

5 - Recovery Oriented Supervision Trainings

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

During FY 2015-16, 202 supervisors completed the program. 66% of these participants represented individuals from un- or under- served communities and 43% spoke a second language.

The ROSTCP program ceased on June 30th 2016. An advanced training is currently in the development stages, with implementation planned for FY 2016-2017.

6 - Interpreter Training Program

The Interpreter Training Program (ITP) offers trainings for bilingual staff that currently performs or interested in performing interpreter services and to monolingual English speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health.

FY 2015-16 Outcomes:

Training Title	Total
Interpreter Training in Mental Health Setting (21 Hours)	58
Advance Training (7 hours)	16
Training MH Providers in Working with Interpreters (4 Hours)	9
Improving Spanish MH Clinical Terminology (7 hours)	102
Total	**185**

7 - Training for Community Partners

Faith Based Roundtable Project

This project continues to bring together clergy and mental health staff to address the mental health issues of the individuals and communities they mutually serve. It has provided an opportunity for faith-based clergy to understand the essence of mental health services focused on recovery as well as for mental health personnel to understand and integrate spirituality in the recovery process. As of FY 2015-2016, all eight service areas continue to participate in these Roundtable sessions. The program funds a consultant in order to assist in facilitating the roundtables, and provide guidance and structure when needed.

There will be no significant change to the program model during FY 2016-17

8 - Intensive Mental Health Recovery Specialist Training Program

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

During FY 2015-2016 55 individuals interested in employment in the public mental health system completed the training. Of these participants, 82% represented individuals from un- or under- served populations, and 75% spoke a threshold language.

During FY 16-17, this program was expanded to recruit 6 additional participants

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

Peer Advocate Training advances the skills of individuals working as mental health peer advocates in the public mental health system. During FY 2015-2016, a total of 19 individuals completed the peer advocate training. Of these participants, 83% represented individuals from un- or under- served populations and 11% spoke a threshold language.

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

This training program is intended to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: the work of family support for mental health; supporting the employment of parents and caregivers of children and youth consumers in our public mental health system; and/or promoting resilience and sustained wellness through an emphasis on increasing the availability of a workforce oriented to self-help, personal wellness and resilience techniques that are grounded in parent advocate/parent partner empowerment.

This program will be solicited with training anticipated to begin FY 2016-17.

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

These trainings prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings include such topics as public speaking, navigating systems, and resource supports for consumers and families. This program is funded with the intent to target/outreach family members about mental health services in the community meeting the objective of the program outline in the MHSA-WET Plan.

Training Component	Train-The-Trainer Participants	New Speakers Trained	Presentation Participants
Adult Consumers Advocacy Speakes		32	170
Family Advocacy Speakers		10	23
Family Support and Advocacy Training	2	43	831
Family Support and Advocacy Training In Spanish		20	160
Family Advocacy Lobby Outreach Program		20	164
Family Advocate and Recovery Training Program			500
Family Advocate Wellness and Diversity Training Program			300
Family Advocate Wellness and Spirituality Training Program			200
Family Advocate and Provider Training Program			150
Parent/Caregiver Advocate Provider Training Program			100
Parent/Caregiver Advocate Wellness and Recovery Training Program			500
Child/Adolescent Consumer Advocacy Speakers Bureau		16	48
Parent Advocacy Speakers' Bureau		20	39
Parent Support and Advocacy Training Bureau	3	10	184
Parent Support and Advocacy Training Bureau in Spanish		11	60
Parent and Teachers Joint Advocacy Program		19	289
TOTALs	**5**	**201**	**3,718**

12 - Mental Health Career Advisors

In the effort to meet the workforce needs of the public mental health system, this program is designed to fund career advisor services. Services include: the provision of ongoing career advisement, coordination and development of career goals, linkage to job training resources, mentoring, and information sharing and advocacy. The Mental Health Career Advisors function as a one-stop shop for upward career mobility. A pilot program began services September 2014.

During FY 2015-16, 69 individuals received an aggregate total of 171 career advisement sessions.

13- High School through University Mental Health Pathway

The County of Los Angeles, thru one contractor, developed and implemented a curriculum that outreached to junior and high school students from the Antelope Valley/Palmdale area (Service Area 1).

19 - Public Mental Health Workforce Financial Incentive Program

The Public Mental Health Workforce Financial Incentive Program is intended to deliver educational/financial incentives to individuals employed in the public mental health workforce, as well as serve as a potential recruitment tool. This program will provide 2 different types of awards, as follows:

Tuition Reimbursement Program

This tuition reimbursement program will provide tuition expenses for those individuals interested in enhancing skills relevant to mental health workforce needs. It will include peer advocates, consumers, family members; parent advocates and professionals employed in directly operated and contracted agencies. Tuition reimbursement students will be expected to make a commitment to continue working in the public mental health system. Additionally, those candidates who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority.

Loan Forgiveness Program

Striving to meet MHSA expectations of a linguistically and culturally competent workforce, County of Los Angeles will explore loan forgiveness programs as a supplement to the loan forgiveness programs developed by the State.

UsCC Recruitment Pilot

This program will target individuals with a B.A. and representing severely underserved communities to continue on to earn a Master's Degree in a clinical field. Award is tied to payback commitment.

This program is expected to be implemented by FY 2016-17.

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

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

During FY 2015-2016 this program was available to 52 MFT, 52 MSW, and 4 Nurse Practitioners students. During this award cycle, all but 4 NP stipends were awarded. 82% of all recipients identified from populations recognized as un- or under- served. During the same cycle, 79% spoke a threshold language.

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

No significant change is expected for this program during FY 2016-17.

General Psychiatric Residency and Child and Adolescent Psychiatry Fellowship Program (Augustus F. Hawkins Mental Health Clinic (AFH MHC), San Fernando Mental Health Clinic, and Olive View Urgent Care Center (Olive View UCC)

Project Summary: Programmatic support is provided to residents and fellows while they provide clinical care through community based, integrated, multidisciplinary team approach within a complex public health system.

Status Report: UCLA Residents and fellows have successfully been receiving guidance and training to enhance and expand existing clinical services at AFH MHC, San Fernando MHC, and Olive View UCC. Clinical services to children and adolescents have been provided by fellows at AFH MHC and San Fernando MHC. Olive View UCC identifies critical needs of every consumer and to address those needs as quickly as possible, preventing hospitalization and helping to relieve the County's general emergency rooms. Open seven days a week, the Olive View UCC provides consumers with a place to get a brief clinical assessment, immediate case management, medication refills, acute mental health care, and crisis intervention service. This provides a wide variety of clinical experiences for residents. Residents at all sites provide increased clinical access for clients, while the addition of the residency and fellowship program has increased the number of DMH training sites and opportunities for workforce development. The integration of the residents and fellows into service delivery has enhanced system-wide collaboration between the Department of Health Services (DHS) and DMH.

Academic Supervision and Training (DMH at Harbor UCLA Medical Center)

Project Summary: Academic supervision and training is provided to psychiatry residents and fellow at DMH at Harbor-UCLA Medical Center.

Status Report: Residents and fellows receive training and academic support in mental health assessment, evidenced based practices, medication support services, and crisis intervention relevant to community mental health. Residents and fellows receive specific training in evidence-based practices and academic consultation with the multidisciplinary team, such as psychiatrists, psychologists, and social workers, for the purpose of improving the clinical abilities of staff members. Trainings and academic supervision are provided by existing faculty members of DMH at Harbor-UCLA. Harbor-UCLA faculty and post-doctoral psychology fellows have provided trainings in evidence-based practices which promote recovery for LACDMH clients. These trainings have further developed the skills of current LACDMH clinicians and enhanced the quality of care for clients.

UCLA Faculty Consultation Services (Edelman Mental Health Clinic)

Project Summary: Specialty consultation is provided to LACDMH program staff and psychiatrists.

Status Report: Specialized faculty consultation is provided by a UCLA Child and Adolescent psychiatrist who specializes in the diagnosis and treatment of psychiatric illness in children and adolescents. The eligible faculty member provides case consultation based on evidenced base practices every week to the program staff and psychiatrists at the clinic.

Clinical Scholars Program (West Central Mental Health Clinic)

Project Summary: Two UCLA Robert Wood Johnson Foundation psychiatrist scholars have engaged with community members, DMH administration, and researchers to develop and improve the public mental health workforce via unique projects and direct service to DMH consumers.

Status Report: Two scholars began with DMH in July 2015. They provide approximately 20 percent of their time to direct service, such as medication evaluations and medication support services, to consumers at West Central Mental Health Clinic. They are currently engaged in countywide projects related to expansion of accessible medications to DMH consumers who suffer with co-occurring disorders and Assisted Outpatient Treatment for persons who fall in the gap of persons with frequent psychiatric hospitalizations and lack mental health treatment.

Geropsych Fellowship Services

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

Status Report: The UCLA Geriatric Psychiatry Fellowship at LACDMH consists of two fellows each year for two days a week, 6 months each. The fellows receive formal and informal training in geriatric psychiatry through the LACDMH community mental health program GENESIS. The fellows are integrated into a team approach requiring home visits countywide. They are exposed to the Los Angeles County Elder Abuse Forensic Center and receive training in Field Safety. Fellows provide clinical services for LACDMH clients. They do assessments, as well as conducting ongoing therapy and treatment. They lead and participate in a series of Older Adult Consulting Team trainings; in addition they submit required documentation to obtain CME approval for their trainings.

Contract Provider Technology Project (CPTP)

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

Project Objectives: The primary objective is to provide a means for non-governmental agency Short-Doyle Contract Providers within the LAC-DMH provider network to obtain the funding necessary to fully participate in the County's Integrated Information Systems Infrastructure and address their technological needs consistent with the MHSA Capital Facilities and Technological Needs Guidelines.

Phase: Implementation

Accomplishments:

- Completed review of three IT Project Proposal submissions from Legal Entity Contract Providers
- CPTT Workgroup Meetings: 01/19/2016, 05/26/2016, and 06/02/2016
- Assisted Legal Entity Contract Providers with IBHIS go-live readiness education and assist in communication with DMH with regard to the IBHIS provisioning and Web Services and EDI certification processes
- A total of 52 Legal Entity Contract Providers have gone live with IBHIS
- A total of 54 Legal Entity Contract Providers have fully expended their project dollars and completed their MHSA IT project

Scheduled Activities for Next Period:

- Continue to assist Legal Entity Contract Providers with IBHIS go-live readiness education and assist in communication with DMH with regard to the IBHIS provisioning and Web Services and EDI certification processes
- Continue CPTT Workgroup Meetings on an as needed basis at least until all Legal Entity IBHIS Rollouts have been completed
- Ongoing project maintenance activities which includes contract management of existing Legal Entity Providers.
- Execute new Technological Needs Funding Agreements (TNFA) with one legal entity that was not part of the original group identified for MHSA funding – Los Angeles Free Clinic (LE #01142).

Integrated Behavioral Health Information System (IBHIS)

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	4/1/2009	*Project End Date:*	6/30/2017

Project Objectives: To acquire Commercial-Off-the-Shelf (COTS) and proven software with the necessary clinical functionality to support the delivery of quality mental health services consistent with the Mental Health Services Act and integrated with administrative and financial functionality.

Phase: Implementation Phase/Production Roll-Out

Accomplishments:

- Completed the migration of one hundred and forty-five (145) Directly Operated programs into IBHIS.
- Completed the transition of thirty-one (31) Contract Providers (twenty-nine (29)) Legal Entities (LEs) and two (2) Fee For Service (FFS) providers) to IBHIS.
- Completed twenty (20) system modifications intended to improve the efficiency of the claiming process in IBHIS. This is a necessary predecessor to bringing on LEs at volume.
- Completed Final System Acceptance.

Scheduled Activities for Next Period:

- Continue with the LE and FFS on-boarding activities as scheduled.
- Review submitted Change Requests in accordance with IBHIS Change Control Plan. Monitor and manage software modification change submissions and approvals
- Test system updates, fixes, and modifications in preparation for resuming contract provider rollouts.
- Continue ongoing DO end-user training, site preparation and user readiness activities for new programs, and training and support for existing clinical and administrative IBHIS users at DO programs.

Personal Health Record Awareness & Education

Project Status: On Schedule *Budget Status:* Within Approved Budget

Project Start Date: 1/13/2015 *Project End Date:* 12/31/2016

Project Objectives: Through the stakeholder process, LAC-DMH received considerable feedback suggesting that many mental health consumers have limited awareness of Personal Health Record (PHR) and how a PHR may be used as a recovery and wellness tool. The written and online PHR awareness and education materials developed through this project will be used to increase consumer/family understanding and awareness. In addition, the objectives were also expanded to comply with new Federal Meaningful Use requirements. As a result, in order to meet all the objectives, this project has been divided into Phase I, and Phase II. This status report only addresses Phase I implementation activities. The Personal Health Record and Awareness web application being implemented in this project is myHealthPointe (mHP) Patient and Practice Portals licensed through Netsmart.

Phase: Implementation Phase (Phase II)

Accomplishments:

- Completion of Phase I Business Requirements/Design and Future Workflows
- Application Configuration Activities
- Completed Test Environment
- User Acceptance Testing

- Completion of Training Materials
- Completion of Communication Materials and Conduct Informational Presentations
- Completed Terms and Conditions of User Documents and Privacy Statement
- Identification of Internal End Users and Set Up User Access
- Completed Web Site development for Client information site and secure Login Page
- Phase I General Go-Live
- Business Workflow Sessions started
- Demo system provided by the vendor to allow project team to navigate through some of the functionality
- Training and Communication Material development started
- Started work on DMH Terms and Conditions of Use and Privacy Statement
- Start Web Development for Client Information site and secure Login Page
- Started work on standing up the new Test environment

Scheduled Activities for Next Period:

- Develop Meaningful Use reporting tools and procedures
- Design and Testing of Secure Messaging (Phase 2)
- Develop workflows for Secure Messaging
- Implement Secure Messaging

Consumer/Family Access to Computer Resources

Project Status: On Schedule

Budget Status: Within Approved Budget

Project Start Date: 1/19/2010

Project End Date: 5/30/2016

Project Objectives:

- Promote consumer/family growth and autonomy by increasing access to computer resources, relevant health information and trainings.
- Provide basic computer skills training to consumers allowing them to effectively utilize the computer resources made available to them.
- Provide appropriate access to technical assistance resources when needed

Phase: Expansion Phase

Accomplishments: Analysis was conducted and it was identified that 15 of the 83 computers were under-utilized; therefore the 15 computers were re-deployed to 8 additional sites in need of computer resources.

Scheduled Activities for Next Period: No activities are scheduled for the next period

Data Warehouse Re-Design

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	July 2013	*Project End Date:*	June 28, 2019

Project Objectives: Redesign the current data warehouse to support the data requirements of the Department of Mental Health's new Integrated Behavioral Health Information System (IBHIS) as well as new data collected from MHSA programs such as Prevention & Early Intervention (PEI), Workforce Education and Training, and Innovation. The redesigned data warehouse will include the full scope of MHSA program and service data including clinical, outcomes, financial, and administrative data.

Phase: Construction Phase (Software Deployment)

Accomplishments: Configuration of two Microsoft SQL Servers and LA County ISD Downey location

Scheduled Activities for Next Period:

Access latest progress and develop plan to address the remaining phases (FY16-17)

Leverage the deliverables from the App Sync Project to implement as part of the final Data Warehouse (FY18-19)

At this time, Financial Lifecycle – Foundation Phase, Development (Date, Other Dimension and Fact tables not yet defined)

- Develop Dimensional Data Model
- Develop Physical Data Model
- Develop Business Requirements Definition
- Develop ETL System Design
- Deploy Data Model
- Deploy ETL System

Telepsychiatry Implementation

Project Status:	On Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	7/1/2010	*Project End Date:*	6/30/2016

Project Objectives: To address service disparities among remote and underserved populations by implementing networked videoconferencing at multiple service locations to allow provision of direct Telepsychiatry treatment services to clients by psychiatrists and specialty tele-consultation between Psychiatrists and primary care providers.

Phase: Post Implementation

Accomplishments: "Top Ten" winner of the prestigious 2016 LA County Productivity and Quality Award

Scheduled Activities for Next Period: None at this time.

The budget projected for Fiscal Years 2017-18 through 2019-20 has a number of contingencies. First, the Department received a one-time allocation of $121.6 million in MHSA funds from the State in August, 2016. In order to create a level of sustainability, the funds will be spread out over Fiscal Years 2016-17, 2017-18 and 2018-19. The approximate breakout of the $121.6 million is:

One-time MHSA allocation ($121.6 mil.) received in August 2016

(Projections are in millions)

Fiscal Year	CSS	PEI	INN
2016-17	$30.8	$7.7	$2.03
2017-18	$30.8	$7.7	$2.03
2018-19	$30.8	$7.7	$2.03

Break down of the **CSS** allocation ($92.4) by services:

Fiscal Year	FSP	CIRS (non-FSP)	Total
2016-17	$25.3	$5.5	$30.8
2017-18	$25.3	$5.5	$30.8
2018-19	$25.3	$5.5	$30.8

The majority of the CSS allocation is going to increase the number of FSP slots (estimated increase of 2,837 slots) available to clients who are part of county initiatives such as Whole Person Care (focused on mental health clients who are high utilizers of inpatient psychiatric facilities or incarcerated) and the Measure HHH and No Place Like Home initiatives to impact homelessness. The one-time allocation, spread across 3 Fiscal Years, will create the service capacity for clients involved in those initiatives.

Fiscal Year 2017-18 through Fiscal Year 2019-20
Estimated Three-Year Mental Health Services Expenditure Plan Budget
Funding Summary

January 23, 2017

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	488,695,776	186,814,820	35,008,197	22,600,000	4,500,000	
2. Estimated New FY2017/18 Funding	401,279,905	100,327,118	26,395,859			
3. Transfer in FY2017/18[a/]	0					
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	889,975,681	287,141,938	61,404,056	22,600,000	4,500,000	
B. Estimated FY2017/18 MHSA Expenditures	473,014,995	149,681,352	23,008,720	22,600,000	4,500,000	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	416,960,686	137,460,586	38,395,336	0	0	
2. Estimated New FY2018/19 Funding	391,500,480	97,875,120	25,761,120			
3. Transfer in FY2018/19[a/]	(5,706,548)			5,706,548		
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	802,754,618	235,335,706	64,156,456	5,706,548	0	
D. Estimated FY2018/19 Expenditures	473,014,995	149,681,352	23,008,720	5,706,548	0	
E. Estimated FY2019/20Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	329,739,623	85,654,354	41,147,736	0	0	
2. Estimated New FY2019/20 Funding	391,500,480	97,875,120	25,761,120			
3. Transfer in FY2019/20[a/]	(5,706,548)			5,706,548		
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	715,533,555	183,529,474	66,908,856	5,706,548	0	
F. Estimated FY2019/20 Expenditures	473,014,995	149,681,352	23,008,720	5,706,548	0	
G. Estimated FY2019/20 Unspent Fund Balance	242,518,560	33,848,122	43,900,136	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	160,725,402
5. Contributions to the Local Prudent Reserve in FY 2018/19	0
6. Distributions from the Local Prudent Reserve in FY 2018/19	0
7. Estimated Local Prudent Reserve Balance on June 30, 2019	160,725,402
8. Contributions to the Local Prudent Reserve in FY 2019/20	0
9. Distributions from the Local Prudent Reserve in FY 2019/20	0
10. Estimated Local Prudent Reserve Balance on June 30, 2020	160,725,402

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

Community Services and Supports (CSS) Component Worksheet

	Fiscal Year 2017/18					
	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
1. Planning Outreach & Engagement	4,457,841	4,423,041	34,800		0	0
2. Full Service Partnerships	306,000,066	141,612,691	114,551,515		49,745,016	90,844
3. Alternative Crisis Services	55,325,561	29,835,884	23,821,994		1,667,419	264
4. Non Full Service Partnerships	41,815,066	18,969,170	15,929,042		6,473,917	442,938
5. Linkage	9,602,479	9,503,174	69,550		9,494	20,261
6. Housing	5,151,228	5,151,228	0		0	0
Non-FSP Programs						
1. Planning Outreach & Engagement	10,914,024	10,828,824	85,200		0	0
2. Full Service Partnerships	0	0	0	0	0	0
3. Alternative Crisis Services	77,864,263	45,189,080	29,973,382		2,701,311	490
4. Non Full Service Partnerships	357,755,963	155,385,226	140,547,412		58,506,673	3,316,651
5. Linkage	9,650,443	9,442,361	139,911		8,313	59,858
6. Housing	9,902,532	9,902,532	0		0	0
CSS Administration	33,850,517	32,771,784	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	922,289,983	473,014,995	326,231,539	0	119,112,143	3,931,306
FSP Programs as Percent of Total	48%					

	Fiscal Year 2018/19					
	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
1. Planning Outreach & Engagement	4,457,841	4,423,041	34,800		0	0
2. Full Service Partnerships	306,000,066	141,612,691	114,551,515		49,745,016	90,844
3. Alternative Crisis Services	55,325,561	29,835,884	23,821,994		1,667,419	264
4. Non Full Service Partnerships	41,815,066	18,969,170	15,929,042		6,473,917	442,938
5. Linkage	9,602,479	9,503,174	69,550		9,494	20,261
6. Housing	5,151,228	5,151,228	0		0	0
Non-FSP Programs						
1. Planning Outreach & Engagement	10,914,024	10,828,824	85,200		0	0
2. Full Service Partnerships	478,358	478,358	0	0	0	0
3. Alternative Crisis Services	77,864,263	45,189,080	29,973,382		2,701,311	490
4. Non Full Service Partnerships	357,755,963	155,385,226	140,547,412		58,506,673	3,316,651
5. Linkage	9,650,443	9,442,361	139,911		8,313	59,858
6. Housing	9,902,532	9,902,532	0		0	0
CSS Administration	33,850,517	32,771,784	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	922,768,341	473,493,353	326,231,539	0	119,112,143	3,931,306
FSP Programs as Percent of Total	48%					

CSS Component Worksheet (continued)

	Fiscal Year 2019/20					
	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
1. Planning Outreach & Engagement	4,457,841	4,423,041	34,800		0	0
2. Full Service Partnerships	306,000,066	141,612,691	114,551,515		49,745,016	90,844
3. Alternative Crisis Services	55,325,561	29,835,884	23,821,994		1,667,419	264
4. Non Full Service Partnerships	41,815,066	18,969,170	15,929,042		6,473,917	442,938
5. Linkage	9,602,479	9,503,174	69,550		9,494	20,261
6. Housing	5,151,228	5,151,228	0		0	0
Non-FSP Programs						
1. Planning Outreach & Engagement	10,914,024	10,828,824	85,200		0	0
2. Full Service Partnerships	0	0	0	0	0	0
3. Alternative Crisis Services	77,864,263	45,189,080	29,973,382		2,701,311	490
4. Non Full Service Partnerships	357,755,963	155,385,226	140,547,412		58,506,673	3,316,651
5. Linkage	9,650,443	9,442,361	139,911		8,313	59,858
6. Housing	9,902,532	9,902,532	0		0	0
CSS Administration	33,850,517	32,771,784	1,078,733			
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	922,289,983	473,014,995	326,231,539	0	119,112,143	3,931,306
FSP Programs as Percent of Total	48%					

PEI Component Worksheet

	Fiscal Year 2017/18					
	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 - SUICIDE PREVENTION						
PEI-01 Suicide Prevention	6,339,293	6,339,293				
PEI Programs - STIGMA DISCIRMINATION REDUCTION						
PEI-02 Stigma Discrimination Reduction Program	4,720,497	4,720,497				
PEI Programs - PREVENTION						
PEI-03 Strengthening Family Functioning	7,593,000	7,593,000				
PEI-04 Trauma Recovery Services	1,650,050	1,650,050				
PEI-05 Inidividuals and Families Under Stress	11,262,710	11,262,710				
PEI-06 At-Risk Youth	7,034,450	7,034,450				
PEI-07 Vulnerable Communities	10,898,000	10,898,000				
PEI Programs - EARLY INTERVENTION						
PEI-03 Strengthening Family Functioning	32,308,481	10,421,836	13,585,260		8,299,821	1,564
PEI-04 Trauma Recovery Services	82,807,452	26,711,427	34,819,364		21,272,651	4,010
PEI-05 Inidividuals and Families Under Stress	117,016,431	37,746,312	49,203,757		30,060,697	5,666
PEI-06 At-Risk Youth	39,367,477	12,698,875	16,553,468		10,113,228	1,906
PEI Administration	12,604,902	12,604,902	0	0	0	0
Total PEI Program Estimated Expenditures	333,602,743	149,681,352	114,161,848	0	69,746,397	13,146

	Fiscal Year 2018/19					
	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 - SUICIDE PREVENTION						
PEI-01 Suicide Prevention	6,339,293	6,339,293				
PEI Programs - STIGMA DISCIRMINATION REDUCTION						
PEI-02 Stigma Discrimination Reduction Program	4,720,497	4,720,497				
PEI Programs - PREVENTION						
PEI-03 Strengthening Family Functioning	7,593,000	7,593,000				
PEI-04 Trauma Recovery Services	1,650,050	1,650,050				
PEI-05 Inidividuals and Families Under Stress	11,262,710	11,262,710				
PEI-06 At-Risk Youth	7,034,450	7,034,450				
PEI-07 Vulnerable Communities	10,898,000	10,898,000				
PEI Programs - EARLY INTERVENTION						
PEI-03 Strengthening Family Functioning	32,308,481	10,421,836	13,585,260		8,299,821	1,564
PEI-04 Trauma Recovery Services	82,807,452	26,711,427	34,819,364		21,272,651	4,010
PEI-05 Inidividuals and Families Under Stress	117,016,431	37,746,312	49,203,757		30,060,697	5,666
PEI-06 At-Risk Youth	39,367,477	12,698,875	16,553,468		10,113,228	1,906
PEI Administration	12,604,902	12,604,902	0	0	0	0
Total PEI Program Estimated Expenditures	333,602,743	149,681,352	114,161,848	0	69,746,397	13,146

PEI Component Worksheet (continued)

	Fiscal Year 2019/20					
	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 - SUICIDE PREVENTION						
PEI-01 Suicide Prevention	6,339,293	6,339,293				
PEI Programs - STIGMA DISCIRMINATION REDUCTION						
PEI-02 Stigma Discrimination Reduction Program	4,720,497	4,720,497				
PEI Programs - PREVENTION						
PEI-03 Strengthening Family Functioning	7,593,000	7,593,000				
PEI-04 Trauma Recovery Services	1,650,050	1,650,050				
PEI-05 Inidividuals and Families Under Stress	11,262,710	11,262,710				
PEI-06 At-Risk Youth	7,034,450	7,034,450				
PEI-07 Vulnerable Communities	10,898,000	10,898,000				
PEI Programs - EARLY INTERVENTION						
PEI-03 Strengthening Family Functioning	32,308,481	10,421,836	13,585,260		8,299,821	1,564
PEI-04 Trauma Recovery Services	82,807,452	26,711,427	34,819,364		21,272,651	4,010
PEI-05 Inidividuals and Families Under Stress	117,016,431	37,746,312	49,203,757		30,060,697	5,666
PEI-06 At-Risk Youth	39,367,477	12,698,875	16,553,468		10,113,228	1,906
PEI Administration	12,604,902	12,604,902	0	0	0	0
Total PEI Program Estimated Expenditures	333,602,743	149,681,352	114,161,848	0	69,746,397	13,146

Innovation Component Worksheet

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000	0		0	
2. Innovation #2	20,000,000	20,000,000	0		0	
3.	0					
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000				
2. Innovation #2	20,000,000	20,000,000				
3.	0					
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000				
2. Innovation #2	20,000,000	20,000,000				
3.	0					
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

Workforce, Education and Training (WET) Component Worksheet

	Fiscal Year 2017/18					
	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	1,935,142	1,935,142				
2. Mental Health Career Pathway	4,550,380	4,550,380				
3. Residency and Internship	0	0				
4. Financial Incentive	14,931,130	14,931,130				
5.	0	0				
WET Administration	1,183,348	1,183,348				
Total WET Program Estimated Expenditures	22,600,000	22,600,000	0	0	0	0

	Fiscal Year 2018/19					
	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	360,000	360,000				
2. Mental Health Career Pathway	819,600	819,600				
3. Residency and Internship	0	0				
4. Financial Incentive	3,343,600	3,343,600				
5.	0					
WET Administration	1,183,348	1,183,348				
Total WET Program Estimated Expenditures	5,706,548	5,706,548	0	0	0	0

	Fiscal Year 2019/20					
	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	360,000	360,000				
2. Mental Health Career Pathway	819,600	819,600				
3. Residency and Internship	0	0				
4. Financial Incentive	3,343,600	3,343,600				
5.	0					
WET Administration	1,183,348	1,183,348				
Total WET Program Estimated Expenditures	5,706,548	5,706,548	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component Worksheet

	Fiscal Year 2017-18					
	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.	0	0				
2.	0	0				
3.	0					
CFTN Programs - Technological Needs Projects						
4. Contract Provider Technology Needs Project	2,500,000	2,500,000				
5. Integrated Behavioral Health Information System	2,000,000	2,000,000				
6.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	4,500,000	4,500,000	0	0	0	0

Appendix

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VIII.**	**11/1/2006**	**1 of 3**

PURPOSE: To establish a procedure for the disenrollment of a Full Service Partnership (FSP) client from a FSP program.

DEFINITION: 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 twelve (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 services for more than twelve (12) months from the date of last contact. The reasons for disenrollment are as follows:

1. Target population criteria are not met. Client is found not to meet target population; in most cases, clients who are discovered to have no major mental illness or serious emotional disturbance (SED).

2. Client decided to discontinue Full Service Partnership participation after partnership established. Client has either withdrawn consent or refused services.

3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and has discontinued FSP services.

4. After repeated attempts to contact client, client cannot be located. Client is missing, has not made contact with FSP agency. Agency may request disenrollment of a client after multiple documented outreach attempts for at least thirty (30) days but not more than ninety (90) days.

5. Community services/program interrupted – Client's circumstances reflect a need for residential/institutional mental health services at this time (such as, an Institute for Mental Disease (IMD), Mental Health Rehabilitation Center (MHRC) or State Hospital (SH). Client is admitted to an IMD, MHRC or SH.

6. Community services/program interrupted – Client will be detained in juvenile hall or will be serving camp/ranch/ CYA/jail/prison sentence. Client is anticipated to remain in one of these facilities for over ninety (90) days.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VIII.**	**11/1/2006**	**2 of 3**

7. Client has successfully met his/her goals such that discontinuation of Full Service Partnership is appropriate. Client has successfully met his/her goals, as demonstrated by involvement in meaningful activities, such as, employment, education, volunteerism or other social activities and is living in the least restrictive environment possible, such as an apartment. The client no longer needs intensive services.

8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.

GUIDELINES: Countywide Programs Administration must authorize all requests for client disenrollment from the FSP program prior to an agency officially terminating services.

1. Upon determining that a client meets disenrollment criteria, the FSP agency will complete the Full Service Partnership Disenrollment Request Form and submit it to the age-appropriate Impact Unit Coordinator for pre-authorization of disenrollment.

2. Impact Unit Coordinator will review the disenrollment request within five (5) business days of receipt. Clients that meet FSP disenrollment criteria will be pre-authorized and forwarded to Countywide Programs Administration. For clients that do not meet disenrollment criteria, Impact Unit Coordinator will complete and send Full Service Partnership Disenrollment/ Transfer Request Supplemental Form to FSP program. FSP program must continue services.

3. Countywide Programs staff will review the request for disenrollment and pre-authorization information and will notify the FSP program and Impact Unit of authorization for disenrollment within two (2) business days. Once disenrollment is authorized, the FSP program may close the case in the DMH Integrated System (IS) and relevant Data Collection System (see VII.A. Outcomes Data Collection or http://dmhoma.pbwiki.com).

   If Countywide Programs staff does not authorize client for disenrollment they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to FSP program and Impact Unit. FSP program must continue services.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
COUNTYWIDE PROGRAMS – FULL SERVICE PARTNERSHIP
GUIDELINES

SUBJECT	GUIDELINE NO.	EFFECTIVE DATE	PAGE
DISENROLLMENT GUIDELINES	**VIII.**	**11/1/2006**	**3 of 3**

4. If FSP agency does not agree with the decision of the Impact Unit or Countywide Programs Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

A client transferring from one FSP program to another FSP program is not considered a disenrollment (see V.C. Transfer of Clients Between Full Service Partnership Programs).

FORMS:

- Full Service Partnership Disenrollment Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

Full Service Partnership Outcomes Measures Application
Living Arrangement Exception Reasons and Corrections

FSP OMA Living Arrangement Exception Reasons and Corrections (Revised 1/29/10)

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Client has Multiple Baselines/Multiple Baseline within 365 days	Only one baseline should be done for a client unless the client has been disenrolled from FSP for 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC.	Multiple agencies may need to coordinate the correction process. Each agency will have to follow steps outline by MHSA Implementation Unit.	Investigate the problem and determine whether there truly is a duplicate baseline. Once you determine there is a duplicate baseline, you need to identify which baseline you wish to keep and delete the duplicate baseline and any assessments (KEC and 3M's) associated with the duplicate baseline. Often multiple agencies need to coordinate the data correction process when client's data resides in multiple agencies.	Submit a Data Change/Request form to delete duplicate baseline. OMA team will investigate which baseline to keep and any KEC's or 3M's that needed to be re-entered due to the assessments associated with the baseline that needed to be deleted.
Partnership Date on Baseline is Prior to 7/1/2005	July 1, 2005 is the earliest possible start date for FSP in Los Angeles County. The July 1, 2005 start date only pertains to a few directly operated programs, most programs started after December 1, 2006.	When making a change to the partnership date, one must always go back and make sure the baseline information is correctly representing the revised 12 month period.	Partnership dates cannot predate CW authorization date. Discuss with Countywide Age group Authorization unit when necessary. Need to make the partnership date change and change living arrangement date range to match. Changes to the partnership date may change the 3M due dates.	Changes to partnership date and living arrangement ranges can be changed directly in the OMA by the provider. If changing of the partnership date affects the 3M(s) due dates, information on the 3M needs to change to reflect accurate time frame of the 3M assessment(s).
Baseline Disenrolled over 365 Days	If a client is re-enrolling into FSP after having left the program for more than 365 days from the date of disenrollment indicated on a KEC, a new baseline is needed.	A client is enrolled in FSP on 7/1/06 and disenrolls on 8/30/06 according to the KEC. The client returns to FSP on 9/2/07, and the agency does a reestablishment KEC when a new baseline should have been done.	Need to confirm a second baseline is needed for the client.	Delete the KEC that was created for re-establishment and instead create a new baseline for the client
Partnership Date in AdminInfo is null/ blank	The report considers the partnership date as the start of the FSP services. Without the date, the report cannot make the comparison of pre-partnership days and changes that took place after the FSP started.	None	Determine when the client was enrolled in the program. This needs to be the first date of service billed in the IS for the program. For FSP, this date cannot predate the countywide authorization date.	Provider needs to input the partnership date and ensure correct date range for the living arrangement and baseline info.

FSP Baseline Exception Reasons

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Maximum "Date To" on Baseline LA Not Equal to Partnership Date - 1	Baseline living arrangement date range must include 365 consecutive, non overlapping days. The last "Date To" date must be the day before the partnership date. The earliest "Date From" date must be 365 days before the partnership date. **Remember that 2008 was a leap year which means there was an extra day in Feb. You need to account for this extra day if your partnership date falls on or between 3/1/08 - 2/28/09.**	If Partnership date= 7/15/09. Date from and to range = 7/15/08 to 7/14/09. Minimum "date from" = 7/15/08. Maximum "date to" = 7/14/09	The most recent "date to" (end date) needs to be one day before the partnership date. Consult the living arrangements example (attached) if needed.	Need to list all the days within the correct date range by the provider. Changes can be made directly in the OMA.
Minimum "Date From" on Baseline LA Not Equal To Partnership Date - 365			The earliest date from (start date) needs to be 365 days before the partnership date. Consult the living arrangements example (attached) if needed.	
Has "Date To" on Baseline LA Greater Than or Equal To Partnership Date			The pre-partnership living arrangements cannot extend into the partnership. The information by definition is based on the 12 months prior to enrollment.	
		Partnership date for leap year =1/15/09. Wrong Date Range= 1/15/08 to 1/1409. This yields 366 days. Correct Date Range= 1/16/08 to 1/14/09, which will yield 365 days	Take into account of the extra day due to a leap year. Need to adjust the range (Move the start date a day later). Affects partnership dates from 3/1/08-2/28/09 inclusive.	
Does Not have a total of 365 Days of Pre-Partnership Living Arrangements	365 days of pre-partnership living arrangements on baseline are required. Validation exists now in OMA to prevent this from occurring. Exclusion due to this reason pertain to very early OMAs that predate the validation.	None	Need to examine the correct date range for the client and ensure all data is captured.	Provider is able to make the changes in the OMA
Residential Type selected Can Not be Checked on Tonight Column	IMD, "Mental Health Rehabilitation Center" (MHRC), Prison, Jail, Community Treatment Facility (CTF)", "California Youth Authority/DOJJ", "Probation Camp/ Ranch", 'lives in a group home (L12), "Lives in a group home (L14), "State Psychiatric Hospital", "Juvenile Hall", "Skilled Nursing Facility (Psychatric)", can not be checked as a residential type in the "tonight" column on baseline. Clients can not be enrolled into FSP until they are discharged from the aforementioned placements. These residential types can be checked in the "Yesterday" column in the baseline LA with other residential types endorsed in the tonight column.	Remember the "tonight" column signifies where the program housed the client on the first day they enrolled in FSP. For example if a client is picked up from jail or a hospital and then housed in an emergency shelter the same night, emergency shelter should be checked in the tonight column.	Mark the appropriate residential setting where the client was housed upon enrollment. If the client was moved around on that first day, pick where the client was at 11:59 as the residential type to record in the "tonight" column.	Provider can make the change by logging onto OMA and checking the appropriate box for a residential type other an those listed in the explanation. Remember that only one living arrangement can be checked to be saved.
Tonight Column Checked for More than one Baseline Living Arrangement	You can only record one residential type in the "tonight column". If the client stayed in multiple locations on the first day of partnership, choose where the client was at 11:59 p.m. The client cannot be in more than one place at 11:59 on the night of partnership.	See above for information on residential types that cannot be selected in the "tonight column".	Select the correct living arrangement type at the start of the partnership.	Provider is able to make the changes in the OMA by ensuring one box and only one box is checked.
Tonight Column Not Checked for any living arrangement	A check in the "tonight" column represents the first residential type the client stays in on the first night of the FSP. This is considered the first "post-partnership" living arrangement of the partnership. A living arrangement must be indicated in the "tonight" column on the baseline.	None	Need to examine the correct living arrangement type the client resides in on the 1st day (at 11:59pm) of the partnership.	Provider is able to make the changes in the OMA
More than one Living Arrangement KEC on the Same Date	Two or more living arragement KEC's filed for the same status change date. Client can only be in one residential placement per night at 11:59pm.	None	Will have to determine which living arrangement KEC(s)is correct and which one(s) need to be deleted .	Submit a Data Change/Request form to delete unneeded residential KEC(s) from the same status change date.

Full Service Partnership Outcomes Measures Application Employment Exception Reasons and Corrections

Baseline Data

- **Total Weeks Not Equal to or Greater than 52:** Assessments where the total number of weeks for all employment statuses including unemployed and retired does not equal 52 weeks or greater.
- **Partnership Date Missing**: The Partnership Date signifies the start of the program (1st day of service claimed). For FSP, Partnership Date = enrollment date and cannot pre-date the Countywide Administration Authorization Date.
- **Duplicate Baseline Detected:** Only one baseline should be done for a client unless the client has been disenrolled from FSP for more than 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC.

Key Event Change (KEC) Data

- **Conflicting Current Employment/Unemployment:** When nothing is reported in all of the Current Employment fields and No is answered to the question: Is the client unemployed at this time?
- **Missing Date of Employment Change:** An employment change is indicated on the KEC but the Date of Employment Status Change is left blank.
- **Conflicting Employment/Unemployment KEC:** When there is nothing reported in all of the Current Employment fields and "No" is answered to the question, "Is the client unemployed at this time?"
- **Missing Partnership Status Change on Disenrollment or Reestablishment:** A disenrollment or reestablishment is indicated on the KEC but the Date of Partnership Status Change is left blank.
- **Employment Change Date on KEC Prior to Partnership Date:** A KEC should not reflect a change that occurred prior to the client's enrollment in the FSP program.
- **Unemployment Reason Reported and Unemployment Not Checked:** The KEC reported a reason for unemployment without indicating the client is unemployed.
- **Unemployment Checked and No Reason Given:** Unemployment is indicated on the KEC but the reasons for unemployment are left blank.
- **Unemployment Reason Conflicts with Unemployment Status:** The KEC indicates the client is employed at the time, but answered the reasons for unemployment.

Field Capable Clinical Services Outcomes Measures Application Baseline Exception Reasons and Corrections

Exception Reasons:

- Baseline excluded because the FCCS update is missing data.
- Baseline excluded because more than 1 update has the same assessment date.
- FCCS update is tied to a baseline that is excluded.
- Baseline is missing data.
- Multiple baselines for the same clinical episode.

Full Service Partnership Outcomes Measures
Employment Status Definitions

Competitive Employment: Paid employment in the community in a position that is also open to individuals without disability.

Supportive Employment: Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.

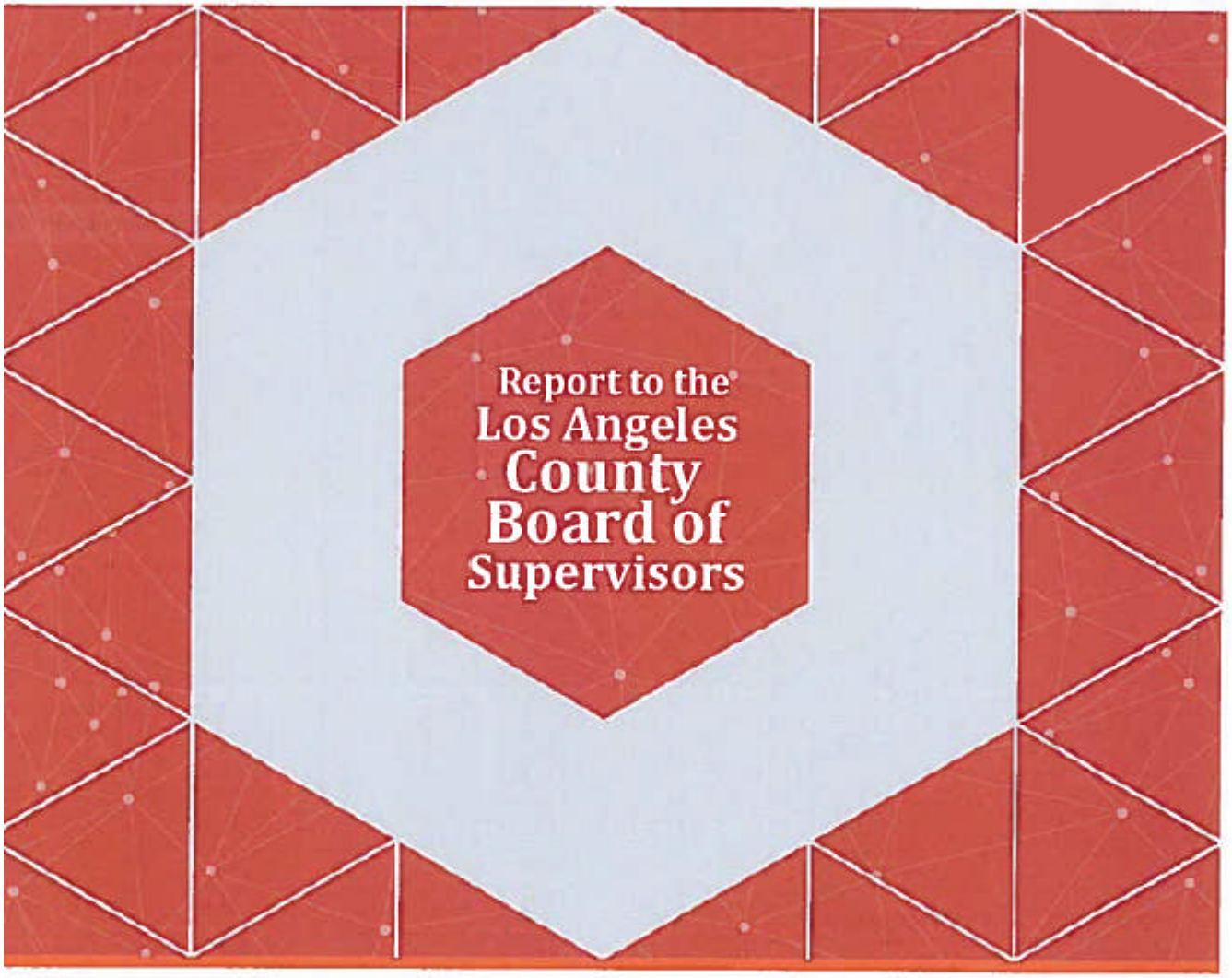
Transitional Employment / Enclave: Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.

Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.

Non-paid (Volunteer) Work: Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.

Other Gainful / Employment Activity: Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does not include such activities as panhandling or illegal activities such as prostitution.)

A Summary of Findings for the Los Angeles County 241.1 Multidisciplinary Team



CAL STATE LA

Denise C. Herz, Ph.D.
School of Criminal Justice & Criminalistics
California State University—Los Angeles

September 2016

OVERVIEW OF THE 241.1 MDT RESEARCH PROJECT

The 241.1 Multidisciplinary Team (MDT) began as a pilot program in the Pasadena delinquency courts in May 2007 under a Crossover Committee (an interdisciplinary committee tasked with improving the 241.1 process in Los Angeles County) convened and led by Judge Michael Nash. The 241.1 MDT approach evolved from the 241.1 Protocol developed by Judge Nash and the Crossover Committee in 1998 and was implemented countywide in 2012. Below is a brief timeline of the events related to the development and expansion of the 241.1 MDT approach in Los Angeles County.

Timeline for the Development of the 241.1 Multidisciplinary Team Approach in Los Angeles County	
1998	Judge Nash convenes an interagency Crossover Committee and establishes the Los Angeles County 241.1 Protocol.
2005-2006	California passes AB 129 allowing dual jurisdiction in counties that chose to pursue this approach (Note: WIC 241.1 specifically dictates separate jurisdiction between the child welfare and juvenile justice systems). The Crossover Committee begins planning to adopt dual jurisdiction using a multidisciplinary approach.
May 2007	The 241.1 MDT Pilot Program launches in Pasadena Delinquency Courts. The MDT includes one dedicated representative from the Department of Children and Family Services (DCFS) 241.1 Unit, the Probation 241.1 Unit, and the Department of Mental Health (DMH) Juvenile Court Services Clinician. Additionally, educational reviews were conducted by attorneys from the Learning Rights Center.
October 2011	241.1 MDT expands to Eastlake Delinquency Court—Commissioner Totten's courtroom and staff in all respective units begin rotating all staff into MDTs. DCFS Educational Consultants replace the education advocacy attorneys when grant money is exhausted.
January 2012	One court at each delinquency court location is dedicated as a 241.1 Court and the 241.1 MDT process is expanded countywide.
September 2012	The Los Angeles County Board of Supervisors pass a motion to hire additional psychiatric social workers to ensure countywide coverage for the 241.1 MDTs (funded from Proposition 63-the Mental Health Services Act).

Although some level of data has been collected for the 241.1 MDT since 2007, an institutionalized, web-based system was not in place until 2013 following the passage of the Board Motion to support the addition of DMH psychiatric social workers for the 241.1 MDT. The current data collection effort on which this report is based was led by a 241.1 Data Subcommittee composed of the following representatives (NOTE: a few of the original members listed below were promoted and moved into different assignments):

- DCFS: Wilhelmina Bradley (241.1 Unit), Marcelino Ramos (Bureau of Information Services) and several representatives from the DCFS Education Unit including William Cochrane, Tran Ly, Patricia Armani, Denise Prybylla, and Gerardo Beltran
- Probation Department: Michael Verner, Suzanne Lyles, Mirsha Gomez, and Delores Bryant-White
- Department of Mental Health (DMH): Nancy Gilbert
- California State University—Los Angeles: Denise Herz and Carly Dierkhising

The database used for this effort is an application built onto the DCFS information system (Child Welfare Services/Case Management System-CWS/CMS) by Marcelino Ramos from DCFS-BIS. Access to the database is provided to the DCFS 241.1 Unit, Probation and DMH, making it an interagency-based data collection system. No additional resources were provided to DCFS, Probation, DMH or California State University—Los Angeles; thus, all efforts related to building/maintaining the database, entering data into the database, and cleaning/analyzing the data are either subsumed in current workloads or provided through in-kind services.

A testament to the innovativeness of the 241.1 MDT Database built by Marcelino Ramos is the selection of the database as a recipient of the 2016 Excellence in Technology - Outstanding IT Project Award at the Los Angeles Digital Government Summit.

OVERVIEW OF KEY WIC CODES AND THE DATA METHODS USED FOR THE CURRENT REPORT

Key Welfare and Institutions Codes Related to 241.1

Welfare and Institutions Code (WIC) Section 241.1: Requires, in part, that whenever a youth appears to come within the description of both Section 300 and Section 602, DCFS and Probation must initially determine the status that will serve the best interests of the youth and the protection of society. Also defines and addresses "dual status" youth, allows these youth to be simultaneously dependent youth and a ward of the court, and outlines the requirements that DCFS and Probation must meet. It also addresses and defines a "lead court/lead agency" system.

WIC Section 300: States, in part, that children who meet the specified criteria will be considered within the jurisdiction of the juvenile court and that the court may adjudge these children to be dependents of the court.

WIC Section 602: States that any individual under the age of eighteen (18) who commits a specified crime is within the jurisdiction of the juvenile court and may be adjudged by the court to be a ward of the court

NOTE: See Appendix A for a description of delinquency court dispositions descriptions.

Types of 241.1 Referrals

There are several types of referrals made to the 241.1 Units. Youth who had an open 300 case and had a pending delinquency petition were the original target population for data collection and the development of the 241.1 MDT; however, the 241.1 Application collects data on all types of referrals.

The target group for this report is still youth with an open 300 case and a pending delinquency petition, but for the first time since data collection began on crossover youth in Los Angeles, we now can report the distribution of all types of referrals. For clarity, a brief description of the different types of referrals is provided below:

- *300 youth with a pending delinquency petition:* These youth have an open DCFS court-involved case, are charged with criminal charges, and are awaiting a delinquency court hearing (hereafter referred to as "300 youth").
- *Emergency Referral (ER), Voluntary Family Maintenance (VFM), Legal Guardian (LG) with a pending delinquency petition:* These youth do not have substantiated cases in dependency court, but they were involved with DCFS in some way when they were charged with a criminal offense and, consequently, face a delinquency court hearing.
- *Declared 602 youth with a pending dependency decision:* These youth are wards of the delinquency court at the time of their referral and subsequently, a case is opened for them in DCFS.
- *Reassessments:* Youth with reassessments were previously 241.1 referrals who received a delinquency disposition and are now returning to court because (1) the court has requested to see them; (2) they committed a new charge; and/or (3) they are being charged with a Probation violation.

- *Reverse 241.1 and AB 12 Referrals:* These are referrals for wards of the delinquency court who are requesting a return to dependency because their delinquency dispositions are coming to an end (NOTE: AB 12 is a bit more complicated than this description—readers can learn more about this particular law by going to http://www.childsworld.ca.gov/PG2902.htm).

It should be noted that except for reassessment referrals, all referrals are "new." In other words, even though the youth referred may have been on Probation in the past, they were not under Probation supervision at the time of the referral. Additionally, some youth receive multiple 241.1 referrals within the same timeframe; thus, unless the narrative in a particular section indicates otherwise, the unit of analysis is referrals not individuals. In the case of referrals, one youth may be represented several times due to multiple referrals.

Type of Data Collected

The use of the 241.1 Application to capture all 241.1 referrals made to the DCFS and Probation 241.1 Units began on October 1, 2013. The database was used to collect three types of data: Referral Information, Initial Data, and Tracking Data.

Referral Information: Basic information is captured in the 241.1 Application for all 241.1 referrals received. In addition to demographic and type of 241.1 referral, it also captures administrative information needed by the DCFS 241.1 Unit to process the referrals.

Initial Data: For all cases except reassessments, additional characteristics are captured in the 241.1 Application by each agency participating on the Team. For example, DCFS enters information on the youth's history in the agency, Probation enters information about the current offense and prior contact with the juvenile justice system, DMH enters general information on the youth's behavioral health needs (if applicable), and Education Consultants/contracted agencies provide information on the youth's educational status/background. These data reflect the youth's status at the time of the referral. It is important to note that the information entered by the agencies reflects that contained in the 241.1 Joint Assessment and submitted to the delinquency court in preparation for the 241.1 hearings (i.e., no additional information is collected).

Tracking Data: The collection of "Tracking Data" is more limited in scope (i.e., it is only collected for a subsample of referred youth). The subsample of youth is identified each month (beginning in October 2013) from all youth who have an open 300 case prior to receiving a disposition from the delinquency court. Specifically, up to 30 of these youth in any particular month are selected as tracking cases. If this list is less than 30, all youth are selected for tracking, but when the number of youth exceeds 30, a random sample of 30 is selected. Both DCFS and Probation are responsible for reporting data on the educational status, placement status, and services status for tracked youth at two points in time: 6 months after their

disposition or until both the dependency and delinquency cases close—whichever comes first. DMH is also responsible for reporting the services youth received from DMH during these two timeframes.

The cases used for this report include all 241.1 referrals received and accepted for processing between October 1, 2013 and March 31, 2016; however, the data are analyzed by year when appropriate. Given limited resources, tracked cases were limited to youth who received dispositions between October 1, 2013 and July 31, 2014. Table 1 provides a breakdown of the total number of cases available for analysis based on the type of referral examined.

Table 1: Summary of 241.1 Cases Used for Analysis

Type of Case	Number
All 241.1 Referrals Received and Approved for Processing	2,438
All "New" 241.1 Referrals	1,281
"300 youth with a pending delinquency petition"—All Referrals	763
"300 youth with a pending delinquency petition"—Unique Youth	718
Youth Tracked for 6 Months After Disposition ("Tracked Cases")	152

PURPOSE OF THIS REPORT

The current report presents a summary of (1) 241.1 referrals from 2013 and 2014, and (2) dispositions received by "300 youth with pending delinquency petitions" in 2013, 2014, and 2015. Additionally, the characteristics of all "300 youth with a pending delinquency petition" processed to date are presented as well as 6-month outcomes for tracked youth.

RESULTS FOR 241.1 REFERRAL TYPES AND DISPOSITIONS

241.1 Referrals Received by Type of Referral and by Year *(Table 2)*

- Overall, the number of 241.1 referrals has decreased 13% over time. This decrease was predominately due to lower numbers of youth in the "new" referral category.
- Slightly more than half of all 241.1 referrals were for "new" referrals and the remaining half were associated with "reassessments."
- Of the "new" referrals, 300 youth with a pending delinquency petition comprised approximately one-third of all referrals and 59% of all "new" referrals.
- The predominant reason for "reassessments" was a court order to see the youth followed by a new arrest and probation violations.

Table 2: Total Number of 241.1 Referrals Received by Type of Referral and by Year*

Type of Referral	2013 Referrals (N=1,058)		2014 Referrals (N=1,021)		2015 Referrals (N=920)	
	N	%	N	%	N	%
"New" 241.1 Referrals						
*New Referrals-All Types Combined**	*592*	*56.0*	*537*	*52.6*	*459*	*50.0*
300 pending delinquency petition	---	---	311	30.5	271	29.5
ER, VFM, or LG pending delinquency petition	---	---	105	10.3	90	9.8
Pending 300 case & pending delinquency petition	---	---	77	7.5	76	8.3
Declared 602 with ER, VFM, or LG	---	---	23	2.2	12	1.3
Declared 602 with pending 300	---	---	21	2.1	10	1.1
Reassessments—Follow-Up Hearings for 241.1 Cases Already Processed						
Reassessment-All Types Combined	*413*	*39.0*	*484*	*47.4*	*454*	*49.3*
Reassessment-Court Order	---	---	236	23.1	211	22.9
Reassessment-New Arrest	---	---	177	17.3	176	19.1
Reassessment-Violation (WIC 777)	---	---	59	5.8	65	7.1
Reverse 241.1	42	4.0	12	1.2	2	.2
AB 12	11	1.0	---	---	---	---
Missing Type of Referral	*53*	*5.0*	---	---	*7*	*.8*

**Data are limited to cases accepted for processing. In 2013, the type of new referral was not distinguished; thus, these referrals are only presented in the combined category.*

Dispositions Received by "300 Youth with a Pending Delinquency Petition" by Year *(Table 3)*

- Between 2013 and 2015, case dismissals increased slightly, informal probation dispositions remained relatively constant, dual jurisdiction dispositions more than doubled, and delinquency wardship (alone) dispositions decreased by half.
- "300 youth with a pending delinquency petition" were most likely to receive an informal probation disposition regardless of year. Just under half of these youth received a disposition of either WIC 654.2, 725(a) or 790. In 2015, youth in this category were more likely to receive a WIC 790 or 725(a) disposition than a WIC 654.2 disposition (see Appendix A for definitions of each code).
- For youth who received a dual jurisdiction disposition, the most likely type was placement in a suitable placement.

- For youth who had their dependency cases closed and were made a delinquency ward, the disposition was most likely for Home on Probation in 2015; however, it was most likely for suitable placement in 2013.
- *NOTE: Dispositions were missing in a number of cases in 2013 and 2014, which could impact the accuracy of the distributions in those years.*

Table 3: Type of Disposition Received by "300 Youth with a Pending Delinquency Petition" by Year

	2013 Referrals (N=588)		2014 Referrals (N=311)		2015 Referrals (N=271)	
	N	%	N	%	N	%
Case Dismissed	20	*3.4*	13	*4.2*	19	*7.0*
Informal Probation (Dependency Case Remains Open)						
All Categories Combined	*277*	*47.2*	*131*	*42.2*	*130*	*47.9*
WIC 654.2	88	*15.0*	51	*16.4*	31	*11.4*
WIC 725(a)	81	*13.8*	44	*14.2*	48	*17.7*
WIC 790	108	*18.4*	36	*11.6*	51	*18.8*
Dual Jurisdiction (Dependency Case Open and Delinquency Court Wardship)						
All Categories Combined	*84*	*14.3*	*104*	*33.4*	*88*	*32.4*
300/602 Home on Probation	19	*3.2*	29	*9.3*	13	*4.8*
300/602 Suitable Placement	60	*10.2*	65	*20.9*	57	*21.0*
300/602 Camp	5	*.9*	10	*3.2*	18	*6.6*
602 Wardship (Delinquency Court Wardship and 300/Dependency Case Closed)						
All Categories Combined	*51*	*8.7.*	*9*	*2.9*	*11*	*4.0*
602 Home on Probation	17	*2.9*	1	*.3*	6	*2.2*
602 Suitable Placement	27	*4.6*	4	*1.3*	2	*.7*
602 Camp	6	*1.0*	4	*1.3*	2	*.7*
602 DJJ	1	*.2*	---	---	1	*.4*
Other/Missing/Pending	156	*26.5*	54	*17.4*	23	*8.4*

**NOTES: Data reflect all referrals rather than unique youth—i.e., one youth may have multiple referrals within one timeframe.*

CHARACTERISTICS OF 241.1 REFERRALS

The data presented in this section are taken from the Initial Forms completed by all agencies for "300 youth with a pending delinquency petition" between October 2013 and March 31, 2016 (N=718) and for Tracked Youth who received delinquency court petitions between October 1, 2013 and July 31, 2014 (N=152). Although the distributions for both groups are presented throughout these sections, the narrative is limited to presenting the results for the "300 youth with a pending delinquency petition" because (1) the results are nearly identical for the Tracked Youth group, and (2) presentation of the results is easier to understand.

The unit of analysis for this section is the individual youth rather than referrals; thus, no youth is represented more than once in the findings presented. During this timeframe, there were 763 referrals in the "300 youth with a pending delinquency petition" category, which yielded a total of 718 unique youth. As shown in Table 4, the majority of youth (94.2%) only had one "new" 241.1 referral during this time, but 5.8% had two or more.

Table 4: Number of "New" 241.1 Referrals for "300 Youth with Pending Delinquency Petition" (N=763 Referrals)

	N	%
1 Referral	676	94.2
2 Referrals	40	5.6
3 Referrals	1	.1
4 Referrals	1	.1

Demographic Characteristics of 241.1 Referrals "300 Youth" Only (Table 5)

- Approximately two-thirds of these 241.1 referrals were male, and a third of referrals were female. The proportion of females in this population is higher than in the general juvenile justice system population (typically 20%).
- Just under half of these 241.1 referrals were African-American and a similar percentage was Latino. African-American youth were over-represented at much higher rates in this population compared to the general population as well as the child welfare or juvenile justice systems individually.
- These 241.1 referrals were 15.82 years old (on average) at the time of their current arrests.
- These youth were most likely to live in group homes at the time of their referral followed by home and with relatives, and a fifth of these youth were AWOL (absent without leave) from their living situation at the time of their arrest.

Table 5: Demographic Characteristics of 241.1 Referrals

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
Gender		
Female	39.6	37.5
Male	60.4	62.5
Race/Ethnicity		
African-American	42.8	44.7
Latino	45.8	41.4
Caucasian	9.5	9.2
Rounded Average Age at Time of 241.1 Referral	15.82 years old	15.82 years old
Living Situation at Time of Referral		
Group Home	38.2	39.5
Home	23.7	23.0
Relative (Includes Legal Guardian)	19.0	23.6
Foster Care or Legal Guardian	15.4	12.5
Other /Missing	3.8	1.3
AWOL at Time of Arrest	19.6	15.8

SEPTEMBER 16, 2016

10

Involvement with the Juvenile Justice System (Table 7)

- Just over a third of these 241.1 referrals were detained at juvenile hall at the time of their arrest.
- 241.1 referrals were most likely to be charged with a violent charge in the current arrest followed by property offenses, and other offenses. Two-thirds of the violent charges involved an assault of some sort, and over half of the charges were felonies.
- Slightly more than one-quarter of the charges occurred at youths' living situations and just under a fifth occurred at school.
- One-third of youth had a prior criminal charge and one-quarter had a prior status offense at the time of their 241.1 referral.
- The majority (over three-quarters) of these 241.1 referrals were represented by the Public Defender's Office.

Table 7: Involvement in Juvenile Justice System for 241.1 Referrals

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
Detained at Time of Arrest	38.3	27.0
Most Serious Current Charge		
Violent Offense	42.2	44.7
Violent Offenses Involving an Assault	66.7	70.6
Property Offense	27.2	29.6
Other Offense	30.1	25.7
Type of Charge		
Felony	51.9	47.4
707b Offense	9.1	8.6
Misdemeanor	38.7	44.1
Was Offense Related to...?		
Living Situation	27.7	30.9
School	17.7	19.1
Missing	5.3	4.6
Recommendation to STAR Court	3.9	---

SEPTEMBER 16, 2016

12

Involvement with the Child Welfare System (Table 6)

- At the time of their 241.1 referral, the average number of previous referrals to DCFS for 241.1 tracked youth and/or their families was 10.8.
- The average number of years 241.1 tracked youth spent in the child welfare system was 5.3 years, and this time was consecutive for slightly more than half of these youth.
- The permanency plan for just under half of these youth at the time of their 241.1 referral was permanent planned living arrangements followed by reunification; remain at home; and guardianship.
- The Children's Law Center provided counsel for almost all these youth, with majority of youth assigned to Unit 1.

Table 6: Involvement in Child Welfare System for 241.1 Referrals

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
Average # of Referrals for Youth's Family	10.8 Referrals (SD=7.8 Referrals)	9.9 Referrals (SD=8.4 Referrals)
Average Length in the System	5.3 Years (SD=4.6 Years)	5.4 Years (SD=6.4 Years)
Time is Consecutive	57.1	59.2
Has Prior 241.1 Referral	14.8	11.2
Permanency Goal at Time of Referral		
Permanent Planned Living Arrangements	41.1	35.5
Reunification	25.6	28.9
Remain at Home	22.4	21.1
Guardianship	6.8	9.9
Other	2.7	3.3
Missing	1.4	---
Dependency Counsel		
Children's Law Center Unit 1	41.2	39.5
Children's Law Center Unit 2	25.1	28.9
Children's Law Center Unit 3	25.3	25.7
Panel Attorney	2.9	2.0
Other	4.3	3.9
Missing	1.1	---

SEPTEMBER 16, 2016

11

Table 7: Involvement in Juvenile Justice System for 241.1 Referrals—Continued

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
Prior Offenses		
Criminal Charges	32.9	27.0
Status Offenses	25.2	20.4
Missing Data	5.3	---
Delinquency Counsel		
Public Defender	81.5	86.2
Alternate Public Defender	4.2	1.3
Panel Attorney	5.7	7.2
Other	3.2	5.3
Missing	5.3	---

*Youth may have multiple charges across offense categories; thus, the offense categories do not add up to 100%.

Mental Health and Substance Abuse Problems (Table 8)

- One-quarter to one-third of 241.1 referrals had a history of hospitalization for mental illness, were prescribed medication, and/or experienced suicidal ideation. Just about one-tenth of these youth had attempted suicide at some point in the past.
- Three-quarters of these 241.1 referrals had a mental health diagnosis, and slightly more than half had a pattern of alcohol/drug use and/or diagnosed abuse or dependency.

Table 8: The Prevalence of Mental Health and Substance Abuse Problems for 241.1 Referrals

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
Mental Health History		
Ever Placed in Psychiatric Hospital	30.9%	31.0%
Experienced Suicidal Ideation	21.7%	24.4%
Ever Attempted Suicide	9.2%	12.5%
Prescribed Psychotropic Medication	26.3%	27.0%

SEPTEMBER 16, 2016

13

Table 8: The Prevalence of Mental Health and Substance Abuse Problems for 241.1 Referrals—Continued

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
Mental Health Diagnoses		
No	12.4%	21.0%
Yes	74.5%	78.9%
Unknown/Missing	13.5%	---
Substance Use/Abuse		
No Substance Abuse Problem	21.9%	30.9%
Misuse/Pattern of Use	24.3%	27.0%
Abuse/Dependency	34.4%	35.5%
Unknown/Missing	13.5%	6.6%

*13.5% of the cases included for this analysis had missing data for all DMH Initial information.

Educational Status and Characteristics (Table 9)

- Complete school records were rarely available for these youth, but partial records were available for slightly more than half of the youth.
- Just under half of these youth did not have an active educational rights holder at the time of the 241.1 assessment.
- Only two-thirds were enrolled in school at the time of the 241.1 assessment, and some of these youth were enrolled during their detention in juvenile hall.
- Less than one-fifth of these youth were attending school regularly, and one-third were attending sporadically or not at all.
- Less than one-quarter of these youth were doing well academically and a quarter was doing poorly. Just under half of these youth were credit deficient at the time of the 241.1 referral.
- About one-third of these youth were either special education eligible or needed to be assessed for eligibility.

Table 9: Educational Status and Characteristics for 241.1 Referrals

	All 300 Youth with Pending Delinquency (N=718)	Tracked Youth (N=152)
	%	%
School Records Available		
Yes-Complete Records	1.5	5.2
Yes-Partial Records	55.4	48.0
Records were Not Available	6.6	4.6
Missing/Unknown	36.5	42.1
Youth Does Not Have an Active Educational Rights Holder	48.6	41.4
Enrolled in School at Time of 241.1 Assessment		
In the Community	40.7	44.7
In Juvenile Hall	14.9	7.9
Missing/Unknown	38.3	42.1
Attendance at School within Past Year (Top 3)		
Regular Attendance	14.8	14.8
Sporadic Attendance	19.4	17.8
Poor Attendance	17.6	14.4
Academic Performance at Time of 241.1 Assessment		
Doing Poorly	23.7	26.3
Doing Well or Average	13.5	13.8
Credit Deficient at Time of 241.1 Assessment	40.9	36.2
Special Education		
Receiving Services	15.0	12.5
Assessment Needed or In Process	21.5	17.9
No Behavior Problems at School	7.0	10.5

*A substantial amount of educational data is missing so results should be interpreted carefully. For the full sample, missing data is 36.5% and for the tracked sample it increases to 42.1%.

RESULTS FOR TRACKED CASES 6 MONTHS AFTER RECEIVING DISPOSITION

This section presents results related to youths' situations six months after they received a disposition from the delinquency court (i.e., they were found responsible for the criminal charges and given some level of supervision through the juvenile court and Department of Probation). As indicated above, the total number of youth tracked during this time is 152, which represents all dispositions given to 241.1 referrals who were 300 youth with a pending delinquency petition between October 1, 2013 and July 31, 2014. Three critical areas were examined over time: Changes in permanency plans and living situations, educational characteristics/performance, and on-going behavior problems as measured through reassessment hearings and new charges (i.e., recidivism). NOTE: Recidivism is measured using any new citation (e.g., a municipal offense) or new criminal charge—whether the charge was sustained or not in delinquency court.

Case Status, Permanency Plans, Living Situations, and Placement Changes over Time (Table 10)

- Six months after disposition, two-thirds of tracked youth still had open child welfare and juvenile justice cases. Approximately a fifth of cases had their probation cases terminated, and fewer had their child welfare cases closed.
- There was little change in permanency plans and living situations for tracked youth. The predominant goal for permanency was Permanent Planned Living Arrangements at the time of the 241.1 assessment and six months after disposition followed by reunification and remain at home.
- Consistent with the findings for permanency plan, there was little change in youths' living situations over time. Slightly more than a third were living in group homes/residential treatment centers followed by living with relatives or at home. At the end of tracking, however, several youth were in juvenile hall or in a Probation camp.
- A third of youth had at least one placement change during the tracking period, and the average number of placement changes experienced was between 1-2 placements.
- With regard to face-to-face contacts with case carrying social workers and assigned deputy probation officers, youth, on average, saw their social workers seven times during this period and they saw their probation officers approximately six times during the tracking period.

Table 10: Case Status, Permanency Plans, Living Situations, and Placement Changes over Time (N=152)

	Beginning of the Tracking Period	End of the Tracking Period
Status of Child Welfare (CW) and Juvenile Justice Cases (JJ)		
Child Welfare & Juvenile Justice Cases Open	---	67.1
Child Welfare Case Closed	---	11.2
Juvenile Justice Case Terminated	---	17.1
Child Welfare & Juvenile Justice Cases Closed	---	4.6
Permanency Plan		
Remain at Home	21.1	19.7
Reunification	28.9	28.9
Guardian/Adoption	9.9	11.9
Permanent Planned Living Arrangements	35.5	36.8
Other	1.3	.7
Living Situation		
Group Home/RTC	39.5	36.8
Home	23.0	17.1
Relative (Includes Legal Guardian)	23.6	21.7
Foster Care or Legal Guardian	12.5	13.8
Juvenile Hall	---	2.6
Camp	---	2.6
Other	1.3	5.3
Placement Changes		
Youth had at Least One Placement Change	n/a	33.6
Average Number of Placement Changes	---	Range: 1-4 Mean: 1.53 SD: .76
Contacts with Social Workers and Probation Officers		
Face-to-Face Contacts with Social Worker	---	Range: 0-23 Mean: 7.2 SD: 4.4
Face-to-Face Contacts with Probation Officer	---	Range: 1-46 Mean: 5.7 SD: 7.0

Educational Characteristics and Outcomes over Time (Table 11)

- Between the 241.1 assessment and the end of tracking period 1, enrollment in school increased dramatically (+35.7 percentage points). NOTE: There is a great deal of missing data at the time of the 241.1 assessment so results should be interpreted cautiously.
- Regular attendance increased (+48.1%) while sporadic attendance decreased slightly. There was also a slight increase in poor attendance.
- Doing poorly at school dropped 2 percentage points while doing average (mostly C's) or doing well increased 36.2 percentage points.
- Behavior problems at school decreased by 35.6 percentage points by the end of the tracking period.
- Overall, six of the eight measures for educational performance showed change in the positive direction.

Table 11: Educational Outcomes for Tracked Youth at the End of Tracking Period 1 (N=152)

	Beginning of the Tracking Period	End of the Tracking Period	Change Over Time	Type of Change
School Enrollment				
Graduated/GED	---	3.2	n/a	+
Enrolled in School	52.6	88.3	35.7	+
Missing/Unknown	43.4	---	---	---
School Attendance				
Attends Regularly	14.8	62.9	48.1	+
Attends Sporadically	17.8	14.5	-3.3	+
Poor Attendance	14.4	19.4	5.0	-
Missing/Unknown	42.1	---	---	---
Academic Performance				
Doing Well or Average	13.8	50.0	36.2	+
Doing Poorly	26.3	24.3	-2.0	-
Missing/Unknown	42.8	---	---	---
No Behavior Problems at School	89.5	53.9	-35.6	+

*Percentages do not add up to 100% because some categories within a variable were not included.

Recidivism at the End of Tracking Period 1 (Table 12)

- Between the 241.1 assessment and the end of tracking period 1, one-fifth of 241.1 tracked youth were referred for a 241.1 reassessment.
- One quarter of tracked youth had a court violation (e.g. a bench warrant) during the tracking period, and approximately one-fifth had a WIC 777 probation violation filed.
- 18.4% of 241.1 tracked youth had a new citation, and 17.8% were re-arrested for a new criminal offense within six months of their disposition. For comparison, Table 12 shows new arrest rates for 1 year after disposition from two studies. In these studies, the arrest rate for Non-MDT cases is 30-36%, which is nearly double the rate of MDT youth during this period.

Table 12: Reassessments and Recidivism for Tracked 241.1 Youth (N=152)

	Herz, 2010 MDT Evaluation	Hui et al., 2011 Study	2016 Report (N=152)
	Non-MDT	Non-MDT	MDT
Referred for a 241.1 Reassessment Hearing	---	---	21.7
Violations			
Court Violations During this Period	---	---	28.3
WIC 777 Violations During this Period	---	---	23.3
New Charges			
New Citations During this Period	---	---	18.4
New Arrests During this Period	36.0 (1 Year)	30.0 (1 Year)	17.8

SUMMARY OF FINDINGS

The findings from the 241.1 data collected by DCFS, Probation, and the Department of Mental Health provide unprecedented insight into "who" 241.1 youth are, the challenges they face, the services and conditions they receive, their participation/adherence to those services and conditions, and their outcomes. Although the numbers for tracked cases was still relatively small, the findings are consistent with last year's report and previous research completed in Los Angeles County and nationwide on crossover youth. Confidence in these findings and increased insight into these youths' experiences will continue to grow as the number of 241.1 youth included in analysis for future reports increases over time. In sum, this is what the current findings tell us:

Characteristics

- Females are more likely to be in the crossover population (i.e., WIC 241.1/involved in both child welfare and juvenile justice systems) than in the general juvenile justice population.
- The overrepresentation of African-American youth is greater within the crossover population than in the child welfare and juvenile justice systems individually.
- These youth and their families have multiple contacts with child welfare and the youth have long lengths of stay in the child welfare system.
- By the time they reach the 241.1 referral stage, many of these youth have had previous contact with the juvenile justice system by way of a criminal charge and/or a status offense.
- They are most likely to live in group homes, at home, or with relatives; and at least a third of their arrests are related to their living situations.
- These youth are struggling at school and engaged in behavioral problems that often lead to their current arrest (i.e., the charge occurred at school).
- Almost all of these youth have an indication of a mental health problem and/or an alcohol/drug problem.

Outcomes for 241.1 Tracked youth

- Overall, 241.1 tracked youth appeared to improve their attendance, academic performance, and behavior over time.
- Recidivism, as measured by new arrests, at the end of tracking was only 17.8%, which is lower than the rates produced for Non-MDT samples (30%-36%). However, the time frame for tracking is slightly different (i.e., 6 months compared to 1 year), making the comparisons not entirely equivalent.
- Approximately one-quarter of tracked youth continue to receive a reassessment and be charged with a probation violation, indicating that youth service plans may not meet the needs and risk levels for youth.

CONCLUSION AND RECOMMENDATIONS

The findings presented in the current report lay the foundation for looking at these issues more directly for dually-involved youth in Los Angeles County. As the data continue to grow, it will be possible to track trends for these youth and determine what characteristics and services are related to more positive outcomes and how strategies can be built to address the characteristics of youth with more challenging outcomes. The literature on effective programming and outcomes for youth with complex needs and risk factors is clear: Effective services require (1) matching youth needs and risks to appropriate levels of service, (2) using multi-modal treatments to address different risks and needs (often related) simultaneously, and (3) meaningfully engaging youth and their families in services.

One final and critical note is related to resources to support a data infrastructure for the 241.1 process. As mentioned earlier in this report, the design and implementation of the 241.1 Application is a major accomplishment and "labor of love" for a number of agency staff who work with dually-involved youth on a daily basis. Despite the Board's mandate to collect data, no resources were provided to support this work. Consequently, staff workloads continuously impact the timeliness and accuracy of data entered into the database. If resourced appropriately (i.e., each agency would have daily access to a staff person who is knowledgeable in data information systems and data collection), the data produced in the 241.1 Application could be used for real-time analysis and case management of all 241.1 cases. Until that time, however, 241.1 Application data will continue to need substantial cleaning prior to analysis, which will delay report writing, and unfortunately, will result in the Application being underutilized and undervalued by all of its participating agencies.

While Dr. Herz will continue with the project in an advisory capacity, she will no longer be able to produce the annual report. Thus, it is critically important to identify sufficient resources to (1) ensure data is entered accurately, completely, and consistently and (2) one or more researchers are able to assist in the monitoring of data quality and produce regular reports for the agencies. Commitment of such resources will align with the State Auditor's report on dual-system youth and their call for one database that accurately captures data on youth who cross into both systems. Specifically, resources to support the following recommendation are strongly encouraged:

- A full-time data entry/quality control staff person for each agency—these staff would also work collaboratively to develop and provide regular trainings for all staff related to the 241.1 MDT process;
- Full-time or part-time assistant to BIS programmer for the 241.1 application to build and run reports for both quality assurance and regular data updates to agencies
- Research support internally or through a contract with university researchers to assist in overall development, monitoring, and analysis of the data on a regular basis
- Create an interface between 241.1 application and all individual agencies (i.e., Probation and DMH information systems).

The 241.1 MDT process and application is unique in Los Angeles County. It represents a historical effort to build collaboration across agencies lasting over 18 years and has been recognized by national models for its interdisciplinary focus and commitment to data. The 241.1 data application is one of a kind in the state as noted by the recent State Auditor's Report. With some investment, the application will be sustainable and allow for on-going evaluation of the MDT process, creating a valuable feedback loop between research and practice. Such a process provides valuable insight into how systems can work together to better serve youth and families, particularly those who penetrate deeply into multiple systems and have poorer outcomes than those who touch no systems or only one system. Without an investment of resources and a commitment to the process, however, it is unlikely the application or the process will be sustainable. Unfortunately, an absence of resources, training, and on-going oversight will slowly erode the foundation built over many years of dedication across collaborative partners.

SEPTEMBER 16, 2016

22

Appendix A: Delinquency Disposition Options
(From Least Restrictive, to Most Restrictive)

1. Dismissal
   - No Probation/Delinquency Court Intervention

INFORMAL PROBATION: AKA - Dual Supervision

2. 654.2 WIC
   - Youth remains a 300 WIC Dependent (DCFS Lead Agency)
   - Will be supervised by the Probation Dept. for 6 months – 1 yr.
   - Does NOT require admission of charges in Court
   - If at SCHOOL = there are exclusions
   - 654.2 WIC fails = PROCEED TO ADJUDICATION

3. 725(a) WIC
   - Youth remains a 300 WIC Dependent (DCFS Lead Agency)
   - Will be supervised informally by the Probation Dept. for 6 months only.
   - Requires an admission of the offense in court.
   - Should be considered for any youth who has failed or is unlikely to succeed at 654.2 WIC.
   - 725A WIC fails = PROCEED TO DISPOSITION = 602 WIC HOP, S/P, CCP, OR DJJ

4. 790 WIC - Deferred Entry of Judgment
   - Youth remains a 300 WIC Dependent (DCFS Lead Agency)
   - Will be supervised by the Probation Dept. for a minimum of 1yr and up to 3 yrs.
   - Requires an admission of the offense in court
   - Cannot be considered in certain extremely serious offenses (707b WIC)
   - 790 WIC fails = JUDGMENT ENTERED = DISPOSITION 602 WIC HOP, S/P, CCP, OR DJJ

FORMAL PROBATION: AKA - DUAL STATUS

5. 300/602 WIC - Home on Probation / Home of Parent
   - Minor is declared a Ward of Delinquency Court, but retains their 300 WIC status in Dependency Court
   - All department guidelines regarding supervision remain in place.
   - Must designate a Lead Agency (DCFS or Probation)

SEPTEMBER 16, 2016

23

6. 300/602 WIC - Suitable Placement - (DCFS I Probation Lead)
   - Minor is declared a Ward of Delinquency Court, but retains their 300 WIC status in Dependency Court
   - All Department guidelines regarding supervision remain in place
   - Must designate a Lead Agency
   - Lead Agency responsible for physical placement and most treatment services

7. 300/602 WIC - Camp Community Placement - (Probation Lead)
   - Minor declared a Ward of the Delinquency Court, but retains their 300 WIC status in Dependency Court
   - All Department guidelines regarding supervision remain in place

8. 602 WIC - D.J.J. (Department of Juvenile Justice)
   - Minor declared a Ward of the Delinquency Court: Dependency Court terminates jurisdiction
   - Can only be considered if the youth is charged with a 707b offense and must be approved by Probation Department Screening Committee and Director.

SEPTEMBER 16, 2016

24

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - Anxiety & Avoidance**	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales - Parent (RCADS-P) Revised Child Anxiety and Depression Scales (RCADS)	6 - 18	RCADS-P: English, Korean, Spanish RCADS: Chinese, English, Korean, Spanish
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire 45.2	16 - 17 16 - 18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18+	No general measure is required				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Armenian, Chinese, English, Korean, Spanish
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent***	7 - 18 7 - 18	PTSD-RI 5 Child/Adolescent: English, Spanish PTSD-RI-5 Parent: English, Spanish PCL-5: English, Spanish
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15					
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)*	3 - 18					
	Managing and Adapting Practice (MAP) - Traumatic Stress**	2 - 18	Youth Outcome Questionnaire - 2.01 (Parent)	7 - 17	UCLA PTSD-RI-5 – Parent***	7 - 18	
	Seeking Safety (SS)	13+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	12 - 18 19+	UCLA PTSD-RI-5 – Child/Adolescent*** PCL-5***	7 - 18 19+	
	Individual Cognitive Behavioral Therapy - Trauma (CBT-Trauma)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	UCLA PTSD-RI-5 – Parent*** UCLA PTSD-RI-5 – Child/Adolescent*** PCL-5***	16 - 18 16 - 18 19+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integration Program (MHIP)-Trauma	18+	No general measure is required		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	No specific measure is required		
FIRST BREAK / TAY	Center for the Assessment and Prevention of Prodromal States (CAPPS)	16 - 25	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Scale of Prodromal Symptoms (SOPS)	16 - 35	English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	8 - 17 12 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	12+	Available in all 13 threshold languages
	Depression Treatment Quality Improvement (DTQI)	12 - 20					
	Managing and Adapting Practice (MAP) - Depression and Withdrawal**	8 - 23					
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	Patient Health Questionnaire - 9 (PHQ-9)	16+	Available in all 13 threshold languages
	Individual Cognitive Behavioral Therapy - Depression (CBT-Depression)	16+					
	Problem Solving Therapy (PST)	60+	Outcome Questionnaire - 45.2	19+			
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+					
	Mental Health Integration Program (MHIP) - Depression	18+	No general measure is required				
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectical Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Difficulties in Emotional Regulation Scale (DERS)	18+	English

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division

Prevention & Early Intervention (PEI) Evidence-Based Practices (EBP) Outcome Measures

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [If parent is unavailable]	2 - 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Aggression Replacement Training - Skillstreaming (ART)	5 - 12					
	Promoting Alternative THinking Strategies (PATHS)	3 - 12					
	Managing and Adapting Practice (MAP) - Disruptive Behavior**	0 - 21	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+			
SEVERE BEHAVIORS/ CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Revised Behavior Problem Checklist - Parent (RBPC) Revised Behavior Problem Checklist - Teacher (RBPC) [If parent is unavailable]	5 - 18	Armenian, Cambodian, English, Spanish
	Multidimensional Family Therapy (MDFT)	11 - 18					
	Strengthening Families Program (SFP)	3 - 16					
	Functional Family Therapy (FFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	Developer Required: Clinical Services System: • Counseling Process Questionnaire • Client Outcome Measure • Therapist Outcome Measure • YOQ/YOQ-SR/OQ	10 - 18	English
	Multisystemic Therapy (MST)	11 - 17			Developer Required: Therapist Adherence Measure Supervisor Adherence Measure	11 - 17	English
PARENTING AND FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable]	2 - 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7					
	UCLA TIES Transition Model (UCLA TIES) CDE	0 - 9					
	Caring For Our Families (CFOF) CDE as of 12/1/12	5 - 11					
	Loving Intervention Family Enrichment (LIFE) CDE as of 12/1/12	10 - 17					
	Reflective Parenting Program (RPP) CDE	0 - 12					
	Mindful Parenting Groups (MPG) CDE	0 - 3	No general measure is required		Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m - 36m	English, Spanish

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
PARENTING AND FAMILY DIFFICULTIES	Caring For Our Families (CFOF) CDE prior to 12/1/12	5 - 11	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	As of 12/1/12, the Eyberg Child Behavior Inventory (ECBI) and Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [If parent is unavailable] are being used for all new clients instead of the Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5)	2 - 16	**ECBI:** Armenian, Chinese, English, Japanese, Korean, Russian, Spanish **SESBI-R:** Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Loving Intervention Family Enrichment (LIFE) CDE prior to 12/1/12	10 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)		
	Families OverComing Under Stress (FOCUS)	5+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	McMaster Family Assessment Device (FAD)	12+	English

* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** For treatment cycles beginning before November 1, 2015 the DSM-IV UCLA PTSD-RI Child/Adolescent, Parent, and Adult Short Form will be required.
PEI EBP's that are not entered into PEI OMA are shaded.
1. Youth Outcome Questionnaire - 2.01 (Parent); Youth Outcome Questionnaire-Self-Report - 2.0; Outcome Questionnaire - 45.2; and PHQ-9 are available in all 13 threshold languages: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Tagalog, Japanese, Korean, Russian, Spanish, and Vietnamese.

SCHOOL BASED SERVICES

FOR

Latina Youth Program

Evaluation Report

CONTRACT YEAR 2015-2016

INTRODUCTION

The purpose of this report is to summarize progress with regard to ongoing operation and outcome trends of Pacific Clinics' School Based Services for Latina Youth Program, for the contract year 2015-2016 (FY 15-16). This report includes documentation on program direct services, education and outreach activities as well as prevention and intervention activities. Additionally, information on client demographics is provided. Client outcome trends are noted and discussed.

Data for this evaluation was gathered through various sources. Program administrator provided feedback on the perceptions of program strengths, achievements and challenges. Client data has been reviewed from computer generated reports used to monitor program activities. Program evaluation reports from previous years were reviewed and information from those reports was included as appropriate.

The report is designed to give an overview of the client participants and program performance. Sections addressing client demographics; program goals and performance on objectives; program outcomes; and lessons learned, are included.

SUMMARY

The program provided services to a total of 193 child and Transitional Age Youth (TAY) participants and their families, who had open cases, during FY 15-16. Additionally, the program's staff provided crisis and urgent services as well as preventive activities such as outreach and education to 1,144 individuals through their Community Client Services and Mental Health Promotion activities/contacts. With regard to cost, Pacific Clinics' average cost per consumer in the Latina Youth Program ranged from $2,451 to $4,347 depending on program site. The overall average cost per student served was $2,977. Although insignificant, this represents a reduction in average cost of $153 per consumer from the previous FY 14-15 ($3130), and continues to be a significantly lower cost than the average cost of PEI funded clients in Los Angeles County ($3,543 FY 14-15; figures not yet available for FY 15-16) by 16%. With regard to open cases, participants ranged in age from 6 to 23 years of age, with the greatest number of participants being between 15 and 17 years of age. This represents a movement toward working with more TAY, than in previous years when participants tended to be younger. With regard to gender, 108 participants with open cases, or 56% were female and 85 participants, or 44% were male. The consumers were distributed among grades 1 through 12, and at the community college undergraduate level. With regard to language, a majority of the participants speak English as their primary language at home. This percentage has ranged from 34% to 53% in past evaluation periods. A small minority of participants speak Spanish as their primary language at home. This number has ranged from 5% to 47% in past evaluation periods. In about 1/3 of participating families, the children prefer English while the parents prefer Spanish as their primary language at home. In past evaluation periods, this percentage has ranged from 19% to 42%.

The greatest majority of program participants were those of Latino ethnic background, at 80%. This is a decrease from an all-time high of 100% during the early years of the program's implementation, but an increase from FY14-15 when Latino participants made up 74% of those with open cases. Caucasian

participants made up 4% of the program population. The percentage of Caucasian participants has ranged from 2% to 13% in past program years. American Indian or Filipino individuals made up 1% each, of the program population. Finally, half of a percent of program participants identified as African American and in nearly 14% of the cases, data was missing or individuals identified as "Other."

With regard to outcomes, review of past interviews with participants and program data revealed that consumers perceived a significant reduction in symptom severity, and improvement in functioning and communication. As in past years the program was successful at preventing suicide among participants. Parents interviewed in past years credit program staff with helping turn their child's life around by providing students with the skills necessary to manage difficult situations at school, and develop a greater sense of control over their behavior both at school and home.

Pacific Clinics' LYP continues to leverage many resources and services benefiting program participants and their families by coordinating collaborative relationships with schools, private and public agencies, as well as other community-based organizations. A hallmark of the program continues to be the reduction of barriers to accessing treatment faced by the community in general and children and adolescents in particular. Services are provided at school sites as well as other locations, and at times which are convenient to the program participants and their families. Additionally, services are provided at no cost to the participants, by staff that are both culturally and linguistically competent. The program staff continue to receive training and supervision in Evidence Based Practices.

Due to its consistent and reliable presence for the past 15 years in the community, the program enjoys the trust of community partners and residents. Here, it is important to mention that Pacific Clinics' Latina Youth Program was recognized by Ian Calderon, Majority Leader, and 57th District and by Senator Tony Mendoza, 32nd District, for the program's support of the Norwalk-La Mirada Unified School District's McKinney-Vento Homeless Education Program on June 17, 2016. Additionally, school teachers, administrators and other staff frequently consult program staff on issues impacting students and their families. As more students, parents, school staff, community residents and media outlets have experience with program staff and services, the program is seen as not only an important asset in the community, but also as a resource for consulting with experts. LYP continues to be welcomed at the many schools in which their services are provided. School administrators have made room in their already overcrowded facilities to house the program. School staff who move from one school to another, are able to provide information about the program to schools that may have been unaware of, or hesitant to collaborate in the past, and bring program services with them to new populations. Services provided by the program include response to crises and urgent requests; education regarding mental health, anti-stigma, and other social issues; ongoing therapy and support groups, including parenting education for families, anger management, conflict resolution, anti-bullying and social skills. As always, the main focus of the program remains on providing direct psychotherapeutic services to children, TAY, and their families in an effort to reduce risk factors associated with suicidality.

FY2015-2016

PROGRAM	M	F	Ethnicity	Total	Age	Total
7495 SFS	5	6	American Indian	1	6	0
	T	11	Black/African	0	7	0
			Filipino	1	8	0
			Latino/Hispanic	7	9	1
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	0	12	0
			Other	2	13	0
			TOTAL	11	14	1
					15	0
					16	3
					17	2
					18	2
					19	1
					20	0
					22	1
					T	11

PROGRAM	M	F	Ethnicity	Total	Age	Total
7896 SB Whittier	48	61	American Indian	1	6	1
	T	109	Black/African	0	7	1
			Filipino	0	8	4
			Latino/Hispanic	98	9	2
			Laotian	0	10	1
			Samoan	0	11	3
			White/Caucasian	3	12	11
			Other	7	13	12
			TOTAL	109	14	14
					15	22
					16	19
					17	11
					18	5
					19	2
					20	1
					21	0
					T	109

PROGRAM	M	F	Ethnicity	Total	Age	Total
7902 SFS	8	11	American Indian	0	6	0
	T	19	Black/African	0	7	0
			Filipino	0	8	1
			Latino/Hispanic	5	9	3
			Laotian	0	10	2
			Samoan	0	11	0
			White/Caucasian	1	12	0
			Other	13	13	1
			TOTAL	19	14	0
					15	1
					16	2
					17	3
					18	2
					19	1
					20	2
					23	1
					TOTAL	19

PROGRAM	M	F	Ethnicity	Total	Age	Total
95A Monrovia	12	15	American Indian	0	6	1
	T	27	Black/African	0	7	1
			Filipino	1	8	0
			Latino/Hispanic	19	9	0
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	3	12	0
			Other	4	13	0
			TOTAL	27	14	0
					15	7
					16	10
					17	5
					18	2
					19	1
					20	0
					21	0
					TOTAL	27

PROGRAM	Male	Female	Ethnicity	Total	Age	Total
95A Pasadena SEA	12	15	American Indian	0	6	0
	Total	27	Black/African	1	7	0
			Filipino	0	8	0
			Latino/Hispanic	26	9	0
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	0	12	1
			Other	0	13	0
			TOTAL	27	14	0
					15	3
					16	3
					17	11
					18	4
					19	5
					20	0
					21	0
					TOTAL	27

SUMMARY CLIENT DEMOGRAPHICS

GENDER		
	N	**PERCENTAGE**
MALE	85	44%
FEMALE	108	56%
TOTAL	**193**	

ETHNICITY - RACE		
	N	**PERCENTAGE**
AMERICA INDIAN	2	1%
BLACK/AFRICAN AMERICAN	1	.005%
FILIPINO	2	1%
LATINO/HISPANIC	155	80%
WHITE/CAUCASIAN	7	4%
OTHER	26	13%
TOTAL	**193**	

AGE		
	N	**PERCENTAGE**
6	2	1%
7	2	1%
8	5	3%
9	6	3%
10	3	1%
11	3	1%
12	12	6%
13	13	7%
14	15	8%
15	33	17%
16	37	19%
17	32	17%
18	15	8%
19	10	5%
20	3	1%
22	1	1%
23	1	1%
TOTAL	**193**	

PROGRAM GOALS AND PERFORMANCE ON OBJECTIVES

The primary goals of the Program are stated as follows:

To promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide.

- To increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services.
- To increase access to services while decreasing barriers and stigma among youth in accepting mental health services.
- To increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion.
- To enhance awareness and education among school staff and community members regarding substance abuse and depression.

Progress on these goals is measured by the following objectives:

1. Partner with the program's core schools in the program service area to develop and conduct parents' workshops to raise family and community awareness about youth high-risk behaviors, cultural variance, stigma around mental illness, and communication strategies.

During the current evaluation period staff provided a total of 1144 contacts. They discussed topics which raise awareness about youth high-risk behaviors, bullying, cultural diversity, stigma, communication strategies and many other topics, to parents, family members and community at large. The activities were divided into four types: Support groups; Community Outreach and Presentations; Presentations to Students and Presentations to School Staff. Community outreach presentations are conducted at monthly school district meetings, the Board of Education meetings, and Service Area meetings. Additionally, program staff have developed and implemented a number of "Wellness Conferences" and media presentations.

2. Based on evidence-based and best practice models of care, program staff will provide individual and family treatment interventions to consumers to improve their level of functioning and reduce risky behaviors.

Program staff provided psychotherapeutic services to 193 consumers and their families. Clinical staff received training and supervision on eleven Evidence Based Practice models, including Aggression Replacement Training (ART), Crisis Oriented Recovery Services (CORS), Child-Parent Psychotherapy (CPP), Interpersonal Psychotherapy for depression (IPT), Managing and Adapting Practice (MAP), Trauma Focused Cognitive Behavioral Therapy (TF CBT), Promoting Alternative Thinking Strategies (PATHS), Seeking Safety, Positive Parenting Program (Triple P), Incredible Years (IY), and ongoing training and supervision in skills involved with Pacific Clinics' own Community Defined Practice, Latina Youth Program (PC Latina Youth). The Latina Youth Program has been recognized LACDMH as a Community Defined Practice, recognizing its status as a set of interventions which in effect comprise a promising approach to preventing suicide among Latina youth. All program participants are screened to assess whether they meet the criteria for inclusion in one of these practices. Additionally, as a best practice activity the program takes into account the community's cultural values and linguistic needs, and addresses these with a great deal of expertise. The program successfully addresses important unmet needs in an effective manner to traditionally under served communities.

3. Based on best practice models, the program will organize and conduct parenting classes in English and in Spanish.

The program provided parenting information through parenting classes, parenting workshops and educational presentations to parents, presented in English and Spanish. During this evaluation period parents, grandparents and other significant care givers (i.e., foster parents, kinship care givers, etc.) were taught skills specifically addressing the needs of elementary school aged children. Another focus area addressed parents' assertive and effective communication with TAY. Issues of anxiety, depression and suicidality in children and TAY; helping bridge the communication gap between home and school; as well as improving communication among parents and children regarding school issues were also addressed. Sessions on general mental health; anxiety for

students transitioning to middle school; bullying; risk factors associated with substance use and abuse; and reducing the stigma associated with mental health services were covered as well.

4. Train new program staff in evidence-based or best practice models, as well as integrate mental health and substance abuse treatment.

   Clinicians, Team Supervisors, and administrative staff receive ongoing training, supervision (in the case of clinicians), and consultation (for supervisors) in Evidence Based and Community Based Practices. Each staff has received training and supervision on a minimum of three and a maximum of five Evidence/Community Based Practices. In total, consumers in the program have access to eleven different Evidence/Community Based Practices, depending on whether they meet criteria for that practice. All program participants are screened to assess whether they meet the criteria for participation in the programs. Once eligibility is confirmed, the participants are offered services under these intervention models. If the participants are in agreement, the lead clinician in the specific intervention model is consulted, and a referral made. The evidence based models are by design, very specific and fidelity to the model is important. In consultation with the trainers, some adjustments have been made, to provide for cultural appropriateness. Training on motivational interviewing has been done in past years and is consistently used in the clinical work, particularly when substance abuse is an issue.

5. Provide education sessions for local school staff on youth high-risk behaviors, mental health stigma, and youth communication strategies for staff at each of the schools in the program service area, where services are co-located.

   During this contract year, educational sessions have been presented to school staff in a variety of formats. This includes information regarding program services, as well as how to refer students and their families; community resources and how to access them; identification of high risk behavior in students at risk for suicide and substance abuse; early prevention and intervention with young children; bullying and cyberbullying; symptoms of depression and anxiety; successful communication strategies with students and parents; community violence; and abuse in dating and intimate relationships. Further, program staff provided consultation on an "as needed" basis to school personnel, including teachers, counselors, school psychologists, principals, assistant principals, speech therapist, and others on the following topics: child abuse and neglect; developing lesson plans for at- risk youth; what risk factors are most commonly faced by students and other mental health issues impacting individuals in the program service area.

6. Organize and conduct peer groups to provide support and education for participants on issues of youth violence, substance abuse, family conflict, anger management, healthy relationships, peer pressure, safe sex practices, and effective interpersonal communication.

During this contract year, peer support groups addressed the following topics: impulse control; anger management; conflict resolution; effective communication strategies; risks associated with substance abuse and self-injurious behaviors; managing depression and anxiety; safer sex; domestic and community violence; cyber and in-person bullying, as well as other issues as they came up for participants. Aggression Replacement Training (ART) groups met for 12 weeks each, and taught participants skills relevant to decision making, impulse control and anger management.

OUTCOMES

As stated previously, a number of risk factors have been associated with higher risk for suicidality in adolescents. At its inception LYP identified nine risk factors, which were targeted for treatment in addition to diagnosed mental illness. The risk factors include: Presence of substance use or abuse, suicidal ideation, past suicide attempts, running away from home, communication problems at home, poor school functioning, difficulty regulating emotions, involvement with the legal system, and negative peer relations. In subsequent years a tenth factor was added. This factor addresses issues related to sexual identity, which research suggests plays a significant role in predicting suicide if children and adolescents are rejected for expressing a sexual orientation or gender identity (SOGI) not consistent with parental expectations.

In past years, the program collected data related to these factors. The discussion that follows is based on that data. Results from pre and post measures suggested that the variables which most seemed to impact decreased severity of symptoms associated with suicidality, were Difficulty Regulating Emotion and Communication Problems. Thus, program participants who endorsed one of those two risk factors within the moderately severe to very severe range at intake **and** who experienced a significant degree of symptom relief, were more likely to experience greater reduction in severity of other risk factors and improved functioning. Additionally, it is important to note that participants who endorsed suicide ideation as a significant problem at intake, experienced a decrease in severity after participating in treatment (based on participant and parent report). This points to a decrease in thinking about committing suicide and in developing or carrying out a plan for suicide. As noted earlier, clinicians reported dealing with students who thought about or attempted suicide at a higher incidence in more recent years. Thus, although more students may be thinking about or attempting suicide, the availability of easily accessible intervention, including hospitalization is helping keep even these most severe of cases safe.

With regard to school functioning, a significant and strong reduction in symptom severity was found to occur in program participants, as reported by the participants themselves and their parents. This suggests that the program is having a positive impact in helping students stay engaged in school. No doubt, the school sites where services are co-located have developed an appreciation for this fact. Thus, the program has experienced increased credibility. This finding is important, as more recent literature reports that Latina adolescents are nearly three times as likely to experience academic disengagement or drop out of school, compared to their African-American counterparts. And, they are more than four times to disengage or drop out than their Caucasian counterparts (U.S. Department of Education, 2000). Programs designed to

intervene at the family level have demonstrated a greater positive impact on both school functioning and on preventing psychological disorders in Latina youth (Martinez and Eddy, 2005). Pacific Clinics' program is no exception. Additionally, programs that help improve communication among parents and children have been demonstrated to improve student functioning and reduce emotional distress in children, while improving school functioning. Here it is important to reiterate that as previously mentioned, including parents, grandparents and other members of the extended family is a routine practice of LYP program staff.

By addressing not only the child or TAY as the identified patient, but the nuclear and extended family, school and surrounding community from a strengths based perspective, the program has been able to significantly reduce problems with communication at home, difficulty regulating emotions and negative peer influences. This helps create a larger support network for children and TAY who now have more resources to turn to for support and guidance. Thus, children and TAY who may have previously turned away from family to negative peers for a sense of belonging, now feel a stronger connection to their family and school community. The added support may increase emotional resources in the individual, which helps improve affect regulation. In turn this may help participants to be more judicious when choosing which peers will have greater influence on them. Additionally, affect regulations has been noted as a factor which helps reduce suicidal ideation and behavior.

LESSONS LEARNED

The Latina Youth Program was implemented by Pacific Clinics in 2001 as a demonstration program focusing on adolescent suicide prevention, particularly among Latina Youth, which was originally funded by SAMHSA. This was a time when suicides were increasing at an alarming rate among this population even as the number of suicides were decreasing in other groups. High risk symptoms and behaviors including presence of substance use or abuse, suicidal ideation, past suicide attempts, running away from home, communication problems at home, poor school functioning, difficulty regulating emotions, involvement with the legal system, and negative peer relations were initially targeted for identification and treatment based on research findings which correlated these with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of factors representing high risk for suicidality as identified in research. Since its inception the program has worked with a participant population that matches or exceeds national statistics with regard to reported substance use, past suicide attempts, and suicidal ideation. As the program progressed, there has been a trend toward increased symptom severity and complexity of problems confronting program participants. This complicates treatment as so many of the factors involved in the increasing challenges facing families, are not ones that can be easily addressed, and require a great deal of case management activity. The program staff are being called upon to do more crisis intervention; provide services for a longer period of time or allow clients to "come and go" as needed; as well as provide more case management and advocacy activities. There has been a trend toward increase in suicide attempts, which have lead to hospitalizations. And, in May of 2014, the program experienced its first completed suicide among its participants. The low incidence of completed suicides, along with increased functioning of program participants, as measured by ratings on symptom severity in the past, and

parent report, support the assertion that the program is having the desired effect of reducing risk for suicidality within the targeted communities.

Based on sound findings in the literature and a great deal of practical experience working within this under served community, the program set out to address many of the barriers to services faced by Latinos. Included among these are issues related to social stigma regarding mental health services, the cost of services and the fragmented nature in organization of services. The program works on reducing the stigma associated with going into a mental health facility by placing service providers within the school setting and meeting participants in their home, place of work, an alternative community setting, or at a shelter, as needed. Program participants, when interviewed in the past, have reported that they "recommend the program's services to any friend who seems to need them." Additionally, the increased visibility of program locations within the school, by being moved to more prominent locations within the campuses, allows students and families to discard any misgivings about the acceptability of participation in mental health services. In the past, a parent stated "If the school feels these services are important enough to have them here, then it must mean that they want us to use them." Issues regarding basic physical access are also addressed by providing services in alternative settings; by providing transportation when needed; and scheduling appointments at times that make sense for program participants. The program staff is proactive when participants do not show up for scheduled appointments. The program staff call participants and offer alternative schedules for appointments, transportation to the program office, a home visit, etc.

The social stigma associated with mental health issues is also decreased by providing educational presentations in the schools, out in the community and through various media outlets. This kind of visibility works on several levels. The staff provide workshops wherein community residents are able to ask questions, and learn new information. This approach helps community residents get answers to questions that they might not otherwise even consider. Hearing other individuals that they identify with, discuss these topics and perhaps even disclose personal experience with some of the symptoms being addressed, helps community members decrease the sense of stigma experienced when considering accessing mental health services. Feedback from client interviews conducted in past years, reveals that attending these workshops in places other than mental health centers, helps individuals feel more comfortable about engaging in these conversations. Collaborative relations with other mental health organizations, as well as with non-traditional partners (churches, city government, etc.) have proved very useful in helping program staff address participants' needs in a more wholistic approach, thus addressing the problem of a fragmented service delivery model. Participants don't have to navigate a number of different agencies all at once in order to address important coexisting needs. The program not only makes accessing mental health counseling and medication support easier, it also provides other resources through the case management component. These might include education and skill development in various areas of social functioning, advocacy with other basic needs, as well as other supportive services. These activities earn the participants' trust and help them identify tangible outcomes. When the psychological benefits of program participation are not readily evident, participants can value these other outcomes.

With regard to cost, funding from Los Angeles County Department of Mental Health (LACDMH) has helped the program leverage in-kind contributions from schools, such as space; and discretionary funding from

private foundations, local vendors and businesses for other program activities, which while not directly related to mental health treatment, have significant impact on the wellbeing of participants and their families. Clinically, the program continues to experience an influx of referrals whenever staff provide educational workshops. This means the program must be prepared to provide services to anyone who self identifies as needing them. This is an ethical as well as practical consideration. When community residents learn that there is an explanation for how they are feeling, as well as a possible way to ameliorate their discomfort and pain, they are quick to seek help. This provides a brief window of opportunity and if individuals are placed on long waiting lists or made to go through complicated administrative processes before they can actually receive help, the chance of losing their trust is increased. Program outreach workers need to constantly update their knowledge of resources in the community in order to provide useful information and advocacy to community members. And, when community members decide that they are ready for services the program must respond in an expeditious manner. Before a full intake is carried out, the program staff focuses on engaging the family. This process described in greater detail elsewhere in the FY14-15 report to LACDMH, includes using jargon-free language to assess what the participants identify as the problem, and what possible solutions they have considered. Additionally, families are engaged in the process of recognizing what strengths they already posses in order to address the current challenges and how they may have been successful in the past in managing similar problems. When families come into the program office they are made to feel welcomed. Their level of comfort or discomfort is directly addressed by everyone from the front office staff to the clinicians. Staff has found that paying attention to small details in the beginning of the relationship, as well as providing clear information and education about what the participants may expect to gain by participating in the program, goes a long way to preventing consumers from dropping out of services.

Profiles of Hope
Courage reaches out, compassion takes hold.

Los Angeles County Department of Mental Health

2016 Media Performance Report

August 2016

Overview

- Planning Parameters
- Media Objectives and Strategies
- Flowchart
- Overview and overall performance
- Performance Details by medium
  - TV
  - In-Cinema
  - Radio
  - OOH
  - Print
  - Paid Social

FRASER COMMUNICATIONS

Parameters Overview

- Target Audience and Geography
  - Adults in Los Angeles county with an emphasis on Young Latinas and African American males and older Caucasian men
- Timing
  - January through July, 2016
- Media Budget
  - $267,139 (includes Red Nation sponsorship costs)
- Creative Assets
  - Three 10-minute "Profiles of Hope" documentaries; 30-second TV, 30-second radio PSAs, outdoor bulletins and newspaper ads featuring Michelle Enfield, Suzanne Whang and Apl.de.ap

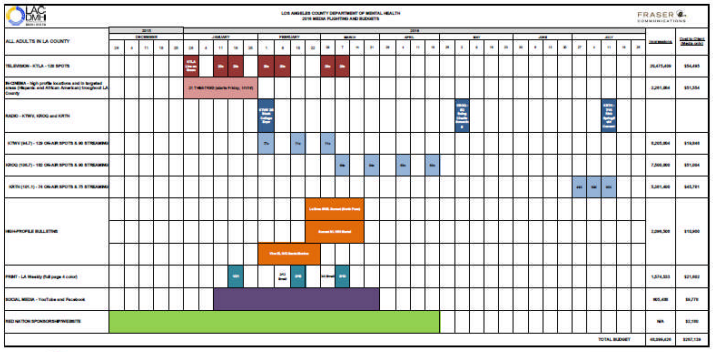
Objectives and Strategies

- **Build county-wide awareness** for "Profiles of Hope" and the range of support services the Los Angeles County Department of Mental Health offers
- Use a **multi-media mix** to reach people at multiple touch points as they go about their daily activities, for optimal message impact
- Leverage our broadcast media partnerships for **custom station integrations and high profile event** extensions that would allow us to feature the video assets
- Layer **targeted media** that heightens visibility and awareness among key groups
- Amplify outreach via **social media**, specifically YouTube (video)

Flighting Strategies

- Stagger TV and Radio weeks for ongoing weeks of coverage
- Layer media so that they work together
  - Multiple layers at launch
  - In-cinema at TV launch for an enhanced market-wide PSA presence
  - Bulletins during radio weeks for sight and sound
  - Enhance with print and digital during the key time period of January through March
- Use social media for amplification throughout 1st quarter

Campaign Flowchart



Media Overview and Overall Performance

- KTLA partnership
  - Profiles of Hope 30-second PSAs, co-branded promotional spots of the Live on Green event and presence at the Spirit Pavilion at the event with viewing of 10-minute video
- In-cinema
  - 30-second PSAs on-screen and in lobbies at select locations.
- High profile radio stations
  - 3 top-ranking general market radio stations, 30-second PSAs and live integrations and Profiles of Hope 10-minute video featured at signature radio station events in LA county
- Outdoor
  - 3 premium bulletins at key locations in Hollywood

Media Overview and Overall Performance

- Print
  - 3 full-page 4 color ads in LA Weekly and 4 dedicated email blasts
- Social Media
  - 10 minute and 30 second POH videos promoted on Facebook and YouTube

*The plan delivered **48,099,426 total impressions** and $110,486 in value added, 41% of total media spending*

Television Overview

- KTLA, a top independent station, provided broad market exposure of the 30-second PSA and added exposure of the 10-minute video.
  - Top news station (#1 Early Morning news against A35-64)
  - **466 spots** aired from 1/11 to 3/13
    - :30 schedule with 114 spots on KTLA (6 weeks)
    - 72 30-second spots on Antenna TV
    - 280 Live on Green co-branded promos started on 12/16 and ran for 2 weeks until the start of event

TV delivered 20,475,409 Impressions

Television Extensions

- Digital
  - 200,000 impressions from digital pre-roll with an **81% completion rate**
  - LACDMH logo and brand description on the Live on Green website
- Spirit Pavilion at Live on Green event
  - 3-day event in Pasadena from 12/29-12/31 was heavily promoted on I-Heart radio stations, on KTLA, in full page ads in the LA Times, on parade tickets sleeves, at local hotels and businesses resulting in event attendance of 30,000+
  - Spirit Pavilion featured speakers and videos throughout the 3-day event
    - Profiles of Hope 10 minute videos ran 6-8 times/day

Radio Overview

- Radio provided broad market reach across 10 weeks February through July.
- Partnered with KROQ, KTWV and KRTH
  - Top-ranking stations with strong listening across POH demographics
  - More than 600 Spots ran across 3 stations
  - Integrated features on-air and at select events
  - Ability to showcase Profiles of Hope and the 10-minute video in non-traditional ways, including digital and social.

21,086,404 Impressions from Radio

Radio – KTWV

- KTWV delivered significant on-air support and event presence over the 3-week schedule from 2/1 to 3/6
  - 182 30-second spots
  - 32 promotional spots for the Black College Expo
    - Greg Mack and Pat Prescott voiced the promo spots
  - 90 streaming spots online at 947thewave.com
- One station newsletter to promote event attendance and the Profiles of Hope booth
- 2 Social Media posts from KTWV Facebook and Twitter promoting the Black College Expo event.

On-Site: Black College Expo

- KTWV booth at the Black College Expo was branded as Profiles of Hope
  - February 6th at the Los Angeles Convention Center
  - Estimated 35,000 attendees
  - 2 LACDMH employees attended expo
  - 75 Profiles of Hope cinch packs handed out at the event
  - 10 minute Profiles of Hope videos played continuously at the booth

Radio – KROQ

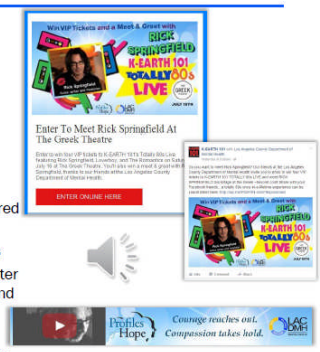
- KROQ radio schedule ran for 4 weeks between 3/7 and 4/24
  - 162 30-second spots
  - 20 promo spots to support contest entries to attend *Being Charlie* movie screening
    - Promo spots were voiced by Dr.Drew
  - Streaming spots online provided 125,596 impressions
- Profiles of Hope/LACDMH representative, Kathleen Piché, was a guest on Dr.Drew's *Loveline* on April 21st.
- Twitter and Facebook social media posts on KROQ page

On-Site: *Being Charlie* Screening

- POH sponsored a screening of *Being Charlie*, directed and produced by Rob Reiner.
  - The drug-addicted son of a California politician finds romance with a fellow patient in rehab.
- Movie screening was attended by Dr. Drew and winners of tickets through KROQ online contest
- All three 10 minute POH videos were shown before the start of the movie

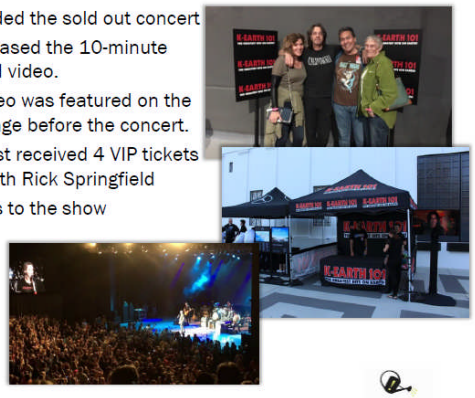
Radio – KRTH

- 211 spots ran on KRTH for 3 weeks in July leading up to the "Totally 80s" concert at The Greek on 7/16
  - :30 second schedule included 69 spots
  - 76 promos and live mentions for Totally 80s concert
  - 66 10-second Music Sponsorship spots
- Digital and promotional
  - Banners containing the 10 minute video delivered 425,000 impressions on CBS Radio websites
  - Streaming audio delivered 35,000 impressions
  - Dedicated contest page on KRTH website to enter and win VIP tickets to the Totally 80s concert and backstage meet and greet
  - E-mail blast sent out to 65,000 recipients
  - Social media posts on KRTH Facebook and Twitter



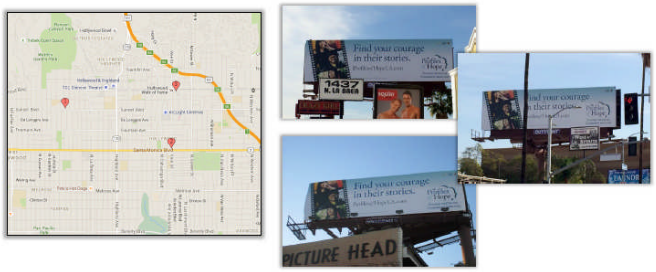
On-Site: Totally 80's Live Concert

- 5,870 people attended the sold out concert
- 2 KRTH tents showcased the 10-minute Rick Springfield POH video.
- :30 second POH video was featured on the jumbo screen on-stage before the concert.
- Winner of the contest received 4 VIP tickets and meet & greet with Rick Springfield
- 20 additional tickets to the show



OOH - Bulletins

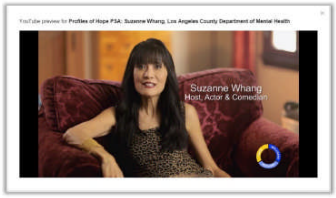
- 3 High Profile Bulletins in Hollywood area
  - Bulletins ran for one month each between February and March



2,096,508 Impressions from OOH

Paid Social – Facebook and Youtube

- Facebook
  - Targeted using interests and psychographic information that aligned best with the Profiles of Hope series and mental health
  - 392,062 reach and 310,407 video views
- YouTube
  - 213,426 impressions and 47,735 views (completed entire :30 second video)



605,488 Impressions from Paid Social

Media Summary

Media	Total Units	Total Impressions**	Value Added Impressions*	Cost to Client
TV	466x	20,475,409	7,885,409	$54,495
Radio	600x	21,086,404	1,976,404	$116,631
Bulletins	3x	2,096,508	----	$10,900
Cinema	21x	2,261,084	376,847	$51,554
Print	3x	1,574,533	251,533	$21,602
Youtube	N/A	213,426	----	$5,428
Facebook	N/A	392,062	----	$4,351
TOTAL		48,099,426	10,491,193	$267,139

* Value Added Impressions are included within the "Total Impressions" column
** Digital impressions from Value Added are noted within the TV and Radio impressions

Thank You

PEI Program Consolidation Abbreviations

AAFEN	Asian American Family Enrichment Network Program
AILS	American Indian Life Skills
ART	Aggression Replacement Training
AF-CBT	Alternatives for Families: A Cognitive-Behavioral Therapy
AMSR	Assessing and Managing Suicide Risk
ASIST	Applied Suicide Intervention Skills Training
BSFT	Brief Strategic Family Therapy
CAPPS	Center for the Assessment & Prevention of Prodromal States
CBITS	Cognitive Behavioral Intervention for Trauma in School
CBT	Cognitive Behavioral Therapy
CDE	Community Defined Evidence Practice
CFOF	Caring for Our Families
CORS	Crisis Oriented Recovery Services
CPP	Child-Parent Psychotherapy
CSECY	Commercial Sexual Exploitation of Children and Youth
DBT	Dialectical Behavior Therapy or Disruptive Behavior
DHS	Department of Health Services
DMH	Department of Mental Health (Los Angeles)
DTQI	Depression Treatment Quality Improvement Intervention
EBP	Evidence-Based Practice
FFT	Functional Family Therapy
FOCUS	Families OverComing Under Stress
FQHC	Federally Qualified Health Center
Ind CBT	Individual Cognitive Behavioral Therapy
IPT	Interpersonal Psychotherapy for Depression
IY	Incredible Years
LGBT	Lesbian, Gay, Bisexual, Transgender, Questioning
LIFE	Loving Intervention Family Enrichment Program
MAP	Managing and Adapting Practice
MDFT	Multidimensional Family Therapy
MHFA	Mental Health First Aid
MHIP	Mental Health Integration Program
MHSA	Mental Health Services Act
MP	Mindful Parenting Groups
MPAP	Make Parenting A Pleasure
MST	Multisystemic Therapy
NFP	Nurse Family Partnership
PATHS	Providing Alternative Thinking Strategies
PTSD	Post-Traumatic Stress Diagnostic Scale
PE	Prolonged Exposure
PEARLS	Program to Encourage Active Rewarding Lives for Seniors
PEI	Prevention and Early Intervention
PE-PTSD	Prolonged Exposure for Post-Traumatic Stress Disorder
PCIT	Parent-Child Interaction Therapy
PP	Promising Practice
PSP	Partners in Suicide Prevention
PST	Problem Solving Therapy
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade, Refer
RPP	Reflective Parenting Program
RRSR	Recognizing and Responding to Suicide Risk
SCALE	School, Community, Law Enforcement Program
SF	Strengthening Families
SS	Seeking Safety
START	School Threat Assessment Response Team
SDR	Stigma and Discrimination Reduction
TAY	Transition Age Youth (ages 16-25)
TF-CBT	Trauma Focused Cognitive Behavioral Therapy
Triple P	Triple P Positive Parenting Program
UCLA TTM	UCLA Ties Transition Model

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

JONATHAN E. SHERIN, M.D., Ph.D., Director
ROBIN KAY, Ph.D., Chief Deputy Director
RODERICK SHANER, M.D., Medical Director

MHSA THREE YEAR PROGRAM & EXPENDITURE PLAN
FISCAL YEAR (FY) 2017-18 THRU 2019-20
AVAILABLE FOR PUBLIC REVIEW

January 23, 2017

The Los Angeles County Department of Mental Health (LACDMH), as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA Three Year Program & Expenditure Plan Fiscal Year (FY) 2017-18 THRU 2019-20. The Public Review and Comment period will begin January 23, 2017 and expires February 21, 2017. During the Public Review and Comment period, an open Public Hearing will be held at Cathedral of our Lady of the Angels, 555 W. Temple Street Los Angeles, CA 90012. The Public Hearing will be hosted by the Los Angeles County Mental Health Commission on February 23, 2017 and the reception is scheduled to begin at 11:30 AM.

The document under review is posted on the LACDMH website (http://dmh.lacounty.info/mhsa/), and hard copies are available at the LACDMH MHSA Implementation and Outcomes Division, 695 South Vermont Avenue, 8th Floor, Los Angeles, CA 90005. Any member of the public may request a hard copy of the document by contacting Debbie Innes-Gomberg, Ph.D. at 213-738-2756.

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

Los Angeles County Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: MHSA Three Year Program & Expenditure Plan
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

550 S. VERMONT AVE., LOS ANGELES, CA 90020 | HTTP://DMH.LACOUNTY.GOV

MENTAL HEALTH SERVICES ACT (MHSA)
THREE YEAR PROGRAM & EXPENDITURE PLAN
FISCAL YEARS 2017-18 THROUGH 2019-20
PUBLIC HEARING

Debbie Innes-Gomberg, Ph.D.

February 23, 2017

WELLNESS • RECOVERY • RESILIENCE

2

Focus of MHSA Three Year Program & Expenditure Plan

- Reports on MHSA-funded services for the prior Fiscal Year (2015-16)
- Projects an estimated budget for Fiscal Years 2016-17, 2017-18 and 2019-20
- Proposes a consolidation of Community Services and Supports (CSS) work plans to increase access into FSP programs, establish a more seamless continuum of care outside of FSP and creates administrative efficiencies.
- Proposes a consolidation of Prevention and Early Intervention (PEI) Programs aligned with PEI regulations.
- Prioritizes funding for the services required for County and State initiatives.

3

Focus of MHSA Three Year Program & Expenditure Plan

- Addition of uniform outcome measures for the Recovery, Resiliency and Reintegration (RRR) component of CSS.
- Adoption of Level of Care metrics for each age group for CSS services.

4

Content of MHSA Three Year Program & Expenditure Plan

- Overview of the community planning process
- Community Services and Supports (CSS) plan programs
  - Unique clients served
  - Average cost per client
  - Program outcomes
  - CSS work plan consolidation
- Prevention and Early Intervention (PEI) programs
  - Unique clients served, countywide and by service area
  - Primary language and ethnicity, countywide and by service area
  - Average cost per practice
  - Outcomes per practice
  - PEI plan modification
- Innovation
- WET
- Capital Facilities and Technological Needs
- Projected Budget

5

Key Dates

December 21, 2016	Presentation of the Three Year Program & Expenditure Plan to the System Leadership Team (SLT)
January 23, 2017	Public posting for 30 days
January 26, 2017	High level overview presentation to the Mental Health Commission
February 23, 2017	Public Hearing convened by the Mental Health Commission
March 23, 2017	Mental Health Commission deliberation on approval of the Three Year Program & Expenditure Plan
April-June 2017	Board letter submission and adoption, posting of final Three Year Program & Expenditure Plan on website and submission to the Mental Health Services Oversight and Accountability Commission

Written Public Comments Not Answered at Public Hearing

1. **What are the existing mechanisms in place to collect data? Who or what unit collects data for DMH?** Client services data (encounters, service codes, demographic information and other information) is captured through electronic health records. Outcome data is collected as well by clinicians in programs and entered into the Outcome Measures Application (OMA) which gathers data and allows DMH to produce reports that result in the outcomes documented in this MHSA 3 Year Plan.
2. **How does DMH ensure community input is reflected in the 3 year plan?** The primary stakeholder body for the MHSA is the System Leadership Team which is comprised of numerous types of stakeholders, including those representing each Service Area Advisory Committee (SAAC). Each SAAC representative has the responsibility to carry SAAC issues forward and to take information from the SLT back. In addition, community presentations are often made on the contents of the 3 year plan, as described in the Community Planning Process part of the 3 Year Plan.
3. **What strategies are being used by DMH to motivate and support involvement from consumers, families, caregivers and residents along with faith-based communities?** The Department has either formal arrangements or has developed networks or workgroups focused on each of those populations, including client councils, NAMI, the faith-based network and others.
4. **How does DMH measure its success? What factors are used?** DMH is held to specific standards through the California Department of Health Care Services on a variety of metrics, including timely access to care. DMH has considered reductions in homelessness, psychiatric hospitalization use and reductions in incarcerations as measures of program success and will develop outcome benchmarks to achieve as part of the implementation of this 3 year plan.
5. **How does DMH identify disparities?** Through a variety of methods that include reviewing prevalence rates to service rates.
6. **How do these plans anticipate Measure H, HHH and No Place Like Home?** With the exception of Measure H, all other initiatives fund only capital and not services. In order to provide the services, DMH is dedicating the one time allocation from the State of $121.6 million to the services (mostly FSP) to address the needs of these populations.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PUBLIC HEARING OF THE
MHSA THREE YEAR PROGRAM AND EXPENDITURE PLAN
FISCAL YEAR (FY) 2017/18 THROUGH 2019/20
Public Comments Card
February 23, 2017

PURPOSE: The public comments card serves two key purposes:

1. **To provide a tool where members of the public can write down questions and provide feedback throughout the MHSA Public Hearing meeting.**
2. **To facilitate the public participation process. At the end of the meeting, we will collect your public comment cards, please make sure you leave your comment cards at the table.**

Contact Information	NAME	PHONE	EMAIL	ORGANIZATION

AGENDA ITEM	QUESTIONS/COMMENTS
	tambien de Victran de Ver, el trato
	que. Los empleados dan Al con
	su modor

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PUBLIC HEARING OF THE
MHSA THREE YEAR PROGRAM AND EXPENDITURE PLAN
FISCAL YEAR (FY) 2017/18 THROUGH 2019/20
Public Comments Card
February 23, 2017

PURPOSE: The public comments card serves two key purposes:

1. **To provide a tool where members of the public can write down questions and provide feedback throughout the MHSA Public Hearing meeting.**
2. **To facilitate the public participation process. At the end of the meeting, we will collect your public comment cards, please make sure you leave your comment cards at the table.**

Contact Information	NAME	PHONE	EMAIL	ORGANIZATION
	WILLIAM LEGERE	(626)533-7801	MR.WLEGERE@GMAIL.COM	BLACC

AGENDA ITEM	QUESTIONS/COMMENTS
3-YEAR MHSA PLAN	WHAT ABOUT AFRICAN-AMERICANS? 60% OF HOMELESS ON AN AVERAGE NIGHT IN SKID-ROW ARE AFRICAN-AMERICAN AS ARE THOSE IN SA6.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PUBLIC HEARING OF THE
MHSA THREE YEAR PROGRAM AND EXPENDITURE PLAN
FISCAL YEAR (FY) 2017/18 THROUGH 2019/20
Public Comments Card
February 23, 2017

PURPOSE: The public comments card serves two key purposes:

1. **To provide a tool where members of the public can write down questions and provide feedback throughout the MHSA Public Hearing meeting.**
2. **To facilitate the public participation process. At the end of the meeting, we will collect your public comment cards, please make sure you leave your comment cards at the table.**

Contact Information	NAME	PHONE	EMAIL	ORGANIZATION
	PAUL [illegible]	310-[illegible]	[illegible]	NAMI SOUTH BAY

AGENDA ITEM	QUESTIONS/COMMENTS
1)	ON PAGE 24 RE: CHILDREN'S FSP THE PIE CHART COLORS DON'T MATCH THE BARCHART. NOT CRITICAL BUT EASIER TO FOLLOW IF CONSISTENT
2)	ON COUNTY WIDE LEVEL - IF HAS REPORTED BY NMH [illegible] AND SAMHSA [illegible] 4% ARE SMI AND 50% ARE AMI THEN IN LA COUNTY WITH POPULATION OF 10M THEN THERE ARE PROBABLY PER SAMHSA 400,000 SMI AND 3,[illegible] AMI - THE
	LA COUNTY HAS BEEN DOING GREAT WORK TO SERVE 19K BUT THERE IS BIG DISPARITY JUST IN NUMBERS AND SURELY IN CERTAIN GROUPS AND AS THERE IS STILL A LACK OF MENTAL HEALTH SERVICES FROM PRIVATE INSURANCE AND
	WITH POSSIBLE IMPACTS TO MEDI-CAL IF ACA IS REPEALED HOW CAN THE MHSA PLANS AND PROGRAMS BE USED TO LEVERAGE TREATMENT ASSISTANCE FOR THOSE NOT SERVED OR UNDERSERVED OR MORE SPECIFICALLY TO THE MHSA PLANS

HOW ARE THEIR NEEDS BEING ADDRESSED OR GAP LEVERAGE? — BRING TO SCALE!!!

[illegible] NOW [illegible] CRITERIA 19K

3) HOW DO THESE PLANS ANTICIPATE MEASURE H, HHH & NO PLACE LIKE HOME

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PUBLIC HEARING OF THE
MHSA THREE YEAR PROGRAM AND EXPENDITURE PLAN
FISCAL YEAR (FY) 2017/18 THROUGH 2019/20
Public Comments Card
February 23, 2017

PURPOSE: The public comments card serves two key purposes:

1. **To provide a tool where members of the public can write down questions and provide feedback throughout the MHSA Public Hearing meeting.**
2. **To facilitate the public participation process. At the end of the meeting, we will collect your public comment cards, please make sure you leave your comment cards at the table.**

Contact Information	NAME	PHONE	EMAIL	ORGANIZATION
	Lolita S. Namocatcat	818 470 5006	namocatcat.lolita@yahoo.com	APCTC

AGENDA ITEM	QUESTIONS/COMMENTS
1.	FSP served client – Needs Dual dynamics – (client / Case manager) relationship or counseling instead of hospitalization.
2.	FSP served client – Work Force resources available for each service area.
3.	For the directory guidelines to the engagement For the [illegible] FSP served client without undergoing any of the Psychiatric medication.
4.	Engagement requirements

speaking of financial crisis situation to FSP served client.

5. National Financial Security Status for the year 2017.

THURSDAY, FEBRUARY 23, 2017
PUBLIC HEARING OF THE M.H.S.A. THREE YEAR PROGRAM
AND EXPENDITURE PLAN FISCAL YEAR 2017/18 THROUGH 2019/20
555 WEST TEMPLE ST.
LOS ANGELES, CA 90012
CAPTIONED BY TOTAL RECALL, WWW.YOURCAPTIONER.COM

QUESTIONS AND ANSWERS

1. **JENNY ROSALES, LATINA COALITION**
2. **MARK K., COALITION**
3. **LOLITA NAMOCATCAT, APCTC**
4. **WILLIAM LECERE, BLACCC**
5. **MARIA JUAREZ**
6. **REBA STEPHENS**
7. **HERMAN DEBOSE, LAC-DMH**
8. **MS. LAMON**
9. **WENDY CABIL, D.M.H./NAMI**
10. **PAUL STANSBURY, NAMI SOUTH BAY**

>> THE MODERATOR: WELL, THAT WAS A LOT OF INFORMATION. THANK YOU, DEBBIE AND EVERYONE ELSE. SO WE COME TO THE PUBLIC COMMENT SECTION OF THE MEETING. WE ARE GOING TO RECOGNIZE YOU. I JUST WANT TO REMIND YOU THAT WE WILL NEED THIS DOCUMENT WHEN YOU STEP UP TO THE MIC. YOUR QUESTIONS SHOULD BE IN WRITING AS WELL AS YOU CAN ASK THE QUESTION OR MAKE THE COMMENT.

WHAT I'M GOING TO TRY TO DO IS ALTERNATE EACH SIDE. IF YOU HAVE MORE THAN ONE QUESTION, I'M GOING TO ASK YOU TO JUST USE SOME DISCIPLINE WITH ALL OF US AND ASK ONE QUESTION AT A TIME. AND THEN I WILL MOVE TO THE NEXT PERSON AND BACK AND FORTH IF WE CAN DO THAT.

IF THE QUESTION CAN BE ANSWERED FOR YOU TODAY, IT WILL BE IF THERE'S SOMEONE FROM THE DEPARTMENT THAT CAN ANSWER IT THEY WILL. IF NOT, THAT WILL BE PUBLISHED ONLINE, IS THAT RIGHT? AS WELL AS IN WRITING.

WE HAVE A CLOCK GOING THERE. TWO MINUTES. AND IT'S BIG AND BOLD. THANK YOU. OKAY. I SAW A HAND OVER HERE OF THE YOUNG –

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> THE MODERATOR: OKAY. THANK YOU. I'LL GIVE HER ANOTHER MINUTE.

>> THE MICROPHONES ARE OVER THERE ON THE SIDE.

>> THE MODERATOR: AND THEN I WILL MOVE TO THE OTHER SIDE.

QUESTIONED BY:
JENNY ROSALES, LATINA COALITION

>> Q: HI, GOOD AFTERNOON. MY NAME IS JENNY ROSALES. I'M FROM THE COALITION LATINAS. MY QUESTION IS WHY THE POLICE TAKE THE PROPERTY TO THE PEOPLE HOMELESS?

>> DR. INNES-GOMBERG AND DR. KAY: I THINK THE COUNTY AS WELL AS THE CITY ARE WORKING ON DIFFERENT OPTIONS. THIS IS NOT SOMETHING THAT THE DEPARTMENT OF MENTAL HEALTH IS DIRECTLY RESPONSIBLE FOR. BUT WE DO RECOGNIZE MANY OF OUR CONSUMERS HAVE AND THEY LOSE PROPERTY IN THE PROCESS OF WHEN THEY ARE HOMELESS.

>> Q: AND NOT ONLY THEY TAKE THE PROPERTY, THEY GET PUT IN JAIL. HOW IS THAT? PEOPLE, THEY SUFFER CHRONIC ILLNESS, AND PEOPLE NEED HELP.

>> DR. INNES-GOMBERG: THANK YOU. THE EXPANSION OF OUR MENTAL HEALTH LAW ENFORCEMENT TEAMS AND OUR SB 82 MOBILE TRIAGE TEAMS WILL HELP WITH TRIAGING CLIENTS.

>> ROBIN KAY: IT'S A GREAT QUESTION, AND I THINK DEBBIE IS RIGHT THAT MHSA, BECAUSE THIS IS THE PUBLIC HEARING, IT'S IMPORTANT TO STRESS THAT MHSA IS FUNDING THOSE EFFORTS THAT D.M.H. IS TEAMING UP WITH LAW ENFORCEMENT SO THAT THEY PROVIDE AN INFORMED RESPONSE TO PEOPLE WHO ARE HOMELESS AND HAVE A MENTAL ILLNESS. THE OTHER THINGS THAT WE'RE DOING IS PROVIDING EDUCATION FOR THE POLICE AND FOR THE SHERIFF'S DEPARTMENT ON THE NEEDS AND ISSUES FACED BY PEOPLE WITH MENTAL ILLNESS. THE CREATION OF MENTAL HEALTH URGENT CARE CENTERS WHERE THE POLICE CAN TAKE PEOPLE INSTEAD OF BOOKING THEM. AND WE ARE WORKING WITH THE DISTRICT ATTORNEY'S OFFICE TO MAKE SURE THAT LAW ENFORCEMENT PROFESSIONALS KNOW THAT THEY HAVE THAT CHOICE AND REALLY UNDERSTAND WHICH INFRACTIONS DON'T REQUIRE THEM TO ARREST SOMEONE THAT WOULD ALLOW THEM TO TAKE PEOPLE TO A MENTAL HEALTH URGENT CARE CENTER FOR TREATMENT INSTEAD OF INCARCERATION. SO WE'RE WORKING REALLY HARD ON THAT, AND MHSA IS HELPING TO SUPPORT IT. THANKS FOR THE QUESTION.

>> THE MODERATOR: THANK YOU. MARK.

QUESTIONS BY: MARK K., COALITION

>> Q: AS YOU KNOW, DENNIS MURATA MENTIONED THAT THEY NEEDED TO HAVE PEERS REGISTERED AND BEING PART OF THE SYSTEM THEY HAVE BEEN WORKING FOR A SYSTEM AND AS WELL AS DOING OTHER THINGS FOR THE SYSTEM. WELL, THERE'S GOING TO BE A CONFERENCE THAT'S GOING TO BE TAKING PLACE IN ABOUT A WEEK AND A HALF AND SHARE CALLED THE WESTERN RECOVERY CONFERENCE. WE ARE GOING A WHOLE LOT AND THERE'S GOING TO BE A WHOLE A LOT OF WORKSHOPS REGARDING THAT. AND A LOT OF THE SUBJECT MATTERS THAT YOU GUYS ARE TALKING ABOUT HERE, THEY'RE GOING TO BE APPROACHED AT THAT CONFERENCE. SO WE NEED TO GET MORE CONSUMERS THAT WE HAVE. AND THERE'S 90 REGISTRANTS NOW. WE NEED MORE THAN THAT, A LOT MORE. SO IF WE CAN DO THAT, PLEASE COME AND SEE ME, COME AND SEE BETA, AND COME AND SEE THE OTHER CONSUMERS WHO ARE INVOLVED WITH GETTING THIS CONFERENCE TOGETHER. THERE ARE A FEW HERE. SO WE NEED – THE CAUSE OF THE CONFERENCE IS FOR THE CONSUMERS IN LOS ANGELES COUNTY IS $10. THE COST OUTSIDE OF THE LOS ANGELES COUNTY IS $150. PLEASE COME. WE WOULD LIKE – WE NEED TO HAVE YOU. WE NEED PEOPLE WHO ARE ASIAN, WE NEED PEOPLE WHO ARE HISPANIC, WE NEED PEOPLE FROM ALL ETHNIC POPULATIONS TO BE THERE. YOU GUYS ARE VERY, VERY IMPORTANT TO THIS PROCESS. SOME OF THE ANSWER THAT IS YOU GUYS ARE LOOKING FOR MIGHT BE AT THAT CONFERENCE. SO PLEASE COME.

>> THE MODERATOR: THANK YOU, MARK. THANK YOU.

>> Q: SO PLEASE COME. GIVE ME YOUR NAMES.

QUESTIONS BY: LOLITA NAMOCATCAT, APCTC

>> Q: HELLO, GOOD AFTERNOON, EVERYONE. MY NAME IS LOLITA NAMOCATCAT. AND MY CONCERN FOR THE UNDERSERVED CLIENTS, IS THERE WORKFORCE RESOURCE DIRECTORY GUIDELINES AVAILABLE FOR EACH SERVICE AREA, THAT THEY DON'T HAVE TO WAIT FOR THEM TO BE INCARCERATED, AND WHERE THEY CAN GO?

>> DR. INNES-GOMBERG: THANK YOU.

>> Q: THAT'S IT.

>> DR. INNES-GOMBERG: THANK YOU. ONE OF THE THINGS I THINK I HEARD YOU SAY TWO THINGS. DID YOU SAY WORKFORCE?

>> Q: YES.

>> DR. INNES-GOMBERG: OKAY.

>> Q: FOR EVERY SERVICE AREA.

>> DR. INNES-GOMBERG: BUT YOU'RE TALKING ABOUT EMPLOYMENT RESOURCES?

>> Q: I MEAN EMPLOYMENT FOR THE HOMELESS UNDERSERVED FSP.

>> DR. INNES-GOMBERG: THANK YOU, WE'LL TAKE A LOOK AT THAT. THANK YOU VERY MUCH.

>> THE MODERATOR: OKAY. WILLIAM.

QUESTIONS BY: WILLIAM LECERE

>> Q: OKAY. I'M WILLIAM LECERE. WHAT ABOUT AFRICAN-AMERICANS? 80% ARE HOMELESS ON AVERAGE AND IN SKID ROW AFRICAN-AMERICAN. WE HAVE A MISSION BECAUSE, I KNOW, I'M MENTIONING THIS BECAUSE THE HIGHEST RATE IS THE AFRICAN-AMERICAN POPULATION. THIS IS A FULL-ON GENOCIDE. CAN YOU COMMENT, PLEASE?

>> THE MODERATOR: THANK YOU. NO ONE UP THERE? OKAY.

QUESTIONS BY: MARIA JUAREZ

>> Q: [SPEAKING SPANISH]

>> THE MODERATOR: WE'RE GOING TO GET SOME TRANSLATION.

>> Q: HELLO, MY NAME IS MARIA JUAREZ, AND I'M WITH LATINAS COALITION. FIRST OF ALL, I LIKE TO MAKE A QUICK COMMENT OR SUGGESTION. MANY TIMES, YOU GO TO CLINICS AND WHERE IT CONSIST ON THE TREATMENT THAT THE EMPLOYEES WITH HIM GIVE TO THE CONSUMER.[sic]

THE DEPARTMENT NEEDS TO DO SOME SORT OF CHECK UP AND SEE WHAT KIND OF SERVICES AND HOW THEY'RE TREATING US, BECAUSE SOMETIMES THEY COME IN AND ONE PROBLEM AND YOU LEAVE WITH TWO. [LAUGHTER]

YOU HAVE SOME AMAZING EMPLOYEES IN THE DEPARTMENT OF MENTAL HEALTH, BUT WE ALSO HAVE SOME THAT ARE NOT SO GOOD. MANY TIMES BECAUSE OF THE LANGUAGE BARRIER, WE ARE MISTREATED. BUT YOU HAVE A GREAT EXAMPLE. ONE OF THOSE EXAMPLES IS RIGHT HERE. PHYLLIS, EVEN THOUGH SHE SPEAKS NO SPANISH, SHE MAKES SURE SHE'S ALWAYS SO VERY, VERY NICE TO ALL OF US.

[APPLAUSE]

LET'S GIVE HER A BIG ROUND OF APPLAUSE. SHE IS AN AWESOME EMPLOYEE. SHE DOES NOT DISCRIMINATE US EVER. HERE IN PUBLIC, I JUST WANT TO SAY THANK YOU IN THE NAME OF ALL OF US IN THE COALITION. MUCHAS GRACIAS.

[APPLAUSE]

>> DR. INNES-GOMBERG: THERE'S NO QUESTION ABOUT HOW WONDERFUL PHYLLIS IS. SHE DOES CUSTOMER SERVICE TRAININGS, AND ONE OF OUR ADULTS CONSUMER STAFF SAYS, I CAN'T BELIEVE HOW HELPFUL THAT WAS. SO THANK YOU VERY MUCH, PHYLLIS. AND I DO KIND OF WANT TO ADDRESS WHAT THE WOMAN SAID. AND, YOU KNOW, SOMETIMES YOU DO COME INTO A CLINIC WITH ONE ISSUE AND THEN YOU REALIZE YOU HAVE THREE OR FOUR. AND PART OF THAT, I THINK, IS GOOD TREATMENT. BUT THE OTHER PARTS, AS I THINK SHE'S – WHERE DID YOU GO? OH, I'M SORRY. THANK YOU. I'M SORRY. BUT PART OF THAT, I THINK, ALSO, AND I KNOW THERE'S NEEDS TO BE TRANSLATION IS THAT OUTCOMES, WHEN I MENTIONED EARLIER THAT WE'RE GOING TO IMPLEMENT AN OUTCOME SYSTEM, THAT WILL HELP US WITH THE ACCOUNTABILITY TO REDUCE THE VARIABILITY IN CARE THAT PEOPLE GET. THAT'S MY GOAL.

>> AUDIENCE MEMBER: MUCHAS GRACIAS.

>> THE MODERATOR: ANYMORE PUBLIC COMMENTS? ONE MORE OVER HERE? OKAY.

QUESTIONS BY: JENNY ROSALES, LATINA COALITION

>> Q: MY NAME IS JENNY ROSALES AND I'M A CONSUMER AND A PROVIDER. SOMETIMES PEOPLE HAVE CHRONIC ILLNESSES, THEY HAVE NO SUPPORT. AS A PARENT, I WANT THE BEST FOR MY CHILDREN WITH WHATEVER DISTURBANCES MY CHILD MIGHT HAVE. BUT I AM UNEDUCATED, SO YOU CANNOT UNDERSTAND. TO ME, EDUCATION MEANS TO BE ABLE TO HELP OTHERS, TO SUPPORT OTHERS, TO BE ABLE TO DO SOMETHING. IT MEANS TO UNDERSTAND WHATEVER AILMENT THEY MAY HAVE, THAT I HAVE AS WELL. THANK YOU.

>> DR. INNES-GOMBERG: THANK YOU VERY MUCH.

>> THE MODERATOR: THANK YOU. OVER HERE. REBA?

QUESTIONS BY: REBA STEPHENS, CONSUMER

>> Q: GOOD AFTERNOON. REBA STEPHENS, CONSUMER. SO IN THE BEGINNING WHEN WE OPENED, WE MENTIONED COMMUNITY. SO I BECAME VERY CONCERNED OR CURIOUS TO KNOW HOW IS COMMUNITY DEFINED WHEN WE TALK ABOUT THE COMMUNITY INPUT?

AND WHEN WE MENTION SAC IN COMMUNITY. AND ESPECIALLY AROUND THE SLT. IT WOULD BE INTERESTING TO KNOW WHAT – WHO'S ACTUALLY SEATED AT THAT TABLE? IS THAT INFORMATION AVAILABLE TO KNOW, YOU KNOW, WHO'S FROM AGENCIES, CLIENTS, THAT INFORMATION IS AVAILABLE?

>> DR. INNES-GOMBERG: IT'S ON OUR WEBSITE. YEAH, IF YOU LOOK UNDER THE SYSTEMS LEADERSHIP TEAM, YOU'LL SEE EACH INDIVIDUAL AND THEIR PRIMARY AFFILIATION.

>> Q: SO THEN WE ARE LOOKING AT AGE GROUPS. YOU KNOW, THIS HAS ALWAYS BEEN PUZZLING TO ME AS TO WHY IT'S SET UP THAT WAY THAT IT'S AROUND AGE GROUPS, BECAUSE FOR INSTANCE, AND I ALWAYS LIKE TO USE SERVICE AREA 6 AS AN EXAMPLE. AND SERVICE AREA 6, THERE ARE CHILDREN. TAY, ADULTS AND OLDER ADULTS. AND I JUST REALLY BELIEVE THAT IF WE ARE GOING TO MAKE A DIFFERENCE IN COMMUNITY, SOCIAL DETERMINANTS, THAT WE WOULD REALLY START TO TAKE A LOOK AT THE TOTAL ENVIRONMENT THAT THE FAMILY OR THOSE WHO YOU ARE CARING FOR LIVE.

SO WHEN I REALLY LISTEN TO THIS PRESENTATION TODAY, IT BECOMES QUITE CONFUSING, BECAUSE I DON'T KNOW HOW YOU'RE REALLY LOOKING AT THOSE NUMBERS. IT SEEMS LIKE WE'RE ALL IN THE BACK. YOU KNOW, ALL OF THE ADULTS. SO HOW DO YOU REALLY SEPARATE AND CLEAR ABOUT WHAT'S GOING ON IN SERVICE AREA 6? YOU'VE MENTIONED PARENTING AND SOME CLASS – WHAT WAS THAT?

>> ONE OF THE PRACTICES.

>> DR. INNES-GOMBERG: PARENT-CHILD INTERACTION THERAPY?

>> Q: SO THE WAY PHYLLIS EXPLAINED THAT TO ME, AND CORRECT ME IF I'M WRONG IF I'M WRONG, PHYLLIS, BECAUSE I'M CALLING YOUR NAME OUT. [CHUCKLES] THIS IS WHAT IS EXPERIENCED BY WAY OF A THERAPIST TO A CLIENT IN REGARDS TO PARENTING.

>> PHYLLIS: WHAT I WAS EXPLAINING IS THAT THE EVIDENCE-BASED PRACTICES ARE USED WITH A PARENT AND A CLIENT THAT'S IN FRONT, AND THEY WOULD USE THOSE PARTICULAR PRACTICES TO TEACH A PARENT. IT'S DIFFERENT FROM HAVING A SEPARATE PARENTING CLASS WHERE THERE'S A GROUP IN THERE. SO THAT'S WHAT THAT IS.

>> Q: THANK YOU. SO I FOUND THAT TO BE INTERESTING AND PERHAPS HELPFUL. BUT WE KNOW THAT IN SOME AREAS, AND ESPECIALLY IN SERVICE AREA 6 THAT THERE ARE NEEDS FOR PARENTING, ANGER MANAGEMENT, DOMESTIC VIOLENCE, GROUPS OF SUCH THAT ARE COURT – DUE TO COURT MANDATE. AND WHAT THE EXPERIENCE THAT MANY OF US ARE HAVING IS THAT WE ARE BEING RESOURCED OUT. AND THAT COULD BE EXPENSIVE. SO, I THINK IT WOULD BE NICE TO KNOW WHERE – WHAT IS THE RESPONSIBILITY OF THE DEPARTMENT WHEN IT COMES TO THE REINTEGRATION PIECE ON THE RECOVERY, RESILIENCY, AND REINTEGRATION? AND, SO, IF THAT IS A CLIENT IS IN A REINTEGRATING PROGRAM, OR REINTEGRATION PROGRAM, SHOULD NOT THE DEPARTMENT BE RESPONSIBLE FOR MEETING THE NEEDS OF THAT PERSON IN ORDER TO REINTEGRATE INTO THE COMMUNITY? BACK INTO THE COMMUNITY?

>> DR. INNES-GOMBERG: I'M GOING TO ANSWER THAT, AND THEN I THINK THE TWO MINUTES IS A BIT UP.

>> Q: OH, I'M UP? DO I GET MY TIME BACK FROM PHYLLIS? JUST KIDDING.

>> DR. INNES-GOMBERG: BUT LET ME JUST SHARE SOMETHING WITH YOU. AND THIS IS A HALLMARK. THIS IS AN ISSUE THAT I THINK MANY COUNTIES STRUGGLE WITH, AND THAT IS ONE OF THE ASPECTS OF THE MENTAL HEALTH SERVICE ACT SAYS THAT THE COUNTIES NEED TO LEVERAGE THE RESOURCES OF A PARTICULAR COUNTY. SO WHAT THAT MEANS IS THAT MENTAL HEALTH CANNOT OR SHOULD NOT BE EXPECTED TO FUND EVERYTHING. BUT SHOULD BE EXPECTED TO PARTNER WITH OTHER ORGANIZATIONS, OTHER COMMUNITY-BASED PROGRAMS, OTHER DEPARTMENTS TO BE ABLE TO DO WHATEVER IT TAKES TO REINTEGRATE AND HELP PEOPLE RECOVER. SO IT'S REALLY THAT BROKERING OF ALL THOSE RESOURCE AND ALL THOSE SERVICES.

QUESTIONS BY: HERMAN DEBOSE, LAC-DMH

>> THE MODERATOR: DID YOU WANT TO ASK SOMETHING?

>> HERMAN DEBOSE: I JUST WANT TO ASK. GOING BACK TO DISENROLLMENT FOR –

>> DR. INNES-GOMBERG: OH, NO! NOT DISENROLLMENT AGAIN. [LAUGHTER]

>> AUDIENCE MEMBER: SLIDE 13. COMMISSIONER COOPEBERG AND I WERE TALKING AND CAME UP WITH THIS QUESTION. WHERE IS THE DATA REPORTED FOR CLIENTS WHO AGE OUT OF ONE AGE GROUP SERVICE AND TRANSFERS TO THE NEXT AGE GROUP TO RECEIVE SERVICE? CHILD… I DON'T KNOW WHAT THAT IS.

>> SYSTEM OF CARE.

>> HERMAN DEBOSE: CHILD SYSTEM OF CARE TO TAY OR TAY TO ADULT CARE. BECAUSE IT WASN'T CLEAR TO US THAT IF HERMAN AGES OUT, DOES THAT MEAN HE HAS SUCCESSFULLY COMPLETED HIS GOALS? AND THAT WAS ONE OF THE THINGS THAT WE WERE STILL A BIT CONFUSED ABOUT.

>> DR. INNES-GOMBERG: YEAH, IT'S A GREAT QUESTION BECAUSE IF SOMEBODY AGES OUT, THE FACT THAT THEY'RE STILL IN CARE MAY BE A GOOD THING. THE FACT THAT THEY'RE STILL IN CARE MAY NOT BE A GOOD THING IF YOU KNOW WHAT I'M SAYING, RIGHT? SO I THINK WE DON'T KNOW, AND I

DON'T KNOW. AND I'M GOING TO LOOK TO KARA AND MY GROUP HERE THAT WHEN SOMEBODY TRANSITIONS FROM SAY CHILD TO TAY TO FSP, WHETHER THAT'S TRACKED ANYWHERE THAT WE CAN TAKE A LOOK AT IN TERMS OF PARTICULAR CASES.

>> KARA: YEAH, WE DEFINITELY TRACK ALL THE MOVEMENTS IN FSP. SO IF THEY TRANSITION FROM ONE AGE GROUP TO ANOTHER, WE CERTAINLY HAVE THAT. WE WOULDN'T HAVE, LIKE, A QUALIFYING, WHETHER IT'S A GOOD THING OR A BAD THING, BUT WE WOULD DEFINITELY BE ABLE TO TRACK THE MOVEMENT. THEY'RE JUST NOT REPRESENTED IN THAT DISENROLLMENT GRAPH BECAUSE THEIR NOT CONSIDERED TO BE DISENROLLED. THEY'RE STILL IN FULL SERVICE PARTNERSHIP.

>> DR. INNES-GOMBERG: THANK YOU. AND I THINK KALENE WANTS TO WEIGH IN. LET'S LET KAYLENE –

>> KALENE GILBERT: AND, SO, AMONG AGE GROUPS, WE HAD A LOT OF CONVERSATIONS ABOUT AGING OUT OF A PROGRAM. AND, SO, WHEN SOMEBODY TURNS 18, LIKE DEBBIE HAD MENTIONED EARLIER, THEY DEFINITELY DON'T AUTOMATICALLY GET MOVED TO THE NEXT AGE GROUP UP. WHAT THE CLINICIANS OR THE PROVIDERS WERE ADVISED TO DO WAS REALLY LOOK AT WHAT THE CLINICAL NEEDS WERE. SO IF WE HAVE SOMEBODY GOING FROM CHILD TO TAY, BUT REALLY, CHILD IS STILL THE RIGHT PROGRAM FOR THEM, THEY CAN STAY AS LONG AS THEY NEED TO. IF THEY HAVE VERY SPECIFIC TAY NEEDS, THEN WE WOULD WORK ON A VERY CLOSE TRANSFER FROM ONE PROGRAM TO THE NEXT. SO IT'S ALL ABOUT THE PERSON'S NEEDS IS HOW WE BASE THOSE DECISIONS.

>> DR. INNES-GOMBERG: THANK YOU.

>> HERMAN DEBOSE: SO MAYBE THAT STATEMENT CHILD FSP PROGRAM HAVE OVER TIME CONSISTENTLY THE HIGHEST PERCENTAGE OF COMPLIANCE WHO DISENROLLED DUE TO MEETING GOALS. SO MAYBE THAT NEEDS TO BE TWEAKED SOME, BECAUSE IF SOMEONE, IF I UNDERSTOOD THE PRESENTERS THAT IF HERMAN AGES OUT, THAT IT DOESN'T MEAN HE MET HIS GOAL, IT MEANS HE HAS BEEN TRANSFERRED SOMEWHERE ELSE. SO MAYBE THERE SHOULD BE AN EXPLANATION TO ADD TO THAT. IF I'M UNDERSTANDING CORRECTLY.

>> SO THE CLIENTS THAT DISENROLL DUE TO SUCCESSFULLY MEETING GOALS ARE CLIENTS THAT WERE AT THE TIME THEY WERE DONE WITH FULL SERVICE PARTNERSHIP COMPLETELY. THEY BELONGED IN THE CHILDREN'S GROUP. THEY WERE IN CHILDREN'S FULL SERVICE PARTNERSHIP AND THEY DID SUCCESSFULLY MEET THEIR GOALS. SO THAT IS EVERYBODY THAT SUCCESSFULLY FINISHED THAT PROGRAM. LIKE IF A CLIENT TRANSFERS FROM CHILD TO TAY, AND THEY DISENROLL WHEN THEY'RE IN TAY, THAT COULD VERY WELL BE A SUCCESSFUL DISENROLLMENT AT THAT POINT UNDER TAY FSP. BUT THAT PARTICULAR GRAPH THAT YOU'RE SHOWING DOESN'T REPRESENT THE MOVEMENT FROM ONE AGE GROUP TO ANOTHER. IT JUST REPRESENTS AT THE TIME THEY FINISHED FULL SERVICE PARTNERSHIP, WHAT AGE GROUP WERE THEY IN, AND WHY DID THEY DISENROLL?

>> DR. INNES-GOMBERG: AND KARA, THAT AGE GROUP IS RELATED TO THE PROGRAM THEY'RE IN AND NOT THEIR AGE?

>> RIGHT. AND THE OTHER THING IS, THE AGE GROUPS HAVE AGREED THAT IF A CLIENT QUALIFIED FOR A FULL SERVICE PARTNERSHIP, THEY HAVE SLIGHTLY DIFFERENT CRITERIA YOU SAW, RIGHT? WHEN DEBBIE PRESENTED FOR THE AGE GROUPS? IF SOMEBODY QUALIFIED FOR TAY FSP, THEY AUTOMATICALLY QUALIFY. AND THEY WERE IN TAY FSP AND NOW THEY NEED TO AGE UP OR MEET THE REQUIREMENTS THAT WOULD BE BETTER SERVED IN THE ADULT FSP, THEY AUTOMATICALLY QUALIFY.

>> HERMAN DEBOSE: OKAY. AND THEN ONE OTHER FOLLOW-UP. A GENTLEMAN MENTIONED A FACT THAT THERE'S A SIGNIFICANT NUMBER AFRICAN-AMERICANS WHO ARE IN SKID ROW, AND NO ONE RESPONDED TO HIS STATEMENT. IT JUST KIND OF WENT BY THE WAYSIDE. AND I'VE SHARED THIS WITH YOU IS THAT AS WE SEE THE NUMBERS INCREASE, IF THERE COULD BE SOMETHING IN THE PLAN OR SOME PLACE TO TALK ABOUT EARLY INTERVENTION OR PREVENTION REACHING OUT TO THAT COMMUNITY, BECAUSE THEN HOPEFULLY, IF WE START SOME INTERVENTION, THE NUMBERS WOULD GO DOWN

RATHER THAN CONTINUALLY INCREASE. BUT I THOUGHT THAT NO ONE RESPONDED TO HIS QUESTION. IT JUST KIND OF STAYED THERE.

>> DR. INNES-GOMBERG: I'M SORRY, YOU ACTUALLY HELPED ME TO UNDERSTAND MORE THE INTENTION OF HIS STATEMENT. THAT'S VERY HELPFUL. AND ALSO WHEN I THINK ABOUT THIS, AND MAYBE WE CAN WORK WITH THE COMMISSION ON THIS IS THAT SO MANY OF THE COUNTY INITIATIVES ARE AROUND REDUCING INTENSIVE SERVICE RECIPIENTS, REDUCING HOMELESSNESS, REDUCING PEOPLE THAT ARE IN JAIL OR REDUCING THE RECIDIVISM OR THAT SORT OF THING. SO THOSE FOLKS, WHAT ARE THE RIGHT PREVENTION AND EARLY INTERVENTION STRATEGIES FOR THOSE PEOPLE BEFORE THEY HAVE A MENTAL ILLNESS, BEFORE THEY GET TO THAT POINT WHERE THEY QUALIFY IN THAT CATEGORY? AND, YOU KNOW, IT MIGHT BE THINGS LIKE FUNCTIONAL FAMILY THERAPY AS A CHILD OR ADOLESCENT OR SOMETHING LIKE THAT. BUT I THINK THAT WOULD BE A REALLY GOOD DISCUSSION TO HAVE.

>> THE MODERATOR: YES. MS. LAMON IS NEXT.

QUESTIONS BY: MS. LAMON

>> Q: YOU KNOW, AS I WAS LISTENING, BECAUSE I HAVE TO DO ALL THE LISTENING NOW BECAUSE I CAN'T READ ANYTHING. I THOUGHT ABOUT THE FOSTER CHILDREN. WE HAVE A LOT OF THEM IN MY AREA. ESPECIALLY IN THE COMPTON UNION AREA. DOES ANY OF YOUR TAY PROGRAM TAKE INTO CONSIDERATION THOSE CHILDREN'S PROBLEM? BECAUSE ONCE THEY GET 18, MOST OF THEM ARE OUT THERE ON THEIR OWN.

>> THEY'RE DISENROLLED. [LAUGHTER]

>> Q: THEY DON'T HAVE ANY PLACE TO GO AND NO PLACE TO STAY. YOU KNOW? NO JOB. SO IS THERE SOMETHING THAT REALLY TAKES A LOOK AT THE KIDS THAT ARE REALLY FOSTER CHILDREN AND TRY TO DO SOMETHING SPECIFIC FOR THEM? I DID SOMETHING FOR ONE IN MY NEIGHBORHOOD. I GAVE HIM 211 FOR 1. AND I TOLD HIM YOUR PROBLEM, THEY WILL PROBABLY HELP YOU. AND I THINK HE TOLD ME THEY DID. OKAY, THANK YOU.

>> THE MODERATOR: KALENE, IS THERE SOMETHING YOU COULD ADDRESS?

>> [AWAY FROM MIC]

>> THE MODERATOR: IS THERE SOMEONE FROM TAY?

>> I CAN ANSWER A LITTLE BIT. I JUST WANT TO ANSWER AS MY OTHER HAT, I'M ALSO A PROVIDER. ABOUT THREE-QUARTERS OF OUR TAY PROGRAM IS FOSTER YOUTH, FORMER FOSTER YOUTH. SO, YEAH, THEY ARE CONNECTED AND WE WORK WITH DCFS AND THE CHILDREN'S PROVIDERS WHO ARE SERVING THOSE KIDS. SO WE HAVE A WARM HAND-OFF AND IT WORKS VERY WELL. YEAH, THAT'S IN THE ANTELOPE VALLEY. I DON'T KNOW WHAT OTHER PEOPLE ARE DOING.

>> THE MODERATOR: THANK YOU. KALENE.

>> KAYLENE GILBERT: I WAS JUST GOING TO SAY FOR THE TAY SERVICES, THE TAY DROP-IN CENTERS WERE REALLY THAT ARE FUNDED THROUGH MHSA WERE GEARED TO BE OPEN TO FOLKS THAT MIGHT NEED TO GET ANY KIND OF SERVICES. AND SPECIFICALLY TARGETING THOSE THAT MIGHT BE EXITING THE FOSTER CARE SYSTEM JUST TO BE THERE TO PROVIDE A WEALTH OF SERVICES FOR WHATEVER THEY NEED. AND THE YOUTH LEAVING THE FOSTER CARE SYSTEM ARE ALSO A SPECIFIC FOCAL POPULATION FOR TAY FULL SERVICE PARTNERSHIP.

>> THE MODERATOR: OKAY, ROBIN.

>> ROBIN KAY: YOU KNOW WE'RE SORT OF DOING A LITTLE BIT OF HITTING ON LOTS OF DIFFERENT INITIATIVES. THE ONE THING I DO WANT TO SAY THAT SPECIFICALLY ADDRESSES THE NEEDS OF THIS PARTICULAR POPULATION IS A, IT'S A TRANSITIONAL RESIDENTIAL PROGRAM THAT INCLUDES FSP. SO OVER THE LAST COUPLE OF YEARS, THE TAY DIVISION HAS IMPLEMENTED A VERY SPECIALIZED FULL

SERVICE PARTNERSHIP IN THREE RESIDENTIAL FACILITIES THAT ALLOW BOTH SUPPORT, CONNECTED TO EDUCATION, CONNECTED TO EMPLOYMENT, AND ALSO PROVIDES THE MENTAL HEALTH SERVICES SPECIFICALLY FOR TAY AGING OUT OF THE FOSTER CARE SYSTEM WITH REALLY SIGNIFICANT MENTAL HEALTH ISSUES. SO, YOU KNOW, THERE'S LOTS OF DIFFERENT EXAMPLES. IT'S HARD TO DESCRIBE THE WHOLE, BUT WE HAVE BEEN WORKING ON VERY, VERY SPECIALIZED PROGRAMS OVER THE LAST COUPLE OF YEARS.

>> THE MODERATOR: OKAY. CAROLINE.

>> CAROLINE KELLY: SO GOING BACK TO THE COMMENT MADE BY, I THINK, WILLIAM, AND HERMAN, AND OTHERS. ONE OF THE BEAUTIES THAT COMES WITH SOMETIMES ADDRESSING ONE GROUP IS YOU SEE HOW MUCH THE LANGUAGE NOW CAN INFORM OTHERS. SO IN LOOKING AT THE CULTURAL AND ETHNIC DISPARITIES, YOU KNOW, THAT WAS SPECIFIC TO THE API PROGRAM, SO JUST AT THE LAST INTEGRATION ADVISORY BOARD MEETING, DR. GALES, WHO IS A PROFESSOR AT LMU PRESENTED AGAIN. HER PRESENTATION WAS SPECIFIC TO THE AFRICAN-AMERICAN COMMUNITY. BUT QUITE FRANKLY, LIKE THE THINGS THAT SHE WAS SUGGESTING FOR THOSE, THE LANGUAGE ABOUT USING CULTURALLY SPECIFIC NON-TRADITIONAL ACTIVITIES, MINIMIZING FEELINGS OF SHAME, YOU KNOW, ALL OF THOSE THINGS COULD HAVE BEEN JUST LIFTED OUT OF HER PROGRAM. SO, AGAIN, THIS IS WONDERFUL TO HAVE THIS LANGUAGE THAT'S NOW PART OF THE PLAN AND IT CAN NOW REALLY BE INCORPORATED WITH THE WORK OF OTHERS IN THIS AREA TO EXPAND IT TO OTHER COMMUNITIES WHO DEAL WITH OTHER ISSUES, YOU KNOW, WITH SIMILAR ISSUES ACROSS-THE-BOARD.

>> THE MODERATOR: THANK YOU. LOLITA.

QUESTIONED BY: LOLITA NAMOCATCAT, APCTC

>> Q: MY NAME IS LOLITA NAMOCATCAT. MY QUESTION IS SPEAKING OF THE UNDERSERVED CLIENTS POPULATION, WHAT IF THE PROPOSED BUDGET EXCEEDS THE ALLOTTED BUDGET? DOES IT AFFECT THE NATIONAL RESERVE BUDGET?

>> DR. INNES-GOMBERG: THEY'RE VERY INDEPENDENT.

>> THE MODERATOR: WENDY.

QUESTIONS BY: WENDY CABIL, D.M.H./NAMI

>> Q: HI, EVERYONE. YOU CAN HEAR ME PRETTY GOOD? OKAY. YES I'M WENDY CABIL FROM ANTELOPE VALLEY. I HAVE EIGHT QUESTIONS FOR YOU AND I'LL JUST READ THEM STRAIGHT THROUGH IF THAT'S BETTER FOR TIME-WISE. THE FIRST IS HOW LONG WILL THE MHSA THREE-YEAR PLAN REMAIN POSTED ON THE D.M.H. WEBSITE?

NO. 2, WHAT ARE THE EXISTING MECHANISM –

>> DR. INNES-GOMBERG: WENDY, LET ME JUST ANSWER AS I CAN, THAT WAY – I CAN'T REMEMBER ALL.

>> Q: YEAH.

>> DR. INNES-GOMBERG: IT REMAINS POSTED UNTIL THE NEXT VERSION OF IT GETS POSTED. AND THEN IT REMAINS POSTED INDEFINITELY. IF YOU GO ON OUR WEBSITE, YOU'LL SEE ANNUAL UPDATES AND THINGS LIKE THAT FOR YEARS BEFORE.

>> Q: OKAY, GOOD, THANKS. OKAY NO. 2, WHAT ARE THE EXISTING MECHANISMS IN PLACE TO COLLECT DATA? WHO OR WHAT UNIT INVOLVED COLLECTS DATA FOR D.M.H.?

>> DR. INNES-GOMBERG: THE OUTCOME DATA? DO YOU MEAN THE OUTCOME DATA? THE FOLKS TO YOUR LEFT, KARA AND HER GROUP, HAVE WORKED WITH OUR I.T. PEOPLE TO CREATE WHAT'S CALLED AN OUTCOME MEASUREMENT APPLICATION, WHICH IS A WEB-BASED SYSTEM THAT COLLECTS MOST OF OUR OUTCOME DATA, NOT ALL OF IT, BUT MOST OF IT. SO THAT'S THE SYSTEM. AND THEN WE PRODUCE REPORTS BASED ON THAT O.M.A.

AND THE OUTCOME MEASURES WE TALKED ABOUT ADDING WOULD THEN, OUR O.M.A. WOULD HAVE TO BE MODIFIED TO BE ABLE TO THEN ACCEPT THAT NEW DATA.

>> Q: OKAY, GREAT. NO. 3, HOW DOES D.M.H. ENSURE COMMUNITY INPUT IS REFLECTED IN THIS IMAGE, SAY THE THREE-YEAR PLAN?

>> DR. INNES-GOMBERG: WE REALLY LOOK TO THE SERVICE AREA ADVISORY COMMITTEES. THE SYSTEM LEADERSHIP TEAM HAS 2 MEMBERS PER SAAC AS WELL SO THERE'S BI-DIRECTIONAL INFORMATION GOING BACK AND FORTH. AND THEN OF COURSE THE PUBLIC COMMENT PROCESS, ANYONE CAN COMMENT.

>> Q: THE FOURTH. WHAT STRATEGIES IS D.M.H. USING TO MOTIVATE AND SUPPORT INVOLVEMENT FROM CONSUMERS, FAMILY MEMBERS, CAREGIVERS, RESIDENTS, ALONG WITH FAITH-BASED COMMUNITIES?

>> DR. INNES-GOMBERG: WE HAVE TALKED WITH OUR COMMISSIONS AND HELENA'S GROUPS AND SHARE, OF COURSE THAT MANAGES SOME OF THAT. WE HAVE NOT SPECIFICALLY THIS YEAR PRESENTED TO THE FAITH INITIATIVE, BUT I THINK THAT'S A REALLY GOOD IDEA. AND IF YOU HAVE RECOMMENDATIONS ABOUT HOW WE CAN MAKE THAT STRONGER, I'D LOVE TO HEAR THEM.

>> Q: NO PROBLEM. I'M SORRY, DENNIS.

>> DENNIS MURATA: THE OTHER THING TOO IS THAT DR. SHERIN IS GOING TO BE AT EACH SAAC. AND I KNOW HE STARTED WITH SAAC 6. SO THAT'S HIS COMMITMENT. HE WANTS TO HEAR FROM THE PARTICIPANTS OR MEMBERS FROM THE DIFFERENT SAACs.

>> Q: THAT'S GREAT. THANK YOU.

>> DR. INNES-GOMBERG: YOU HELD THE MICROPHONE BUT DIDN'T TALK INTO IT. [LAUGHTER]

>> Q: THE WAY YOU MIGHT WANT TO ANSWER THIS ONE – [LAUGHTER]

>> DENNIS MURATA: ALL RIGHT.

>> Q: I KNOW THAT'S HAPPENING, AND I KNOW HE'S COMING TO ANTELOPE VALLEY MARCH 16. AND IN OUR PARTICULAR AREA, AND WHEN I WENT TO SAAC 6 AND BRIEFLY GOT A CHANCE TO HEAR WHAT HE HAD TO SAY THERE, HE DID MAKE IT PLAIN AND CLEAR THAT HE IS AVAILABLE, HE'S ACCESSIBLE. IT'S UP TO THE COMMUNITY TO GET THE CONSUMERS TO THAT, TO THOSE MEETINGS.

>> DENNIS MURATA: YES.

>> Q: AND, SO, I'M SCRATCHING MY HEAD TRYING TO FIGURE, OKAY, HOW MANY DAYS LEFT? YOU KNOW? SO I'M GOING TO NEED MORE HELP THAN JUST THE SAC MEMBERS.

>> DENNIS MURATA: OKAY, HELENA, CAN YOU HELP HER WITH THAT? [CHUCKLES] SHE SAID, YES.

>> Q: THANKS. OKAY, SOUNDS GOOD. MOVING ON THEN.

>> THE MODERATOR: YOUR OTHER QUESTIONS?

>> Q: YES, SINCE ANTELOPE VALLEY HAS A DIRE NEED FOR PSYCHIATRISTS, WHAT'S REQUIRED TO INCREASE TELEPSYCHIATRY SERVICES?

>> THE MODERATOR: DR. SHANER?

>>DR. RODERICK SHANER: SO WE HAVE A NUMBER OF WAYS TO DO IT. THE FIRST ONE IS, WHILE THERE ARE INSUFFICIENT PSYCHIATRISTS IN THE ANTELOPE VALLEY, THERE ARE OPEN POSITIONS. WE USE AND HEAVILY ADVERTISE, AND WE'RE DOING LOCATION-SPECIFIC ADVERTISEMENTS NATIONALLY. IF YOU HAVEN'T SEEN THE ONE ON THE ANTELOPE VALLEY, SEND ME AN E-MAIL. IT WILL MAKE YOU WANT TO LIVE THERE FOREVER. IT'S REALLY, IT HAS A BEAUTIFUL DESCRIPTION OF IT.

FOR THOSE WE CAN'T FILL IN THE MEANTIME, WE TAKE SOME OF THOSE AND WE USE THEM TO SUPPORT PSYCHIATRISTS IN THE TELEHUB SO THAT THEY CAN PROVIDE SERVICES TO THE ANTELOPE VALLEY. WE DON'T THINK THAT'S AS GOOD AS FACE-TO-FACE, IT JUST ISN'T, BUT IT HELPS.

AND THEN FOR THE REMAINDER, WE USE WHAT ARE CALLED LOCUM TENENS PSYCHIATRISTS WHICH ARE SORT OF YOU RENT THEM FROM ORGANIZATIONS THAT CLEARLY THEM AND MAKE SURE THEY'RE OKAY. AND BY DOING THAT, WE CAN FILL THE BASIC REQUIREMENT. WE HAVE OTHER PROJECTS AS WELL. THE MOST – THE NEWEST ONE, WHICH IS ALL OF TWO WEEKS OLD, SO WE DON'T HAVE A LOT OF OUTCOMES DATA YET IS TO TRY TO PARTNER WITH FEE-FOR-SERVICE PSYCHIATRISTS. THESE ARE PRIVATE PSYCHIATRISTS THAT TAKE MEDI-CAL AND DO A PARTNERSHIP, BECAUSE OFTEN TO GET INTO THE CLINICS IN ANTELOPE VALLEY, THE WAY LIMITED STEP, THE REASON WHY IT TAKES LONG TO GET AN APPOINTMENT IS BECAUSE OF LACK OF A PSYCHIATRIST AS OPPOSED TO OTHERS. SO WE PARTNER, WE'RE OFFERING TO PARTNER WITH PRIVATE PSYCHIATRISTS. AND IT ACTUALLY INCREASES THEIR RATE AS WELL, BECAUSE WE PAY FOR THE COLLABORATION WITH THE CLINIC. WE'VE JUST ACTUALLY SENT OUT ANNOUNCEMENTS TO ALL PSYCHIATRISTS WHO ARE BASED IN ANTELOPE VALLEY WHICH YOU CAN COUNT ON THE FINGERS OF ONE HAND. BUT ALSO TO PSYCHIATRISTS IN SERVICE AREA 2, AND WE'RE WAITING TO SEE IF WE GET A RESPONSE. AND WE'LL BE FOLLOWING UP WITH THEM AS WELL. SO THOSE ARE OUR STRATEGIES RIGHT NOW.

>> AUDIENCE MEMBER: I APPRECIATE THAT. I'LL BE LOOKING FORWARD TO IT. BUT ONE MORE THING. HOW MANY IS A NUMBER OF PSYCHIATRIST ASSIGNED TO AN AREA OR CLINIC IN THAT AREA BASED ON THE NUMBER OF PATIENTS? I MEAN, WHAT'S THE PATIENT TO PSYCHIATRIST RATIO? IS THERE…?

>> DR. RODERICK SHANER: THE WAY WE ASSIGN PSYCHIATRIST IS ROUGHLY LOOKING AT BOTH VARIOUS MEASURES OF WORKLOAD. CASELOAD IS ONE. BUT YOU KNOW, THAT CAN BE DIFFERENT DEPENDING ON WHAT THE PROGRAM DOES. AND THEN ANOTHER IS TO LOOK AT THE DEGREE TO WHICH THE PSYCHIATRIST'S TIME WHERE THERE IS OCCUPIED. THERE'S ONLY A CERTAIN – IF YOU ARE SEEING PEOPLE FACE-TO-FACE 100%, YOU HAVE NO TIME TO CHART OR ANYTHING. SO WE LOOK AT THOSE METRICS AND CONSTANTLY CHANGE THE NUMBERS OF PSYCHIATRISTS AVAILABLE.

IN ANTELOPE VALLEY, THE NUMBERS OF PSYCHIATRISTS, WE'RE JUST TALKING ABOUT DIRECTLY OPERATED PROGRAMS, THERE ARE CONTRACTED PROVIDERS TOO, WE USE THE SAME METRICS AS ANY PLACE ELSE, AND WE'RE ABLE TO FILL THOSE WITH THAT COMBINATION OF EMPLOYED PSYCHIATRISTS, TELEPSYCHIATRISTS, AND LOCUMS.

>> THE MODERATOR: DR. SHANER, THANK YOU VERY MUCH. WENDY, I KNOW YOU HAVE OTHER QUESTIONS.

>> Q: CAN I JUST PUT THEM ON THE RECORD?

>> THE MODERATOR: YES, YOU CAN IN WRITING AND WE WILL GET THE ANSWERS TO YOU. THERE IS A COMMENT OR QUESTION OVER HERE?

>> Q: THANK YOU.

>> DR. INNES-GOMBERG: AND WENDY, THANK YOU FOR THOSE QUESTIONS. THOSE ARE GOOD ONES.

QUESTIONS BY: PAUL STANSBURY, NAMI SOUTH BAY

>> Q: THANK YOU. FIRST, I JUST GOT AN E-MAIL FROM A NAMI NATIONAL. JUST FOR YOUR INFORMATION, ON TONIGHT'S GREY'S ANATOMY, IT WILL BE ABOUT MENTAL ILLNESS, SO YOU MAY WANT TO WATCH GREY'S ANATOMY TONIGHT. I'M NOT SURE WHAT TIME IT IS. CHECK YOUR LOCAL LISTING.

>> DR. INNES-GOMBERG: 9 O'CLOCK. [LAUGHTER]

>> Q: OKAY. THANK YOU. I WANT TO COMMEND THE COUNTY FOR THE GREAT WORK AND THE PLAN AND BEING A MODEL FOR OTHER COUNTIES TO MAKE SURE THAT THE PUBLIC APPRECIATES THE MHSA DOLLARS THAT ARE WELL SPENT AND THAT SOMETIMES WE GET SOME BAD PRESS. SO THANK YOU FOR THAT.

ALSO ONE COMMITTED FOR THE NON-FAIL CRITERIA, I THINK IT'S A VERY VALUABLE FROM FAMILY PERSPECTIVE. IT'S BEEN A GREAT HELP TO KNOW THAT YOU DON'T HAVE TO BECOME SO CHRONICALLY ILL TO GET HELP. ALSO, AN INCREASE IN THE AMOUNT OF SERVICE. HOWEVER, A QUESTION. THIS IS SOMEWHAT RHETORICAL. AND WHEN WE GO BACK TO THIS QUESTION OF SCALE AND LEVERAGE, BASED ON THE DATA, WE KNOW THERE SHOULD BE MANY MORE PEOPLE WITH MENTAL ILLNESS BEING NOT BEING SERVED BASED ON THE PROBABILITY OF MENTAL ILLNESS IN OUR COMMUNITY. YOU MENTIONED A QUESTION OF LEVERAGE. AND HOW MIGHT WE DISCUSS, ESPECIALLY WITH MENTAL ILLNESS DISPARITIES STILL BEING AN ISSUE WITH PRIVATE INSURERS, HOW CAN WE WORK WITH OTHER AGENCY TO SEE MAKE SURE THAT OTHER PEOPLE WHO ARE NOT SERVED, THE UNDERSERVED, AND THE UNDERREPRESENTED ARE BEING SERVED? ANY COMMENTS YOU MIGHT SUPPLY? THANK YOU.

>> DR. INNES-GOMBERG: I'M GOING TO COME OVER TO THE TABLE TO SEE IF FOLKS WANT TO WEIGH IN ON THIS. PAUL, IT SOUNDS LIKE WHAT YOU'RE ASKING IS HOW DO WE WORK WITH DIFFERENT AGENCIES, DEPARTMENTS TO BE ABLE TO MAKE SURE THE SERVICES ARE LEVERAGED? SO THE CLIENTS GET WHAT THEY NEED, AND MENTAL HEALTH DOESN'T PAY FOR EVERYTHING, BUT WE MAKE SURE THAT OTHER – IS THAT RIGHT?

>> Q: BASED UPON NATIONAL MENTAL HEALTH AND BASED ON SAMHSA, FOR SERIOUSLY MENTALLY ILL, THERE'S LOT MORE PEOPLE IN THE PUBLIC WHO HAVE A MENTAL ILLNESS WHO ARE NOT TOUCHED BY THIS 119,000, WE'RE TALKING 1 OUT OF 5 OR SERIOUS MENTAL ILLNESS MAYBE 300,000 PEOPLE AT LEAST IN THIS COUNTY WHO ARE NOT BEING TOUCHED. AND, SO, HOW DO WE MAKE SURE THEY GET SERVICES? HOW MIGHT WE HELP IN THAT SITUATION? IT'S A DIFFICULT QUESTION, BUT HOW MIGHT WE HELP IN THAT ISSUE?

>> DR. INNES-GOMBERG: IT'S A GREAT QUESTION. I THINK THE MILD TO MODERATE, FOR EXAMPLE, THAT ARE NOT THE RESPONSIBILITY OF US, BUT THE [AWAY FROM MIC].

>> [AWAY FROM MIC] [LAUGHTER]

>> DR. RODERICK SHANER: WELL, LET ME THINK ABOUT THIS FOR A WHILE, BECAUSE I ONLY GET 2 MINUTES. [LAUGHTER] NO. SO, THERE ARE MANY WAYS THAT WE KNOW WE SHOULD BE OUTREACHING AS A COMMUNITY TO PEOPLE WHO NEED HELP. PROBABLY THE MOST WORK IS DONE ON IDENTIFYING OTHER PARTS OF THE WHOLE MENTAL HEALTH SYSTEM WHERE PEOPLE COME FOR TREATMENT.

SO WE WORK CLOSELY, AND THERE'S A LOT OF NATIONAL AND LOCAL WITH HEALTH PLAN AND OTHER SAFETY NET HEALTH PLANS TO HELP PRIMARY CARE PROVIDERS RECOGNIZE WHEN THERE'S A MENTAL HEALTH ISSUE. OR EMERGENCY ROOM PROVIDERS WHERE 20% TO 30% OF ALL EMERGENCY ROOM TREATMENT IS THAT. OR SUBSTANCE ABUSE TREATMENT PROVIDERS, BECAUSE WE KNOW 50% OF PEOPLE UNDER SUBSTANCE ABUSE HAVE UNDERLYING MENTAL HEALTH ISSUES AS WELL. AND HELP EDUCATE THOSE PROVIDERS ABOUT HOW TO HELP THOSE CLIENTS FIND WITH WARM HAND-OFFS AND GOOD INFORMATION, FIND THEIR WAY TO THE MENTAL HEALTH SYSTEM. THAT'S ONE OF MANY WAYS I THINK THAT'S DUPLICATED IN OTHER NON-HEALTH SYSTEMS AS WELL.

>> THE MODERATOR: THANK YOU. VERY SUCCINCT THERE.

>> DR. RODERICK SHANER: UNUSUAL, HUH? [LAUGHTER]

>> ROBIN KAY: AND YVETTE, THE ONLY OTHER THING I WOULD ADD THAT PEOPLE SHOULD KEEP THEIR EYES ON IS THAT STARTING IN APRIL, THE COUNTY WILL BEGIN IMPLEMENTING WHOLE PERSON CARE WHICH WILL GIVE US THE OPPORTUNITY TO INTERVENE AT CRITICAL POINTS FOR PEOPLE WHO ARE BEING ENCOUNTERED IN THE CRIMINAL JUSTICE SYSTEM, IN THE HEALTH SYSTEM, IN THE EMERGENCY ROOMS WHO ARE HOMELESS, WHO ARE PREGNANT AND PARENTING YOUNG WOMEN. THERE ARE

NUMBER OF DIFFERENT PROJECTS LOOKING AT SORT OF CRITICAL TIME PERIODS AND CRITICAL SITUATIONS IN PEOPLE'S LIVES WHEN THEY MAY BENEFIT FROM BEING CONNECTED WITH THE MENTAL HEALTH SYSTEM. SO MORE TO COME ON THAT. THE NUMBERS ARE PRETTY AMBITIOUS, SO I THINK WE'LL MAKE EVEN A BIGGER DENT THROUGH THAT COLLABORATION.

>> THE MODERATOR: THANK YOU, ROBIN. DENNIS?

>> DENNIS MURATA: OKAY. SO YOU HAD A QUESTION ABOUT EMPLOYMENT FOR CONSUMERS. SO AS ROBIN MENTIONED WHOLE PERSON CARE, ONE OF THE GOOD THINGS ABOUT – I SHOULDN'T SAY IT IN THAT WAY. AMONG THE GOOD THINGS ABOUT WHOLE PERSON CARE IS THAT HIRING OF COMMUNITY HEALTH WORKERS. SO IF YOU DIDN'T RECEIVE, I THINK CAROLINE, I THINK THEY WENT OUT TO ALL THE COALITIONS AND ALL THE USCC GROUPS? THEY'RE HIRING FOR COMMUNITY HEALTH WORKERS, SO PERSONS WITH LIVED EXPERIENCE AS WELL AS SHARED EXPERIENCE. SO IF YOU HAVEN'T RECEIVED THAT, THEN MAYBE WE CAN SEND THAT OUT AGAIN. BECAUSE THAT'S GOING TO BE AN ONGOING PROCESS.

>> THE MODERATOR: OKAY.

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> THE MODERATOR: THANK YOU. I WAS JUST REMINDED THERE'S ALSO THE EMPLOYMENT CONFERENCE COMING UP?

>> CAROLINE KELLY: IN APRIL, RIGHT? DR. KAY, COULD YOU JUST CONFIRM THE DATA OF THE EMPLOYMENT CONFERENCE THAT THE D.M.H. IS DOING IN APRIL? OKAY, THERE'S AN EMPLOYMENT CONFERENCE COMING UP IN APRIL. WE INVITE YOU TO LOOK AT THE WEBSITE. YOU KNOW, THAT'S ANOTHER RESOURCE FOR YOU. WE REALLY HOPE TO HAVE A GREAT TURNOUT THERE. AND WE'LL HAVE THE DATE SOON. I THINK THAT'S IT FOR PUBLIC COMMENT, RIGHT?

SO WE WANT TO THANK DR. INNES-GOMBERG AND HER WHOLE TEAM, BECAUSE THIS IS VERY MUCH A TEAM APPROACH. SO ALL OF THE DIFFERENT SUBGROUPS THAT CAME TODAY.

[APPLAUSE]

WE ALSO WANT TO THANK THE MEMBERS OF THE SLT WHO HAVE WORKED ON THIS THROUGH THE WHOLE YEAR PROCESS. WE ALSO WANT TO REMIND YOU THAT WHILE, YOU KNOW, THERE ARE SET POSITIONS ON THE SLT, THE PUBLIC IS INVITED TO COME TO ALL OF THE MEETINGS. THEY ARE OPEN FOR THE BROWN ACT TO EVERYONE. AND YOU DO NOT HAVE TO NECESSARILY SIT ON THE SLT TO SERVE ON SOME OF THE SUBCOMMITTEES. SO THERE ARE MULTIPLE WAYS OF BEING INVOLVED. AND, YOU KNOW, YES?

>> [AWAY FROM MIC]

>> CAROLINE KELLY: OKAY, APRIL 5 IS THE DATE OF THE EMPLOYMENT CONFERENCE. WE HOPE THAT YOU WILL HELP TO PROMOTE THAT, AND WE HOPE THAT MANY OF YOU WILL ATTEND. SO, AGAIN, THERE ARE WAYS TO BE INVOLVED IN THE MHSA PROCESS. YOU'VE HEARD FROM A COUPLE OF DIFFERENT SOURCES TO THAT, DR. SHARON IS EXPECTING TO SEE THE SACS ASSUME A BIGGER ROLE, WHICH MEANS THAT GET INVOLVED WITH YOUR SAC. YOU KNOW? USE THAT AS AN OPPORTUNITY, INVITE YOURSELF, SEE YOURSELF AS WELCOME AT ALL OF THESE SACS. THEY SHOULD AND I'M SURE WILL WELCOME YOU TO BE PART OF THAT PROCESS.

ONE OF THE THINGS THAT THE COMMISSION IS GOING TO DO NEXT YEAR, BECAUSE THIS IS A FAIRLY, IT'S A LOT OF INFORMATION AND IT CAN BE VERY COMPLICATE TO DO TAKE IN AT ONCE IS THAT EVERY OTHER MONTH, WE WILL HAVE A PRESENTATION FOR A TOTAL OF FIVE PRESENTATIONS ON ONE ASPECT OF MHSA. AND THEN IN BETWEEN THOSE MEETINGS, SO IN THE TWO MONTH INTERIM, WE WILL ACTUALLY VISIT ONE FACILITY THAT FALLS IN THAT CATEGORY HOPEFULLY WITHIN EACH DISTRICT. SO WE INVITE YOU TO COME TO THE COMMISSION MEETINGS. YOU KNOW, WE'LL BE POSTING THOSE ON OUR AGENDA WHEN IT HAPPENS. SO IF YOU WANT TO LEARN ABOUT THE MENTAL HEALTH SERVICES ACT IN SMALLER CHUNKS, THAT'S HOW WE'RE GOING TO DO IT. OUR SIXTH MEETING WILL CONTINUE TO BE THIS TOWN HALL. SO THE MORE THAT YOU'RE INVOLVED, THIS IS REALLY MEANT TO BE PART OF YOUR

PROCESS, AND IT IS TO BENEFIT EVERYONE IN THE COUNTY. SO THANK YOU VERY MUCH FOR BEING HERE. WE, AGAIN, THANK ALL THE WORKERS WHO GAVE US LUNCH TODAY. WE THANK THE DIOCESE FOR OUR ABILITY TO BE HERE, AND WE THANK MS. TOWNSEND ALSO FOR BEING A HELP.

>> AUDIENCE MEMBER: JUST A QUICK QUESTION. WHEN WILL THE REGISTRATION FOR THE EMPLOYMENT CONFERENCE BEGIN?

>> [AWAY FROM MIC]

>> CAROLINE KELLY: YEAH, WE'LL TRY TO GET THAT INFORMATION POSTED AND CIRCULATED AS SOON AS WE CAN. ALL RIGHT. ANYTHING FINAL? YES.

>> THE MODERATOR: PARKING VALIDATION IS AVAILABLE AT THE SIGN-IN DESK IN THE BACK IF YOU DON'T HAVE IT ALREADY. THANK YOU VERY MUCH FOR COMING.

>> CAROLINE KELLY: ALL RIGHT. THANK YOU, EVERYONE.

[APPLAUSE]

[MEETING ADJOURNS AT 3:00 P.M.]

TO OBTAIN ADDITIONAL INFORMATION CONTACT:

DEBBIE INNES-GOMBERG, PH.D.

DIGOMBERG@DMH.LACOUNTY.GOV

PHONE: (213) 738-2756