WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE
FISCAL YEAR 2019-20

Los Angeles County - Department of Mental Health

Los Angeles County Board of Supervisors
Adopted on June 4, 2019

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	February 14, 2006
Workforce Education and Training (WET) Plan	April 8, 2009
Technological Needs (TN) Plan	May 8, 2009
Prevention and Early Intervention (PEI) Plan	September 27, 2009
Innovation I: Integrated Clinic Model, Integrated Services Management Model, Integrated Mobile Health Team Model and Integrated Peer-Run Model	February 2, 2010
Capital Facilities (CF) Plan	April 19, 2010
Innovation 2: Developing Trauma Resilient Communities through Community Capacity Building	May 28, 2015
Innovation 3: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions	October 26, 2017
Innovation 4: Transcranial Magnetic Stimulation	April 26, 2018
Innovation 5: Peer Operated Full Service Partnership	April 26, 2018
Innovation 7: Therapeutic Transportation	September 26, 2018
Innovation 8: Early Psychosis Learning Health Care Network	December 16, 2018
Innovation 9: Recovery Supports for Conservatees	September 26, 2018

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

Introduction (continued)

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.

While this Annual Update reports on MHSA-funded services for Fiscal Year 2017-18, it is also meant to project a budget for Fiscal Year 2019-20. The Department estimates the component allocations to be:

Program	Amount
Community Services and Supports	$448,933,000
Prevention and Early Intervention	$112,241,000
Innovation	$29,543,000

A full budget projection is included on pages 178-182 of this Annual Update.

While this Annual Update has Service Area maps, you may want to consult the following link for more information http://gis.lacounty.gov/districtlocator/ .

Any questions or comment should be directed to:

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DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

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Greetings LA County!

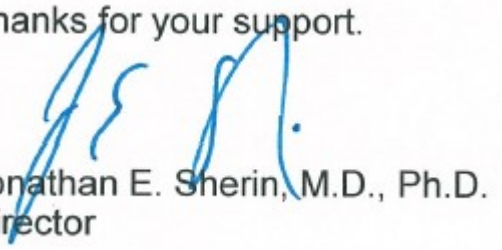
Since its passage, the Mental Health Services Act (MHSA) has provided California an unprecedented opportunity to engage our communities in informing, developing and promoting the most impactful array of resources possible through the Department of Mental Health. Building on the success achieved over the past decade plus, we are now engineering an even more robust and highly resourced stakeholder engagement process that capitalizes on the energy and leadership of our guiding bodies including the Service Area Advisory Committees, the Underserved Cultural Communities, the Mental Health Coalitions, the Systems Leadership Team, and our Board appointed Commission that is helping to coalesce the iterative systems we need in place to plan properly and transparently.

There are many service expansions under way in LA County, some of which depend almost exclusively on funding from MHSA, including:

- Resourcing and leveraging partners to increase access to care via home visiting, schools, libraries, parks, health clinics, and other community platforms to mitigate the development and progression of mental illness and intervene as early possible;
- Expanding mobile outreach, engagement, and triage to homeless populations;
- Doubling down and optimizing our investment in Full Service Partnerships to keep those suffering form mental illness out of the hospitals, off of the streets, and out of the jails:
- Increasing the inventory of interim, permanent supportive and board and care housing; and
- Utilizing technology to diversify our mental health treatment options.

In the coming years, it is my hope that our MHSA resources will continue to help those in most need live freely in stable and dignified environments of choice, develop strong personal relationships, and engage in meaningful life activities.

Thanks for your support.



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

Executive Summary

Introduction

The Mental Health Services Act (MHSA) of California (Proposition 63) was passed by California voters in 2004, aimed at expanding and transforming California's county mental health service systems. Welfare and Institutions Code Section 5847 states that after submitting a Three-Year Program and Expenditure Plan, county mental health programs shall prepare and submit annual updates for MHSA programs and expenditures. This Annual Update for the Los Angeles County Department of Mental Health (LACDMH) reports on the program that served clients during Fiscal Year (FY) 2017-2018.

Actions since the Last Annual Update

Over the first half of FY 2018-2019, after the FY 2018-2019 MHSA Annual Update was adopted by the Board of Supervisors, LACDMH posted several mid-year adjustments to the plan, including the following:

- Transfer of Community Services and Supports (CSS) funding to Capital Facilities and Technological Needs, May 16, 2018 and November 29, 2018
- Innovation projects, further described in the Innovation Section
- Transfer of CSS funding to Workforce Education and Training, June 21, 2018

Community Services and Supports

CSS includes the following services:

- Recovery, Resilience, and Reintegration (RRR)
- Alternative Crisis Services
- Linkage Services
- Housing
- Planning, Outreach, and Engagement (POE)
- Full Service Partnership (FSP)

The number of unique clients who received a direct Mental Health Service through a CSS Plan: 132,397

In the subsections below, we describe the numbers of clients served in each of the services.

Recovery, Resilience, and Reintegration

Recovery, Resilience, and Reintegration (RRR) services provide a continuum of care so that clients can receive the care they need, when they need it and in the most appropriate setting to meet their needs. RRR services are designed to meet the mental health needs of individuals in different stages of recovery. Table 1 shows the numbers of clients served, by age group.

Table 1. Unique Clients Served, by Age Group

Age Group	Unique Clients Served
Child	23, 538
Transitional age youth	15,195
Adult	54,701
Older adult	13,236

Alternative Crisis Services

Alternate Crisis Services (ACS) provide a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. Table 2 shows the numbers of clients served by alternative crisis services: urgent care centers, law enforcement teams, and enriched residential services.

Table 2. Alternative Crisis Services

Program	Unique Clients Served	Outcomes
Urgent Care Services (UCC)	41,423	While urgent care centers vary by location, only 7% of clients, on average, present at psychiatry emergency departments within 30 days of the UCC visit; Olive View UCC's percentage is much higher.
Law Enforcement Teams	19,728	2% arrested 68% hospitalized
Enriched Residential	851	

Linkage

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. Table 3 shows the numbers of client contacts with jail and service area navigation.

Table 3. Client Linkage

Program	Number of Client Contacts
Jail Linkage	639
Service Area Navigation	12,273

Housing

- As of June 30, 2018, LACDMH has a total of 1,439 units.
- During FY 2017-2018, the Department invested in 366 units.

Planning, Outreach, and Engagement (POE) Activities

- A full array of community-defined activities occurred through the Under-Served Cultural Community groups, including a new group for those with disabilities as well as through Service Area-specific outreach and education activities, including raising community awareness related to trauma, the Armenian Genocide, anti-bullying, and suicide prevention.
- Outreach and engagement staff were present at community events throughout the year, including at libraries, places of worship, homeless shelters, and career and community wellness fairs.

Full Service Partnership

Over 14,000 clients were served by Full Service Partnerships (FSP) in FY 2017-2018. Table 4 describes the numbers of clients served in FSPs by age group.

Table 4. Full Service Partnerships

Age Group	Number of Unique Clients Served
Child	4,081
Transitional age youth	2,619
Adult	6,007
Older Adult	1,566

We assessed the impact of FSP enrollment on client outcomes by measuring changes in the proportions of clients and in the numbers of days spent with homelessness, justice involvement, psychiatric hospitalization, or independent living (Table 5).

Comparing a client's life before and after FSP enrollment shows:
- FSP reduces homelessness
- FSP reduces justice involvement
- FSP reduces psychiatric hospitalization
- FSP increases independent living

Table 5. Impact of FSP on Post-Partnership Residential Outcomes*

FSP Program	Percentage by Clients	Percentage by Days
Homeless		
Transitional age youth	23% reduction	43% reduction
Adult	29% reduction	68% reduction
Older Adult	28% reduction	60% reduction
Justice Involvement		
Transitional age youth	60% reduction	34% reduction
Adult	17% reduction	65% reduction
Older Adult	13% reduction	46% reduction
Psychiatric Hospitalization		
Child	12% reduction	23% reduction
Transitional age youth	45% reduction	24% reduction
Adult	25% reduction	66% reduction
Older Adult	12% reduction	23% reduction
Independent Living		
Transitional age youth	31% increase	41% increase
Adult	47% increase	45% increase

*Children (N=9,234); Transitional age youth (N=4,762); Adults (N=13,713); Older adults (N=1,715) Figures represent cumulative changes, inclusive of all clients.

Prevention and Early Intervention

Prevention and early intervention (PEI) services include the following:
- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction
- Prevention
- Outreaching for Increasing Recognition of Early Signs of Mental Illness Program

- Program to Improve Timely Access to Services for Underserved Populations
- Access and Linkages to Treatment

This section reports on client use of some of these services.

Early Intervention

Some 44,212 clients received an Early Intervention direct mental health service: 89% were children and transitional age youth. These practices have resulted in the following reduction in symptoms and improvement in functioning.

- **Depression**: After completing Depression Treatment Quality Improvement, Managing an Adaptive Practice, Mental Health Integration Program, Group and Individual cognitive behavioral therapy (CBT) for Depression, Interpersonal Psychotherapy for Depression, Problem Solving Therapy for older adults, or the Program to Encourage Active Rewarding Lives for Seniors (PEARLS), clients achieved average reductions in depressive symptoms of at least **40%** and/or average improvements in functioning of at least **45%**.
- **Trauma**: After completing Alternatives for Families-CBT, Managing and Adapting Practice (MAP), individual CBT, Child Parent Psychotherapy, or Trauma Focused CBT, clients achieved average reductions in post-traumatic stress symptoms of at least **40%** and/or average improvements in functioning of at least **45%**.
- **Improving Parenting Skills to Reduce Disruptive Behavior in Children**: After completing Parent Child Interaction Therapy, Loving Intervention, Family Enrichment Program, Brief Strategic Family Therapy, Triple P Positive Parenting Program, MAP, or Families Overcoming Under Stress (FOCUS), clients achieved average reductions in disruptive behaviors of at least **40%** and/or average improvements in functioning of at least **45%**.
- **Severe Behavioral Conduct**: After completing Functional Family Therapy or Multisystemic Therapy, clients achieved at least a **30%** improvement in functioning.
- **Anxiety**: After completing MAP, individual CBT, or Mental Health Integration Program, on average, clients achieved average reductions in anxiety symptoms of at least **40%** and/or average improvements in functioning of at least **45%**.

Suicide Prevention

- The Latina Youth Program reduced behaviors and the intensity of those behaviors associated with suicide risk.
- The Suicide Prevention Hotline continues to reduce self-rated suicidal intent and responded to 99,574 chats, calls, and texts. The hotline has capacity to respond in Spanish, Vietnamese, and Korean, as well as English.
- The Partners in Suicide Prevention team participated in 133 suicide prevention events, including providing Applied Suicide Intervention Skills Training (ASIST); Question, Persuade, and Refer (QPR); Mental Health First Aid (MHFA); and Assessing and Managing Suicide Risk (AMSR) trainings. The trainings collectively resulted in attendee-rated significant increases in knowledge about suicide prevention and help seeking.
- The School Threat Assessment Response Team (START) assessed 219 students and intervened with 86. Of the 86 students, 65% were assessed with a pre- and post-suicide and violence risk measure. The majority (54%) of students with an intervention were rated as having a low initial risk for suicide and remained low risk after the intervention. In contrast, 52% of the intervention students were initially rated as having a moderate risk for violence and reduced their risk to low after the intervention.

♥ Stigma and Discrimination Reduction

- 35,138 individuals participated in these activities, including Mental Health First Aid training and the WhyWeRise campaign.

⊘ Prevention

- The Department has implemented an array of 40 prevention activities and services geared toward addressing—either through education or support—the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support.

Community Planning Process

After consultation with stakeholders, at the end of Fiscal Year 2017-18, the Department decentralized its stakeholder feedback process through the eight Service Area Advisory Committees (SAAC) and through the creation of YourDMH. Consequently, feedback on this Annual Update and unmet needs in each Service Area was sought by attending each SAAC. The following are the dates of SAAC meetings:

SAAC 1	February 21, 2019	SAAC 5	November 27, 2018
SAAC 2	October 11, 2018	SAAC 6	October 18, 2018
SAAC 3	October 11, 2018	SAAC 7	October 12, 2018
SAAC 4	October 18, 2018	SAAC 8	October 5, 2018

The key themes across SAACs include:

- Comprehensive services for clients with co-occurring mental health, substance use and health conditions.
- Drop-in center and one-stop shop approaches to service delivery.
- Real-time resource identification and availability.
- Increasing capacity for mental health services, including optimal caseloads for Recovery, Resilience and Reintegration.
- Service coordination and collaboration – homeless, hospital discharge, client transportation, school campus involvement.
- Populations of interest- LBGTQ, parolees and probationers, sex trafficking victims.
- Ensuring age group subject matter expertise and the needs of clients of various ages is preserved in the reorganization of the Department.
- Expand Promotores approach to other cultures.

Community Planning Process (continued)

Service Area 1 – Antelope Valley
Meeting: February 21, 2019
Presenter: Debbie Innes-Gomberg, Ph.D.

Mental Health Services	
Need	• Psychiatric inpatient service capacity for children, adolescents and adults. • Emergency department capacity • Explore collaboration with Kern County • Additional capacity for FSP and RRR • Non-specialty mental health services • Urgent care center capacity needed (in progress) • Need enhanced navigation capacity. (Discussed the role of Whole Person Care and Peer Run Service Staff
Housing/Homelessness	
Need	• Increased shelter capacity, including capacity to housing families • Increased supportive housing

Service Area 2 – San Fernando Valley
Meeting: October 11, 2018
Presenter: Robin Ramirez

Mental Health Services	
Possible Solutions Discussed	• Have providers share information about their service. • Work closely with Health, Veterans and Community Colleges. • Could use more money on campus to provide PEI services on site and expanding definitions of PEI services. • Increase Integrated Health and MH programs such as College of the Canyons; co – located service providers, DPSS, DHS etc., Collaboration with COC and UCC. • Addressing limitations (especially geographic challenges of Access and the need for transportation esp. in unincorporated areas). • Better coordination with hospital discharge planning.
Housing/Homelessness	
Possible Solutions Discussed	• Updates information on SA 2 Housing Situation. • Educating community on homelessness. Everyone in campaign - Lori - Hope of the Valley can provide contact. • Panel to discuss 6 Strategies for homeless outreach and coordination • Increased focus on homeless, especially TAY homeless.
Outreach Efforts	
Possible Solutions Discussed	• Social events (evenings/weekends) game nights, non-related directly to MH for 30+, focus to decrease isolation and etc. Masonic lodges as possible venues. • Increased materials outreach to Armenian and Farsi speaking communities. • Increased outreach to Latino community. • Karla Wheeler at West Valley MH Clinic talked about "Ideas from clients to Outreach Older Adults." • Monthly Forum – Speakers "We" can relate to with a positive message. • Information about Senior Housing / Supportive Housing. • Arrange (tickets?) for theatre / Concerts / Cultural Events. • NAMI peer-to-peer classes in English / Spanish / Farsi seminars. • Offsite Classes, Increased Activities, Creative Artist, Poetry, Skills. • Gardening Club, Game Night. • Social Club with Music from 70's, 80's, 90's. • Chances / Opportunities to Socialize.

Community Planning Process (continued)

Service Area 2 – San Fernando Valley (continued)

Children and Families	
Possible Solutions Discussed	• Increased focus on children panel on what we are doing and gaps in services. • Early Childhood MH – training teachers, parents, consultation for early identification resources early upstream. • DMH needs to provide support for family members: groups etc. (Not just NAMI) Using PEI funds for this purpose.
Resources	
Possible Solutions Discussed	• Public speaking trainings for consumers NAMI – "In our own voice" • Increase voting. Richard is putting together voter information guide. Voter information guides are always available at homeless connect events. • Sponsor a Service Area II summit: Psychiatrist, Judges, Hospitals etc. to draw people in for a larger service area event. • Develop a SA2 Resource Guide
Co-occurring Services	
Possible Solutions Discussed	• Provide more trainings to providers proving co-occurring (substance abuse and mental health services) as they seem ill equipped to do so. • More programs like River Community and Sobering Centers is needed because many of the sober livings are not safe places.

Service Area 3 – San Gabriel Valley
Meeting: October 11, 2018
Presenter: Debbie Innes-Gomberg, Ph.D.

Mental Health Services	

Unmet Need/Problem	• Recovery Resilience and Reintegration
	  ◦ What is the optimal case load?
	  ◦ How do we optimally provide these services?
	  ◦ How do we measure capacity?
	• How is it impacted by the capacity of the Full Service Partnership (FSP) program?
	• More mental health services provided in other languages.
	• More capacity to support those with co-occurring disorders.
	• Specialized mental health services for those 21 and over.
	• The ability to support consumers in their journey through specialized services.
	• The ability to support older adults in FSP, can the Department handle capacity?
	• Is the County capable of keeping up with the age groups and they grow and shift?

Possible Solutions Discussed	• Replicating the Promotores program in other languages. Can this same model be replicated? • Recruitment of staff who speak the languages of the clients served in Service Area 3.

Community Planning Process (continued)

Service Area 4 – Metro
Meeting: October 18, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Resources	
Unmet Need/Problem	• Lack of childcare resources in the Service Area • Lack of foster homes in the Service Area resulting in children being sent to the Antelope Valley • How can the SAAC provide resources in real time, ex: undocumented clients. • The Housing resource list needs to be shared on broader level and current. • Pest control cleaning is needed for bed bugs: There is a bed bug issue in SA 4 resulting in home services being delayed until the home is professionally cleared. • Lack of housing.
Recommendation	• A SAAC member referenced San Francisco's Peer Networking to the Homeless in the Parks and its successes as a possible solution to the housing crisis.
Community Partners	
Unmet Need/Problem	• Law Enforcement should be educated and trained to gain a better understanding of the mentally ill. • More collaborations • How does the SAAC get invited to participate in the meeting hosted by Diversion and Re-entry? • Better communication across the county: What commissions exist? How do we know they exist? • Los Angeles Unified School District (LAUSD) needs to work in tandem with DMH: Accessing child and families during school days, is very difficult. A formalized MOU is needed to provide mental health services on school grounds. • DMH needs to remember to include Spanish media when they invite other news media outlets to attend events.
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios • Including LGBTQ as part of collecting demographic information
SAAC 4	
Unmet Need/Problem	• How do we best organize ourselves given we no longer have age groups and now Discipline Chiefs? How do we best convey our needs? • More people involved in outreach efforts. More involvement and outreach efforts to get more people to attend the SAAC meetings. Chances / Opportunities to Socialize. • What can the SAAC do to better support Dr. Debbie Innes-Gomberg, Deputy Director?

Community Planning Process (continued)

Service Area 4 – Metro (continued)

Comments/ General Recommendations
• Mental Health Accountability report will be released soon. It can be found on the Mental Health Accountability website. • Clean environment • With the new DMH building, will there be a new clinic? • DMH belongs to all ethnicities not just Blacks, Whites, and Asians • What population will the new DMH site house? • What does the acronym WDACS stand for? Workforce Development, Aging and Community Services • Any discussion on the Right Balance for triple R?

Service Area 5 – West
Meeting: November 27, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Mental Health Services	

Unmet Need/Problem	• In-home care for ages 0-5
	• Recovery Resilience and Reintegration
	  ◦ How do we optimally provide these services?
	  ◦ More money is needed to provide a lower level of care from FSP
	• More mental health services provided in other languages. There are barriers to using the translation line.
	• More child providers in the Service Area.
	• FSP
	  ◦ More slots are needed.
	  ◦ How do we streamline the FSP referrals?
	  ◦ Better documentation of the client's needs in order for clients to be enrolled into the FSP program.
	• Provide more training for child care centers.
	• Low-barrier drop in centers
	• More funding is needed for the 0-5 population, Spanish speaking and undocumented clients

Housing	
Unmet Need/Problem	• Service Area is in need of shelters, people have to leave the Service Area to get housing. • A need for different levels of housing.
Comments/Suggestions	

	• Information about mental health services should be more accessible
	  ◦ It was suggested a user friendly website be available for parents/consumers seeking services for Board and Cares, IMDs, etc.
	  ◦ Users/family members should have the ability to review and rate the mental health facilities.
	  ◦ The Department should explore ways to improve the way in which information is disseminated to family members about what mental health services are available

Community Planning Process (continued)

Service Area 6 – South
Meeting: October 18, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Parolees, specifically those inmates who did not receive mental health treatment while incarcerated	
Unmet Need/Problem	• Parolees are not able to utilize the mental health services funded by MHSA. • Parolees who did not receive mental health treatment while incarcerated are released without any linkage to a community mental health agency.
Other Information	Mandatory referrals are made to a Parole Outpatient Clinic (POC) for a mental health assessment for those inmates who are in a mental health treatment program at the time of the prerelease case referral. To provide continuity of care, a POC referral appointment shall occur as soon as possible but not more than 30 days after release to parole.
Possible Solutions Discussed	• Parolees are able to utilize non-MHSA funded programs in the County • Change legislation: create advocacy
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ) Transition Age Youth (TAY)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios
Questions	• How can DMH/SAAC support the caregivers and community that work with LGBTQ youth receiving mental health services?
Peer Advocates	
Unmet Need/Problem	People in recovery need the proper training as to what is culturally and socially acceptable behavior
Questions	"What may be normal in the hood, isn't normal in the "real" world."
Education about mental health services	
Unmet Need/Problem	• Training should be available to teachers to educate them on the importance of school-based services • Frontline staff such as clerks need more Customer Service and possibly Peer trainings as to how to treat the clients. They give off a feeling as if it is "them vs. the Clients" the SAAC would like it to feel like a community and togetherness.
Staff delivering mental health services	
Unmet Need/Problem	• Not providing enough individual therapy • The need to provide cultural competent services • High caseloads • Retention of staff in Service Area 6 • Those staff that recently graduated are in need of training, some are not ready to provide the services in Service Area 6.
Questions/Comments/ Recommendations	• Cultural competent services in Lynwood are not available. The PET team was called and they were not available. The person was told to call the police for a mental health emergency, 9 black and white police cars arrived which can cause more trauma. • DMH needs to incentivize or make working in SA 6 appealing to staff. SA 6 feels that staff are reluctant to work in the Compton and surrounding areas, thus contributing to the lack of culturally appropriate and competent staff problem in the SA. • The stipend program should be re-evaluated. Stipend recipients are ready to deliver services but the hiring process is taking too long.

Community Planning Process (continued)

Service Area 6 – South (continued)

Mental Health Services	
Unmet Need/Problem	• Mental Health needs to be personalized. • Accountability for the directly-operated clinics: We need to take a look at the standards of the contract agencies. Are the contract agencies being held to the same standards as the directly operated? • Services needed for the sex traffic population. • How do we enhance what we already know? • The SAAC would like services tailored to the "hood" not to the what the outside world thinks the services should look like. They want services from the inside perspective and not the outside in. • More outreach and engagement to the directly operated clinics.
Questions/Comments/ Recommendations	• There has been a lot of progress in SA 6 since 1951. It was worse in the 1970s and progress is happening. • Using SAAC funds as an incentive for peers to conduct outreach and engagement
Service Area 6 Community	
Unmet Need/Problem	• Process of healing ourselves • No monolingual Spanish speakers present at the SAAC meetings, more outreach efforts, possibly changing location of meetings. • When do we start seeing results? • Building communities to help deter from utilizing services • Social support spaces needed

Comments/ General Recommendations

- Due to the lack of access to computers by the homeless population, DMH needs to focus on advertisement on the radio (KJLH), TV, and billboards. Social media is not enough.
- Invite Carlotta Childs-Seagle, Deputy Director, to the SAAC 6 meeting
- The SAAC would like to collaborate with Department of Public Health and Innovation 2, Health Neighborhoods.
- The data and numbers mean nothing to them. The percentage of African American are not accurate due to so many uncounted numbers.
- A SAAC member was upset that this discussion is just now happening. A once a year discussion about the SA unmet needs is unacceptable.
- Your DMH is a possible solution to raise the voice regarding the lack of services.
- The SAAC should contact elected officials and State Legislators to discuss prevention and support.
- A request for Pre-Prevention "Sit at the table" with DMH administration and collaborate. Let the SAAC/community be a part of the change for the future that will impact the services 100 years from now.
- A client at West Central had to wait 6 weeks for an intake appointment. When she finally got her appointment it was for a meet and great and not an intake. The client was then given an appointment for a month out, which was then cancelled and replaced with a Help and Wellness support group appt. The client in crisis was told that the clinic is no longer accepting walk-in clients until the new year. Per West Central supervisor the clinic is back logged 3-4 months and only have 3 therapists on staff, with one on leave. The client is now advocating for all the clients and fears that with the holidays approaching the need for therapy will rise.
- There is a need for Peer respite homes where people who need to get away can go.
- What is the purpose of the Office of Consumer and Affairs? How do families and peers utilize their services? It is recommended the Office of Consumer Affairs attend the SAAC meetings to present about the services available.

Community Planning Process (continued)

Service Area 7 – East
Meeting: October 12, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Mental Health Services	
Unmet Need/Problem	• More mental health services provided in other languages. • A need for post hospital release program. • In home services for consumers with difficulties leaving their home. • More integrated care. • A need for an urgent care center, none exist in SA 7. • More Wellness Centers. • Access to care regardless of documented status. • Too long of a wait time for mental health services.
Questions/Comments/ Recommendations	• How are some families more successful at obtaining services than others? • Spotlight success stories
Resources	
Unmet Need/Problem	• Lack of housing for families. • Lack of shelters in SA7, the one currently located in SA 7 is for Countywide use. • Transportation needed to retrieve documents from other agencies in order to apply for services. • Resource Service Centers distributed equally throughout the SA 7. • Money for birth certificates
Collaborations	
Unmet Need/Problem	Commissioners should be regular attendees at the SAAC meetings. More partnerships are needed within the Service Area.
Recommendation (s)	Host a town hall meeting for SA 7.
Staff delivering mental health services	
Unmet Need/ Problem	• Not providing enough individual therapy • The need to provide cultural competent services • High caseloads • Retention of staff in Service Area 7 • More education for intake staff in regards to helping the undocumented receiving services. • More outreach and engagement efforts for those consumers that are hard to reach.
Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• There is a need for more culturally appropriate services, specifically LGBTQ culturally relevant services. • Housing • More drop-in centers with features that include basketball courts, creative space and art studios • Including LGBTQ as part of collecting demographic information • Currently, only one TAY Drop-in Center in the Service Area.

Community Planning Process (continued)

Service Area 8 – South Bay
Meeting: October 5, 2018
Presenter: Kara Taguchi, Psy.D. and Robin Ramirez

Mental Health Services	
Unmet Need/Problem	• Better coordination and more partnerships • between mental health, law enforcement, and homeless services • between other municipalities and non-County entities • Services needed at more public locations • Equal distribution of services throughout Service Area 8 • Better communication about the various services within DMH • Better hospital discharge planning • Lack of clinicians and space to provide mental health services to the underserved • Access to children during school hours at the schools.
Questions/Comments/ Recommendations	• Provide services at parks • Create a one-stop location where clients can receive mental health and social services • Mobile service treatment (a recreational vehicle (RV) with showers) • Provide mental health workers at train stations to help avoid arrests • Gender Dysphoria training for clinical staff • Provide transportation to and from mental health services appointment
Housing	
Unmet Need/Problem	• Lack of shelters in Service Area 8

UCC Leadership Meeting
Meeting: October 24, 2018
Presenter: Debbie Innes-Gomberg, Ph.D. and Robin Ramirez

Lesbian, Gay Bisexual, Transgender, and Questioning (LGBTQ)	
Unmet Need/Problem	• Find a way to collect data that is a better representative of the LGBTQ • Better representation in Sacramento for LGBTQ advocacy • Better data collection methods for transgender community • How do we better document the need? • Incorporate data collection for LGBTQ into our electronic health record.
Native Americans	
Unmet Need/Problem	• Find a way to collect data on the tribes. It's not enough to just identify the number of Native Americans served.

Community Planning Process (continued)

In addition, the Department posted an early partial draft of this Annual Update on the DMH website on December 13, 2018. On February 14, 2019, the Mental Health Commission's Executive Board was briefed on the Annual Update. The public hearing was convened by the Mental Health Commission on March 28, 2019.

Public comment received during the posting period and at the public hearing are summarized below.
Advocacy for increases in:

- Housing in all forms, including Boards and Care, housing dedicated to older adults, families, quality housing and access to immediate housing.
- Promotion of mental health services via billboards, public transportation, radio, TV and internet to reduce stigma.
- Promotores services.
- Psychiatric Mobile Response Teams.
- Prevention approaches, including school-based after-school support.
- Client input into housing plans and mental health service delivery.
- Co-occurring mental health and substance use services
- Welcoming atmospheres in clinics. Metal detectors and large numbers of signs indicating what you cannot do should be replaced with more welcoming approaches.
- Services in the Antelope Valley, in particular psychiatric inpatient capacity, homeless shelters and co-occurring substance use and mental health treatment.
- Create one-stop shops and peer resource centers is each Service Area
- Suicide prevention approaches for teenagers, particularly in the Antelope Valley.

The full transcript of the public hearing comments and questions are posted in the appendix.

The Commission approved the Department's Annual Update at its regularly scheduled meeting on April 25, 2019.

MHSA County Compliance Certification

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) 738-4108	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
Program Development and Outcomes Bureau
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 **Annual Update**, including stakeholder participation and nonsupplantation requirements.

This **Annual Update** has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update and Expenditure Plan, attached hereto, was adopted by the County Board of Supervisors on **June 4, 2019**.

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

All documents in the attached annual update are true and correct.

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

Signature

6/18/19
Date

MHSA County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

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

Local Mental Health Director	County Auditor-Controller
Name: Jonathan E. Sherin, M.D., Ph.D.	Name: Arlene Barrera
Telephone Number: (213) 738-4601	Telephone Number: (213) 974-0729
E-mail: JSherin@dmh.lacounty.gov	E-mail: abarrera@auditor.lacounty.gov

Local Mental Health Mailing Address:

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

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

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

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

Signature 4/25/19
Date

I hereby certify that for the fiscal year ended June 30, 2018, 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 12/13/18 for the fiscal year ended June 30, 2018. I further certify that for the fiscal year ended June 30, 2018, 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.

Arlene Barrera
County Auditor Controller (PRINT)

Signature 5-8-19
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"

First District	Second District	Third District	Fourth District	Fifth District
Hilda L. Solis	**Mark Ridley-Thomas**	**Sheila Kuehl**	**Janice Hahn**	**Kathryn Barger**
Susan Friedman	Harold Turner	Merilla McCurry Scott, PhD	Patrick Ogawa	Brittney Weissman, MPP
Lawrence Murata-Shih	Kita Curry, PhD	Rev. Kathy Cooper Ledesma	Vacant	Judy Cooperberg, MS, CPRP
Imelda Padilla-Frausto	Reba Stevens	Stacy Dalgleish	Vacant	Vacant

May 8, 2019

Jonathan E. Sherin, M.D., Ph.D.
Director, Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Sherin:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2019-20 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On April 25th, 2019 the Chairman and a quorum of the Los Angeles County Mental Health Commission (Commission) made a motion following the Public Hearing of the Mental Health Services Act Fiscal Year 2019-20 Annual Update conducted at the Cathedral of Our Lady of the Angels in Los Angeles County:

MOTION: The Los Angeles County Mental Health Commission moves to approve the Fiscal Year 2019-20 Annual Update.

It is, therefore, with pleasure that the Commission approves your Department's submission of the Fiscal Year 2019-20 Annual Update, which was publically posted on February 22nd, 2019 and presented at the March 28th, 2019 Public Hearing. We would also like to 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 you are achieving.

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

Sincerely,

Merilla McCurry Scott, Ph.D.
Chairperson

Merilla McCurry Scott

MS:DIG:PM

Address: 550 South Vermont Ave. 12th Fl, Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: https://dmh.lacounty.gov/about/mental-health-commission/

Los Angeles County Board of Supervisors Adopted Letter

DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

JONATHAN E. SHERIN, M.D., Ph.D.
Director

Curley L. Bonds, M.D.
Chief Deputy Director
Clinical Operations

Gregory C. Polk, M.P.A.
Chief Deputy Director
Administrative Operations

June 04, 2019

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES
38 June 4, 2019

CELIA ZAVALA
EXECUTIVE OFFICER

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTHS MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2019-20 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health Mental Health Services Act Annual Update for Fiscal Year 2019-20.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2019-20 (Attachment). The MHSA Annual Update has been certified by the County Mental Health Director and the County Acting Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

The MHSA Annual Update for FY 2019-20 builds upon the DMH approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSA programs for FY 2017-18, including clients served by MHSA programs, and Service Area and program outcomes. Additionally, the Annual Update describes the DMH ongoing planning process and progress towards implementing program expansions from the Three-Year Program and Expenditure Plan for FYs 2017-18 through 2019-20. Board adoption of the MHSA Annual Update is required by law and necessary for DMH to submit the Annual Update for FY 2019-20 to the Mental

Los Angeles County Board of Supervisors Adopted Letter

Health Services Oversight and Accountability Commission (Commission). Additionally, the Welfare and Institutions Code requires the following: 1) the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be certified by the County Mental Health Director and the County Acting 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; 2) a draft MHSA Three-Year Program and Expenditure Plan and Annual Updates be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans; and 3) the 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 accordance with these requirements, DMH, on February 22, 2019, posted the MHSA Annual Update on its website for 30 days for public comment. The Mental Health Commission also convened a Public Hearing on March 28, 2019, where DMH presented the update and addressed public questions. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2019-20 at its meeting on April 25, 2019.

Implementation of Strategic Plan Goals

The recommended action is consistent with the County Strategic Plan Goal III (Realize Tomorrow's Government Today), via Strategy III.4 (Engage and Share Information with Our Customers, Communities and Partners), and County Strategic Plan Goal I (Make Investments that Transform Lives), via Strategy I.2 (Enhance our Delivery of Comprehensive Interventions).

FISCAL IMPACT/FINANCING

There is no fiscal impact associated with the adoption of the MHSA Annual Update. DMH utilizes the budget process to appropriate the MHSA funds for use during the respective fiscal year.

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

AB 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. More specifically, AB 1467 amended the Welfare and Institutions Code and requires that each county mental health program prepare a MHSA Three-Year Program and Expenditure Plan and Annual Updates, which were to be adopted by the County Board of Supervisors and submitted to the Commission. AB 1467 also amended the Welfare and Institutions Code requiring that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be certified by the County Mental Health Director and the County Acting Auditor-Controller. This requirement includes the County Mental Health Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions. Additionally, the statute was amended to require that the MHSA Three-Year Program and Expenditure Plan and Annual Updates be circulated for public review and comment and that a public hearing be conducted at the close of the comment period. The Commission most recently provided direction to the counties to complete MHSA Annual Updates through a memo dated April 24, 2015, and distributed the MHSA Fiscal Accountability Certification Form to be completed by the County Mental Health Director and County Acting Auditor-Controller. The public hearing notice requirements referenced in Welfare and Institutions Code Section 5848 (a)

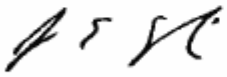
Los Angeles County Board of Supervisors Adopted Letter

and (b), have been satisfied and are recorded in the MHSA Annual Update for FY 2019-20. Additionally, DMH has complied with the certification requirements referenced in Welfare and Institutions Code Section 5847(b)(8) and (9). Compliance has been recorded in the MHSA Annual Update for FY 2019-20 via a signed MHSA Fiscal Accountability Certification Form.Additionally, with this update, there are many service expansions under way in Los Angeles County, some of which depend almost exclusively on funding from MHSA, including:• Resourcing and leveraging partners to increase access to care via home visits, schools, libraries, parks, health clinics, and other community platforms to mitigate the development and progression of mental illness and intervene as early possible;• Expansion of mobile outreach, engagement, and triage to homeless populations;• Doubling down and optimizing our investment in Full Service Partnerships to assist individuals experiencing mental illness to remain out of hospitals, off of the streets, and out of the jails;• Increasing the inventory of interim, permanent supportive and board and care housing;• Utilizing technology to diversify our mental health treatment options;• Providing trauma-informed and prevention related training to other County Departments, school staff and other community based providers to create a trauma-informed system of care;• Partnering with philanthropic partners to leverage funding and expertise to target specific at-risk, vulnerable populations, including children and youth in the foster care system, transgender youth, and men and boys of color;• Creating opportunities for capacity building and increased partnerships with grass-roots organizations to serve at-risk communities; and • Expansion of information and referral systems that can provide greater access and service navigation to individuals in need, while collecting meaningful data to inform the direction of future service investments.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2019-20 will ensure compliance with the MHSA, as amended by AB 1467, and allow for uninterrupted access to vital mental health services.

Respectfully submitted,



JONATHAN E. SHERIN, M.D., Ph.D.
Director

JES:ES:SK:pd

Enclosures

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

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
DTQI:	Depression Treatment Quality Improvement
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
IY:	Incredible Years
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
OMA:	Outcome Measures Application
OND:	Operation New Dawn
OQ:	Outcome Questionnaire
PATHS:	Providing Alternative Thinking Strategies
PCIT:	Parent-Child Interaction Therapy
PDAT:	Public Defender Advocacy Team
PE:	Prolonged Exposure
PEARLS:	Program to Encourage Active, Rewarding Lives for Seniors
PEI:	Prevention and Early Intervention
PEMR(s):	Probation Electronic Medical Records
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:	Su 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
TSV:	Targeted School Violence
UC:	Usual Care
UCC(s):	Urgent Care Center(s)
UCLA:	University of California, Los Angeles
UCLA TTM:	UCLA Ties Transition Model
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 December 2017.
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 December 2017.
Unique client means a single client claimed in the Integrated Behavioral Health Information System. Data as of December 2017.

Community Services & Supports

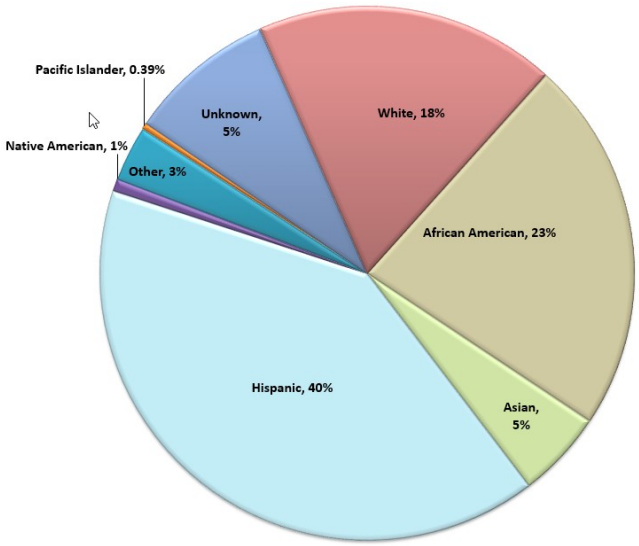
Full Service Partnership - Recovery Resilience & Reintegration - Alternative Crisis Services - Linkage - Housing - Planning Outreach & Engagement

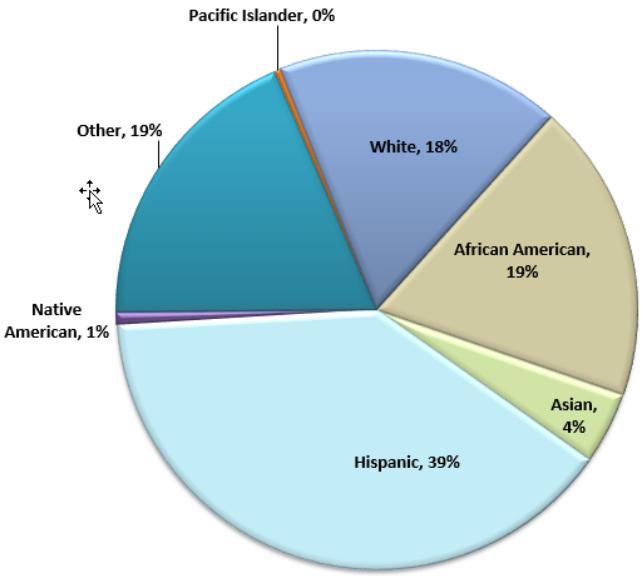
CLIENTS

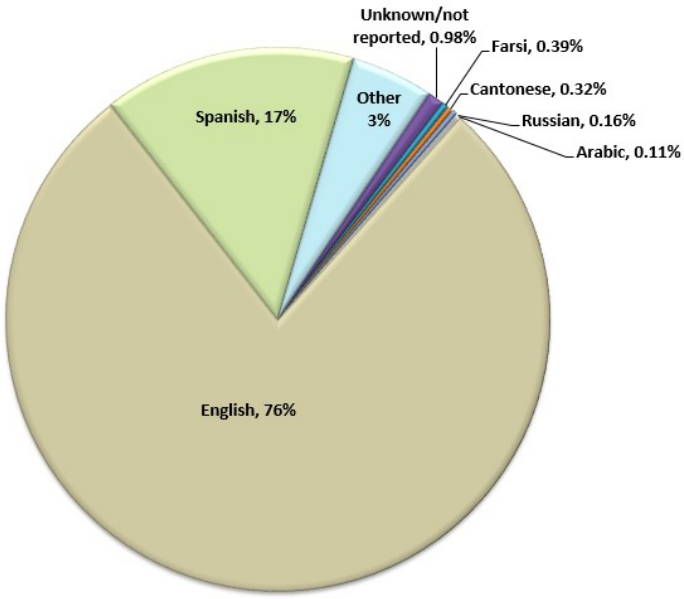
- 132,397 clients received a direct mental health service
- 40% of the clients are Hispanic
- 23% of the clients are African American
- 18% of the clients are White
- 5% of the clients are Asian
- 78% have a primary language of English
- 15% have a primary language of Spanish

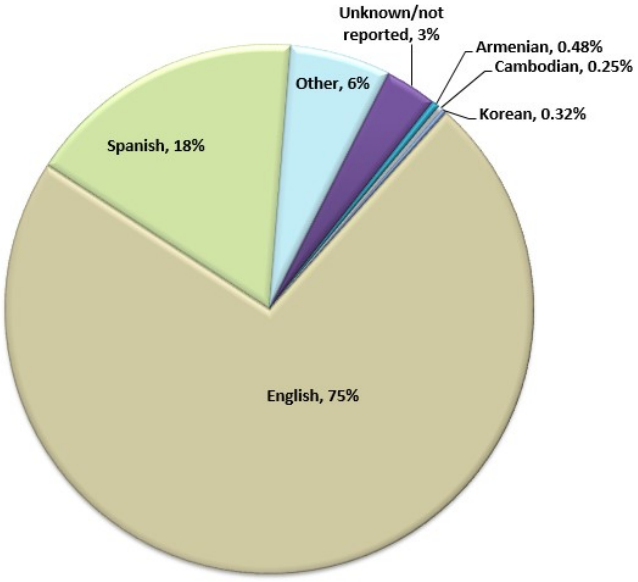
NEW CLIENTS

- 61,985 new clients receiving CSS services Countywide with no previous MHSA service
- 39% of the new clients are Hispanic
- 19% of the new clients are African American
- 18% of the new clients are White
- 75% have a primary language of English
- 18% have a primary language of Spanish

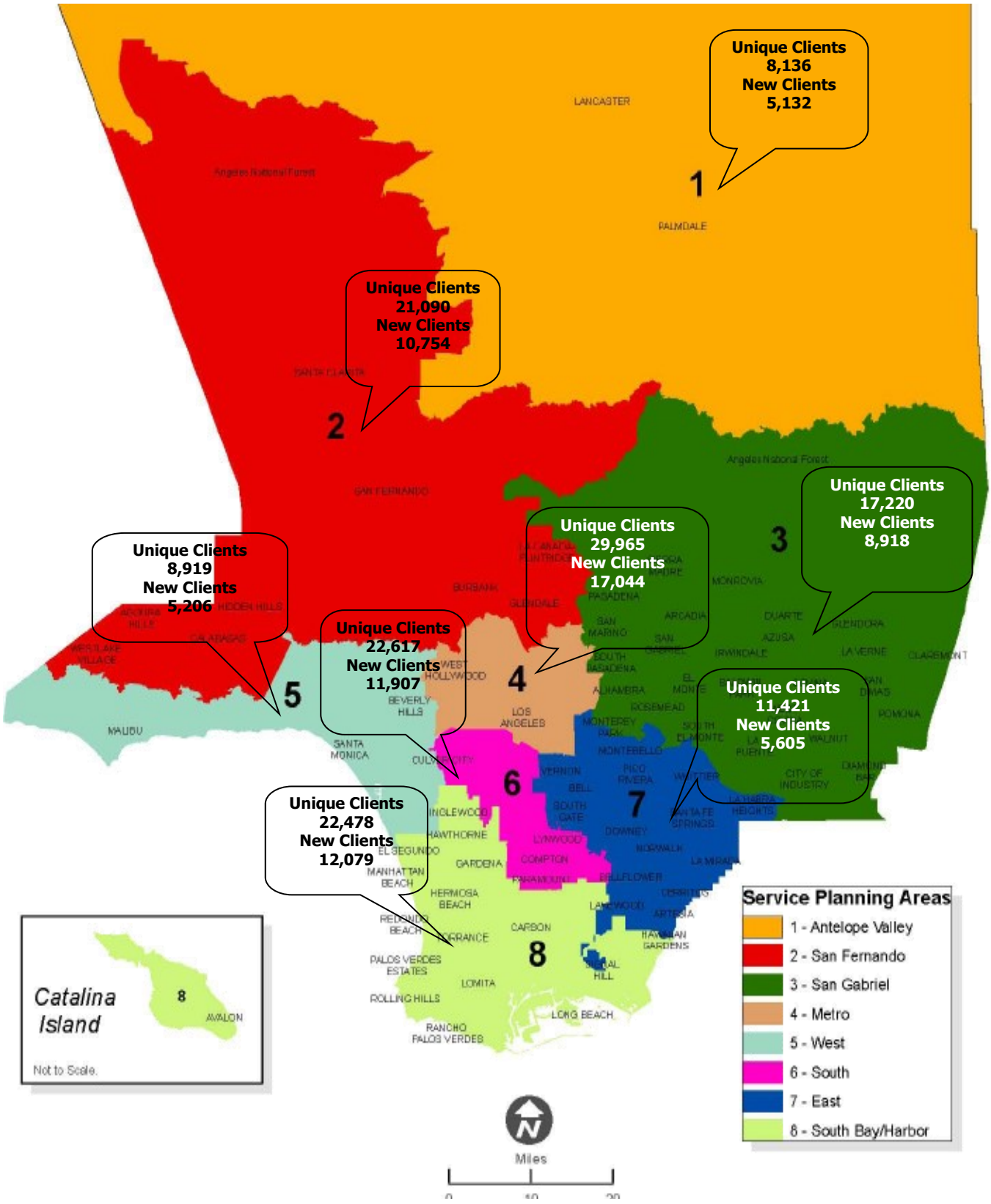




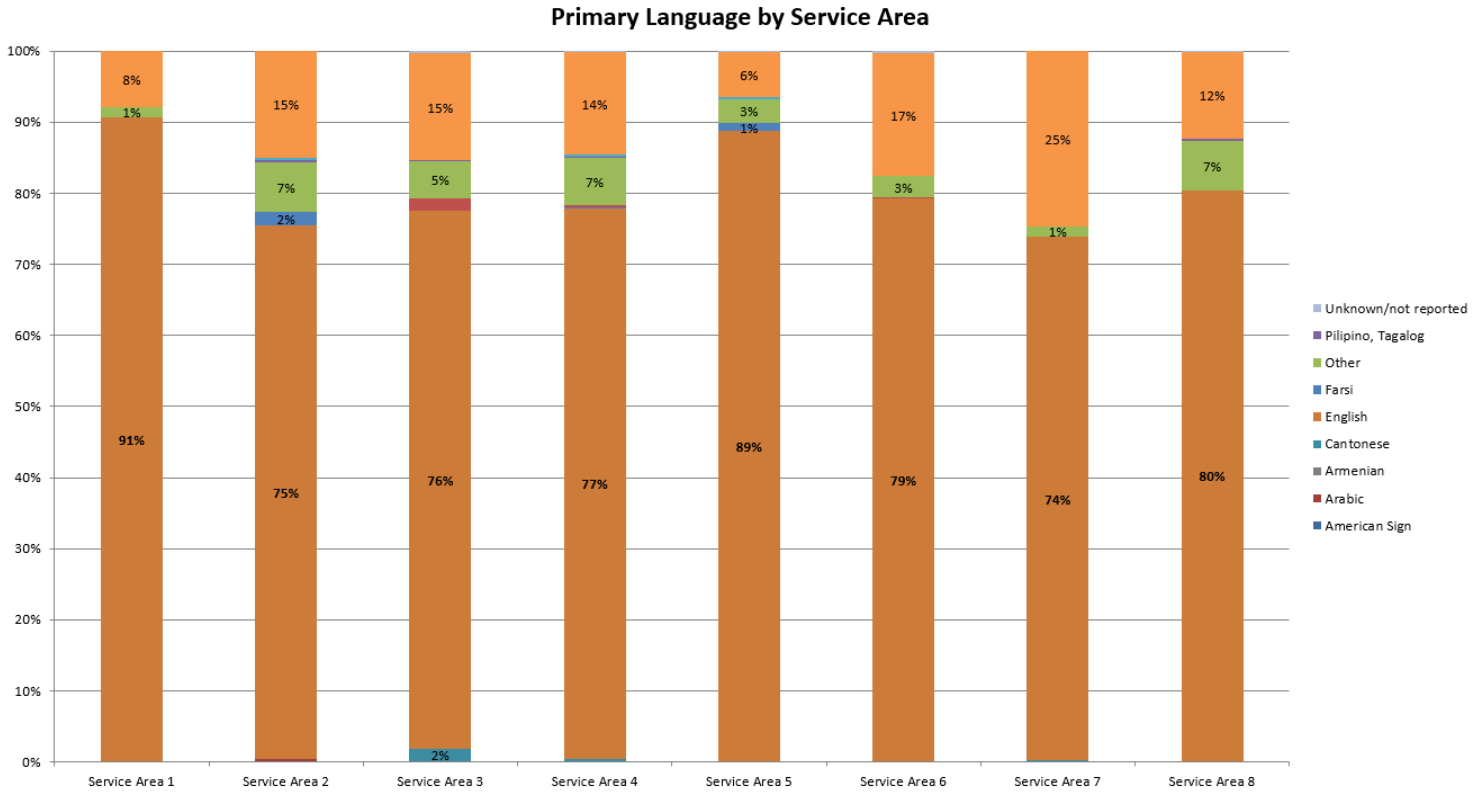


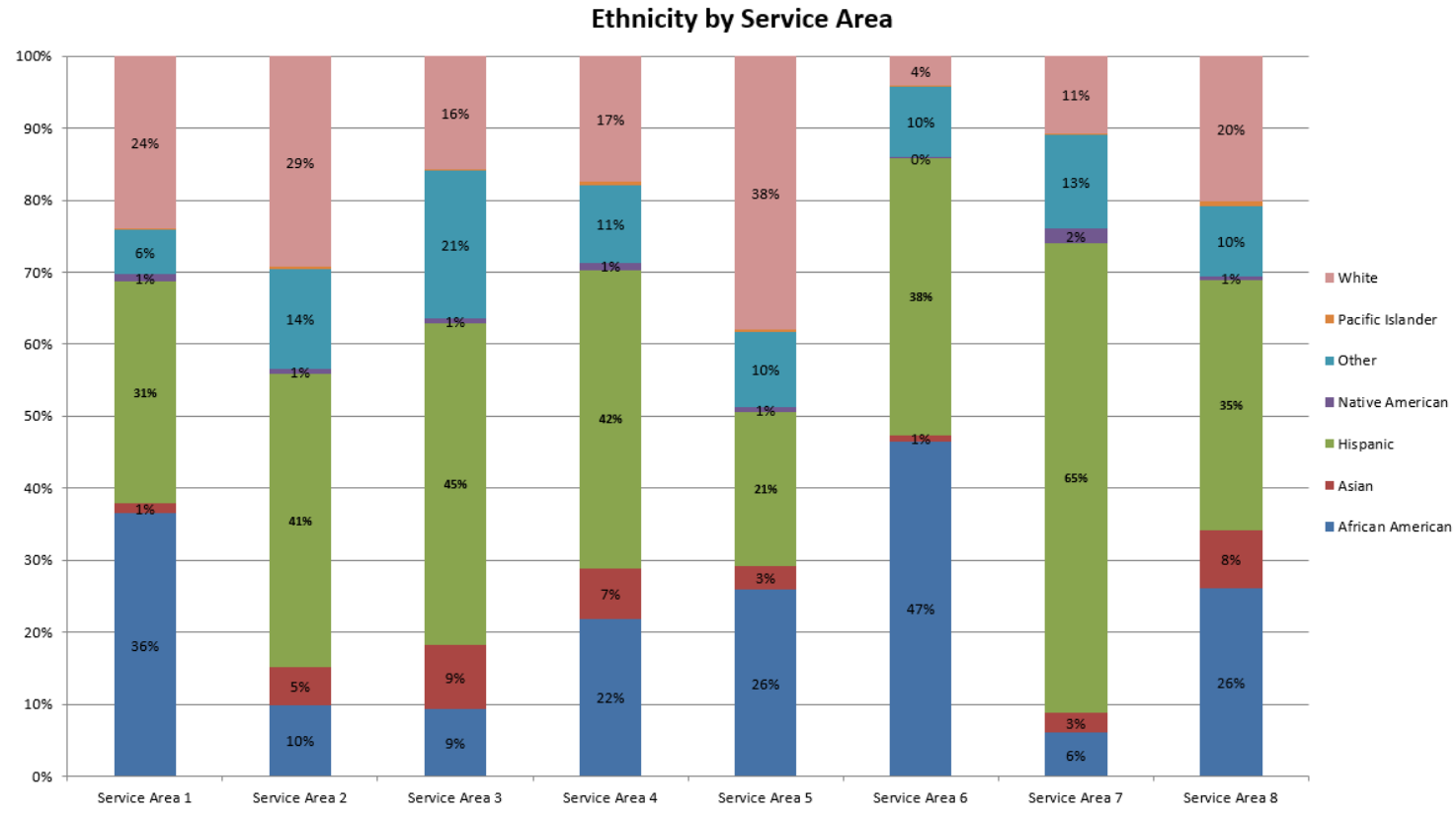


Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2017-18



Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2017-18





FULL SERVICE PARTNERSHIP

CHILDREN , TRANSITION AGE YOUTH , ADULT , AND OLDER ADULT

PROGRAMS & SLOTS

PROGRAM	SLOTS[1]
Child	2,070
Wraparound Child	523
Intensive Field Capable Clinical Services	765
TAY	1,395
Wraparound TAY	226
Adult	6,524
Integrated Mobile Health Team	300
Assisted Outpatient Treatment	300
Forensic	970
Homeless	1,630
Housing[6]	999
Older Adult	885

UNIQUE CLIENTS SERVED
Children[3] - 4,081
TAY[4] - 2,619
Adult[5] - 6,007
Older Adult - 1,566

AVERAGE COST PER CLIENT[2]
Children - $16,647
TAY - $12,306
Adult - $11,995
Older Adult - $8,900

[1] Slot allocation for FY 2018-19.
[2]Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.
[3] Children: unique clients served inclusive of Child and Wraparound Child & TAY FSP programs.
[4] TAY: unique clients served inclusive of TAY.
[5] Adult: unique clients served inclusive of Adult, Assisted Outpatient Treatment (AOT), Integrated Mobile Health Team (IMHT), Homeless, and Forensic FSP programs.
6 Homeless: Services implemented FY 2018-19.

FOCAL POPULATION

Children, Ages 0-15
with serious emotional disturbance (SED) and

- 0-5 who is 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 is transitioning back into a less structured home/community setting.

Transition Age Youth, 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.

Adult, Ages (26-59)
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);
- living with family members without whose support the individual should be at imminent risk of homelessness, jail or institutionalization.

Older Adult, Ages (60+)
serious mental illness and one or more of the following risks:

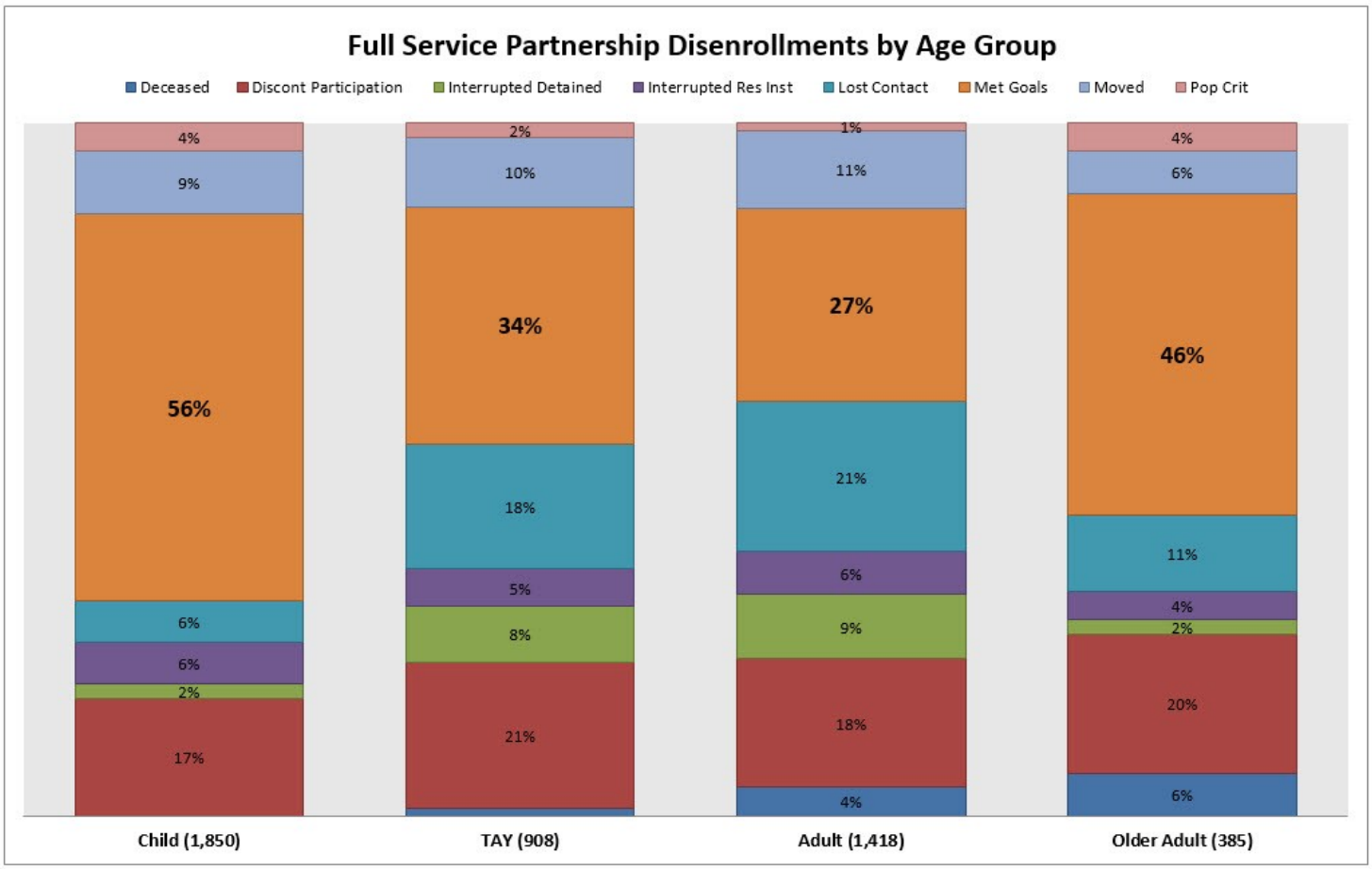
- homeless or at imminent risk of homelessness;
- hospitalizations; jail or at risk of going to jail;
- imminent risk for placement in a skilled nursing facility (SNF) or nursing home or being released from SNF/nursing home;
- presence of a co-occurring disorder;
- serious risk of suicide or recurrent history;
- or is at risk of abuse or self-neglect

FULL SERVICE PARTNERSHIP

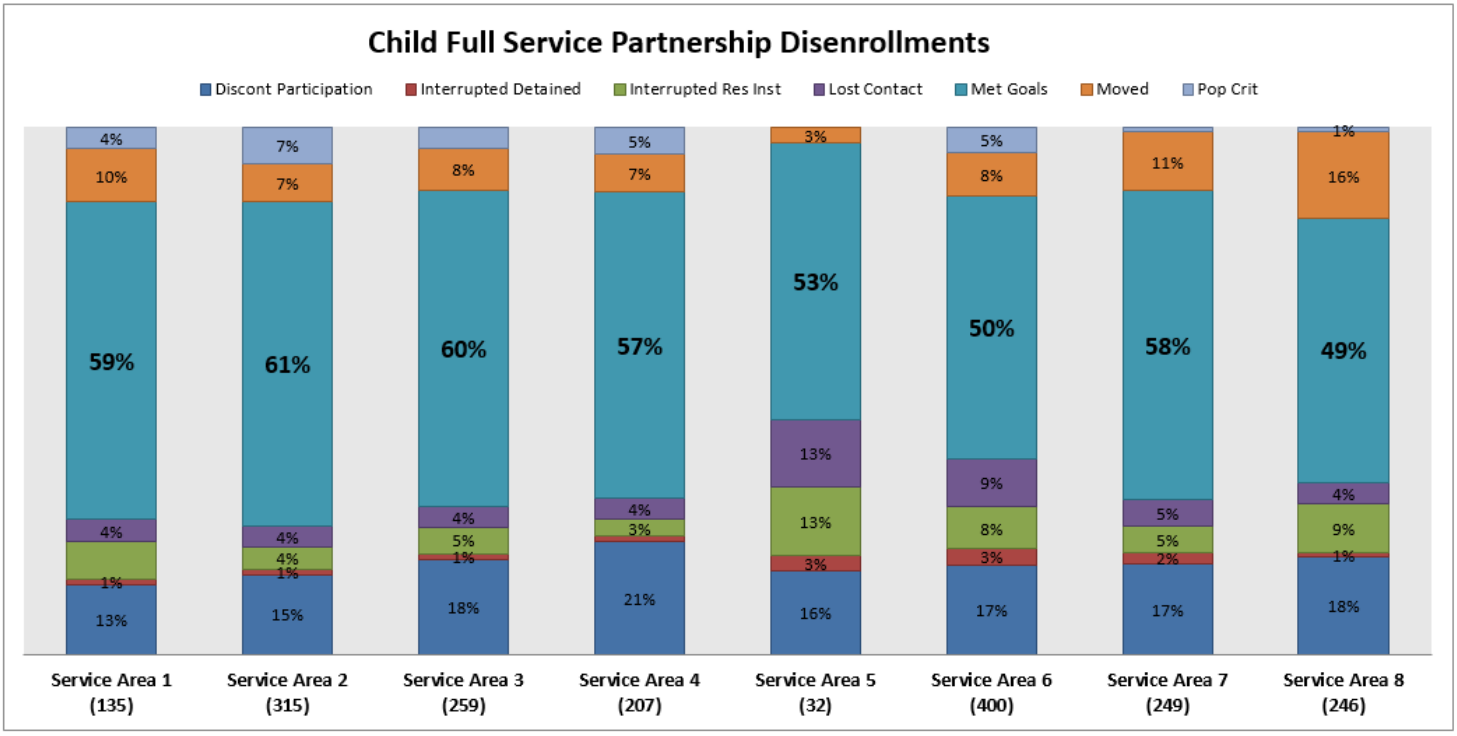
DISENROLLMENTS FY 2017-18

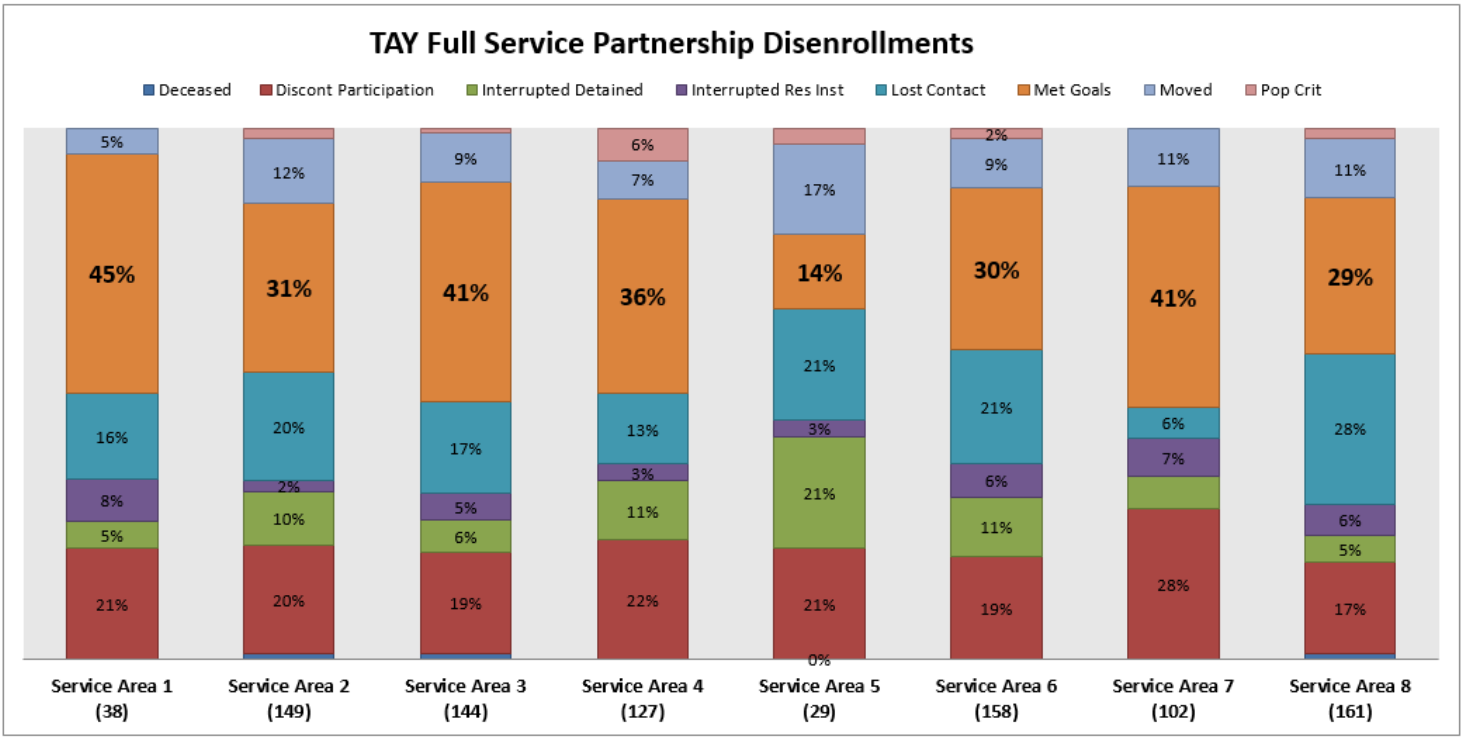
Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to FSP 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, refused services after enrolling, or no longer wishes to participate in FSP.
3. Client moved to another county/service area. Client relocated to a geographic area either outside or within L.A. County, and will not be receiving FSP services of any type anywhere in Los Angeles County.
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/DOJJ/jail/prison sentence. Client is anticipated to remain in one of these facilities for over ninety (90) days.
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 and is ready to receive services at a lower level of care.
8. Client is deceased. This includes clients who died from either natural or unnatural causes after their date of enrollment.

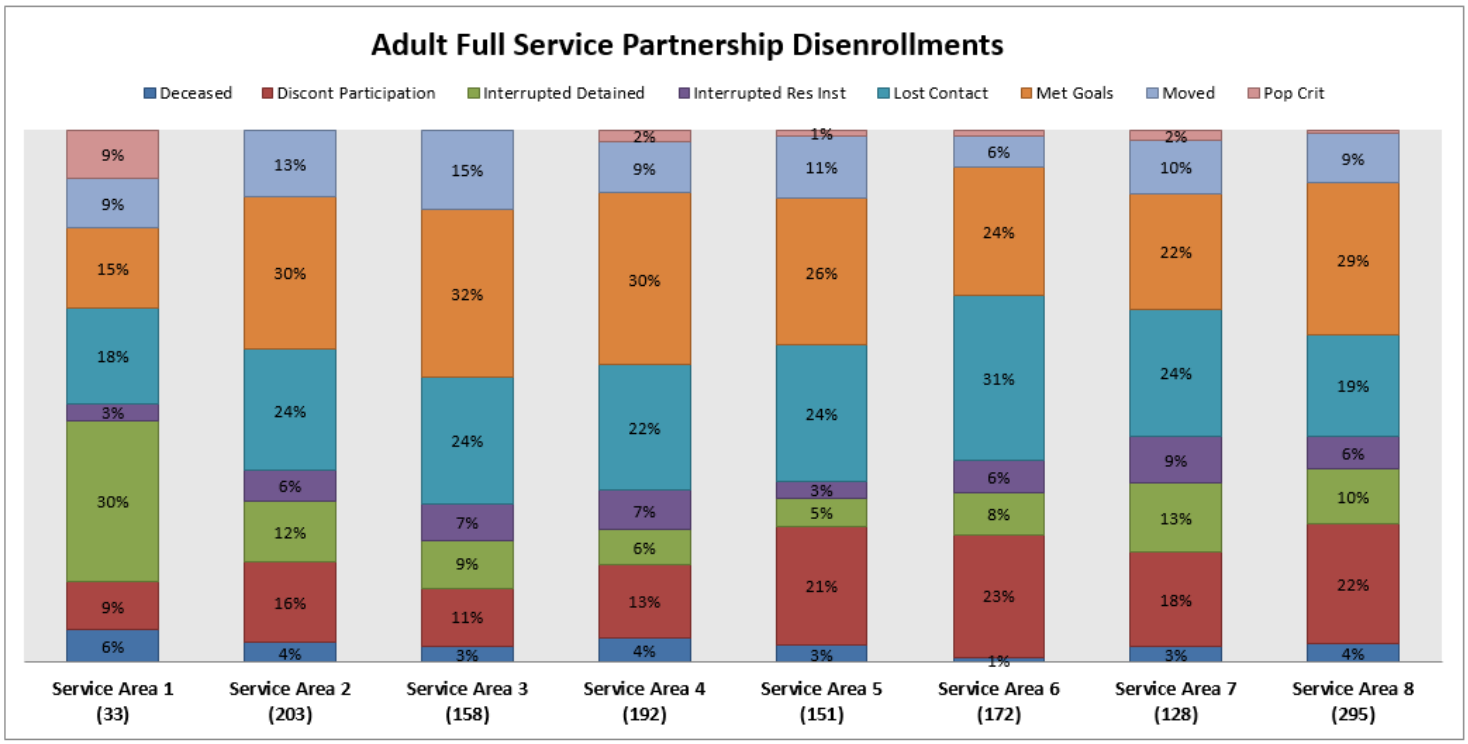


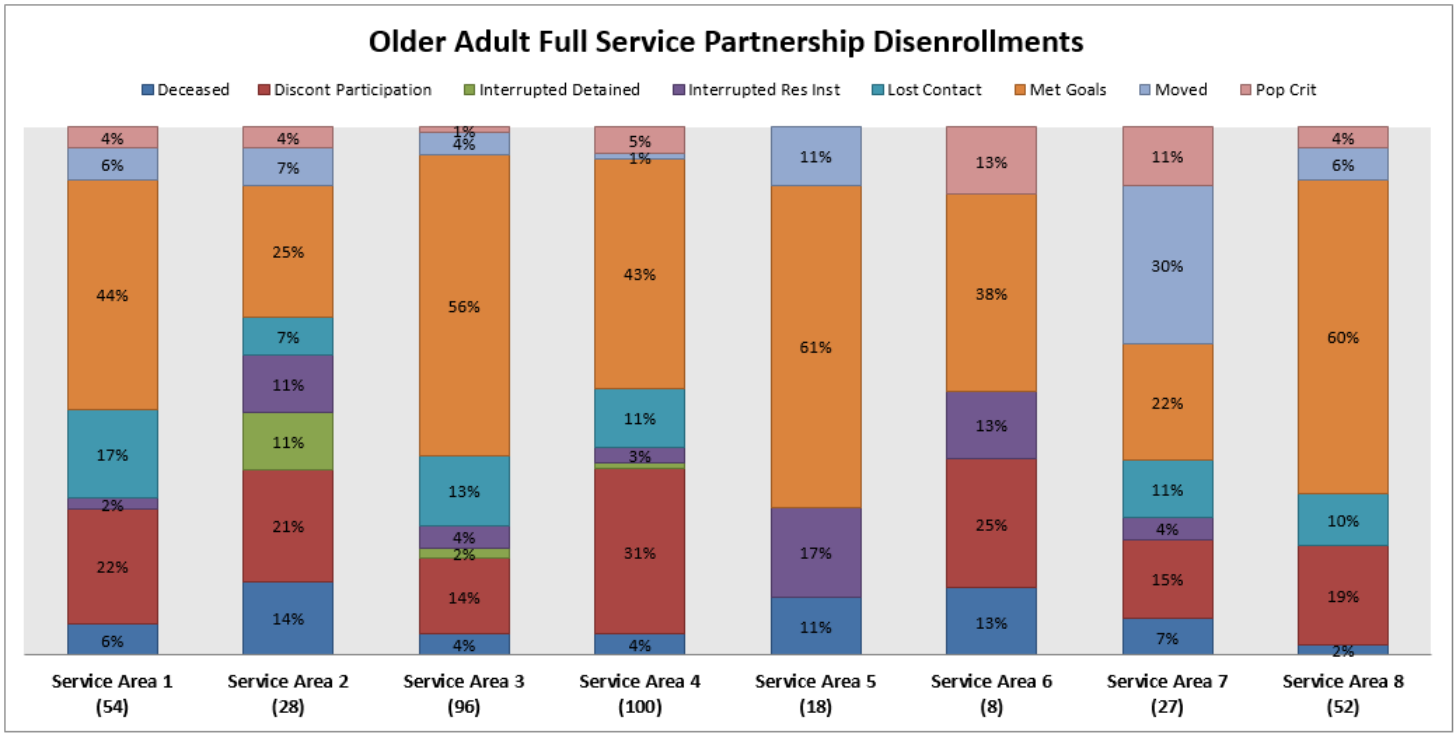
DISENROLLMENTS CONTINUED





DISENROLLMENTS CONTINUED





RESIDENTIAL OUTCOMES

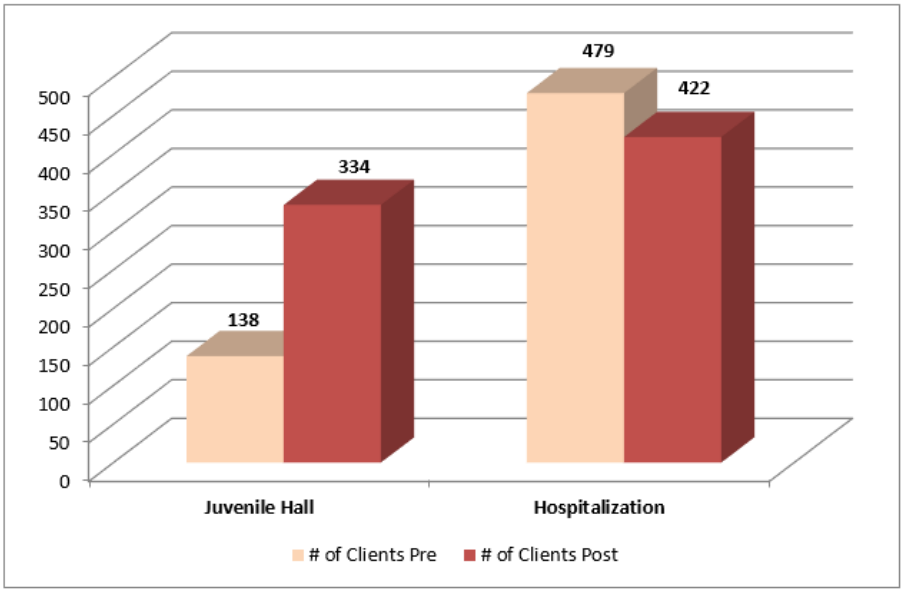
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2018. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis. See Appendix for a list of reasons data does not meet reporting standards.

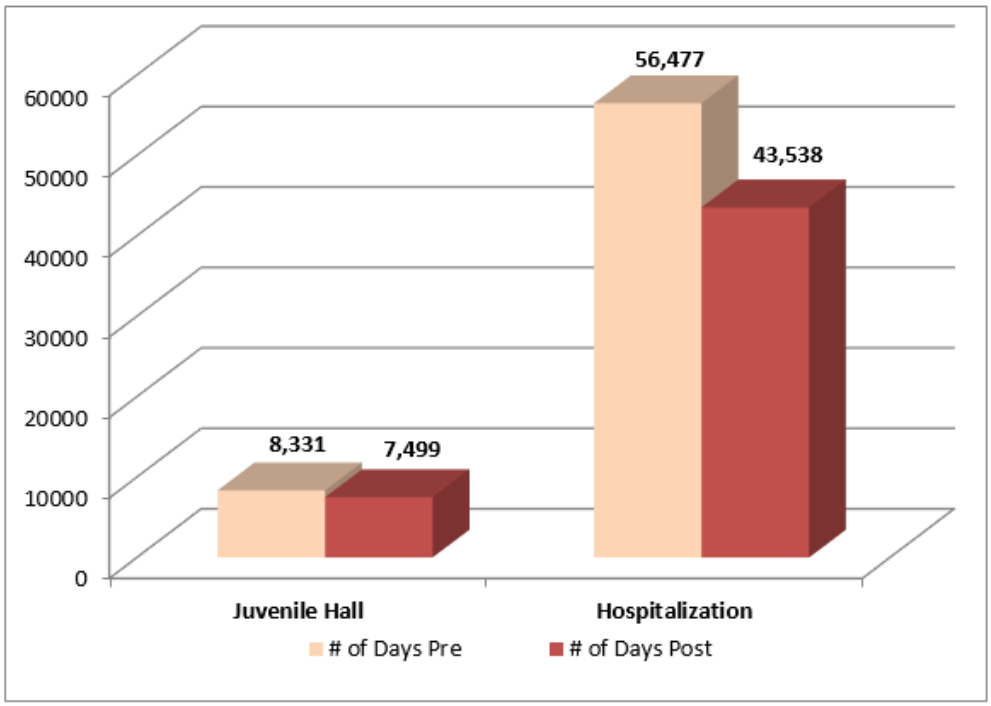
CHILD FSP

NUMBER OF BASELINES: 9,504
NUMBER OF CLIENTS: 9,234

- 23% reduction in days hospitalized
- 10% reduction in days in juvenile hall
- 12% reduction in the number of clients hospitalized
- 142% increase in the number of clients in juvenile hall*

* There was a 142% increase in the number of clients in juvenile hall post-partnership. Data indicates 138 children (approximately 1.5% of the baselines included) reported being in juvenile hall 365 days prior to partnership and 334 children (approximately 3.5% of the baselines included) after partnership was established.

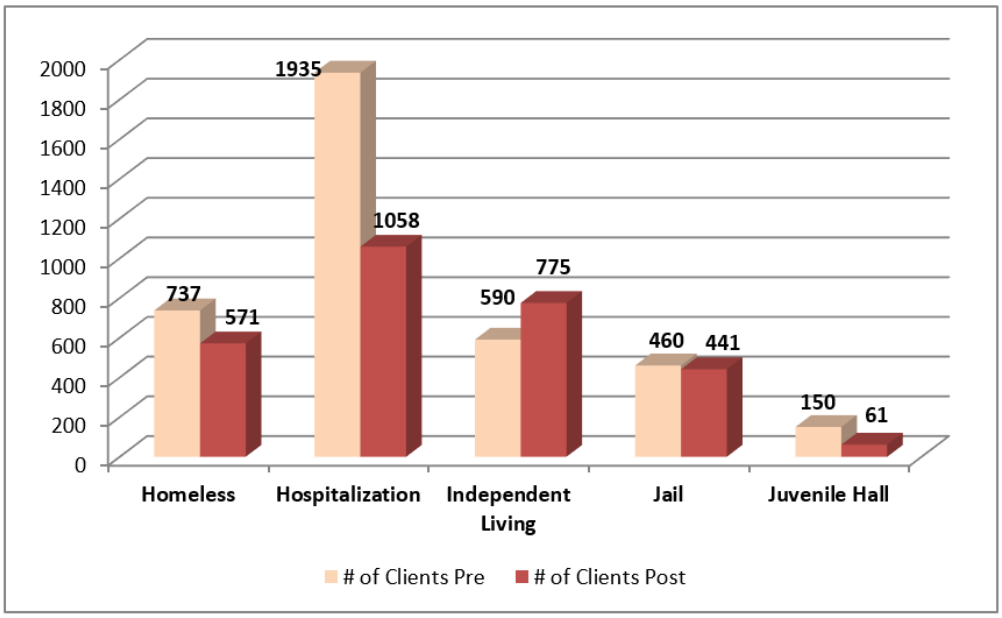


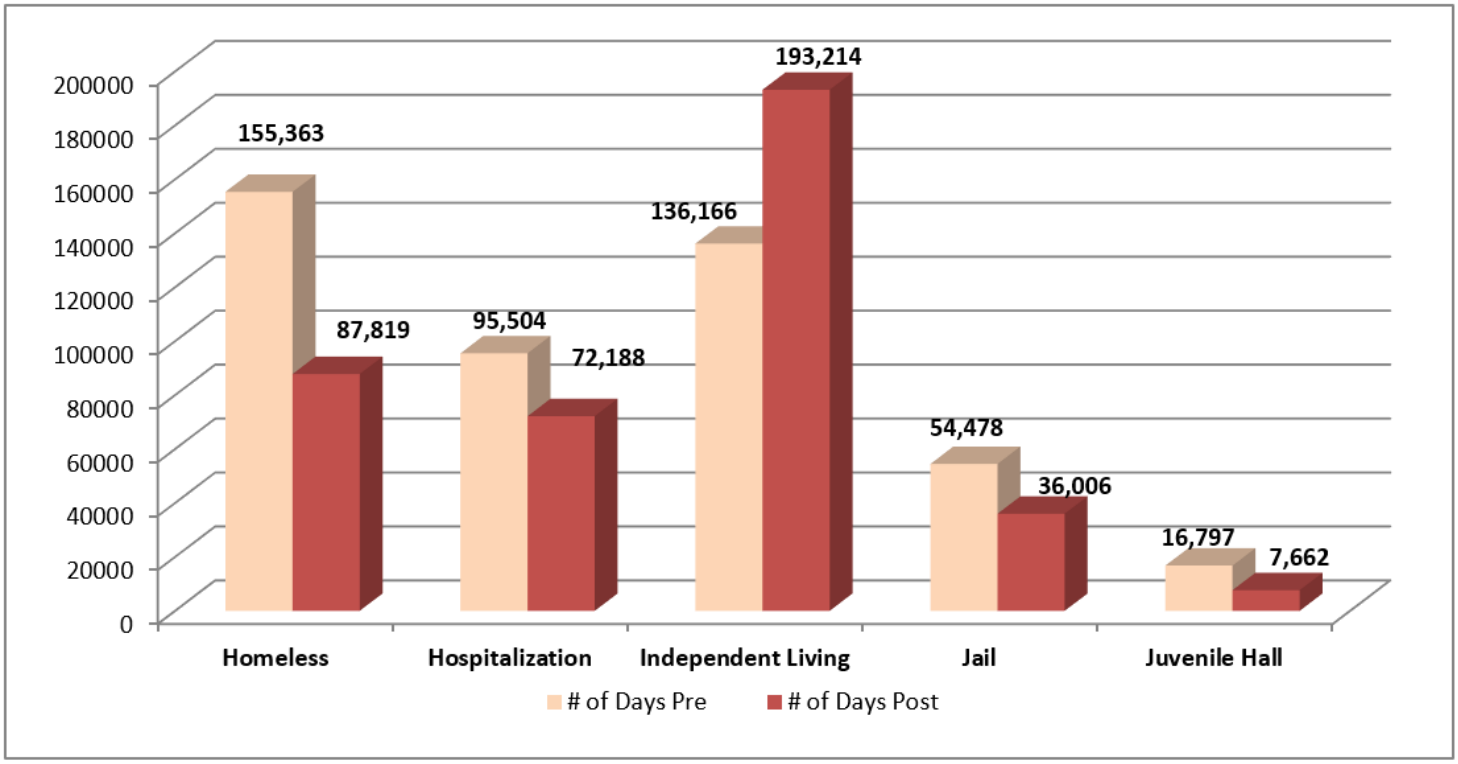


RESIDENTIAL OUTCOMES
CONTINUED

TAY FSP
NUMBER OF BASELINES: 4,907
NUMBER OF CLIENTS: 4,762

- 43% reduction in days homeless
- 24% reduction in days hospitalized
- 34% reduction in days in jail
- 41% increase in days living independently
- 54% reduction in days in juvenile hall
- 23% reduction in clients homeless
- 45% reduction in clients hospitalized
- 4% reduction in clients in jail
- 60% reduction in clients in juvenile hall
- 31% increase in clients living independently

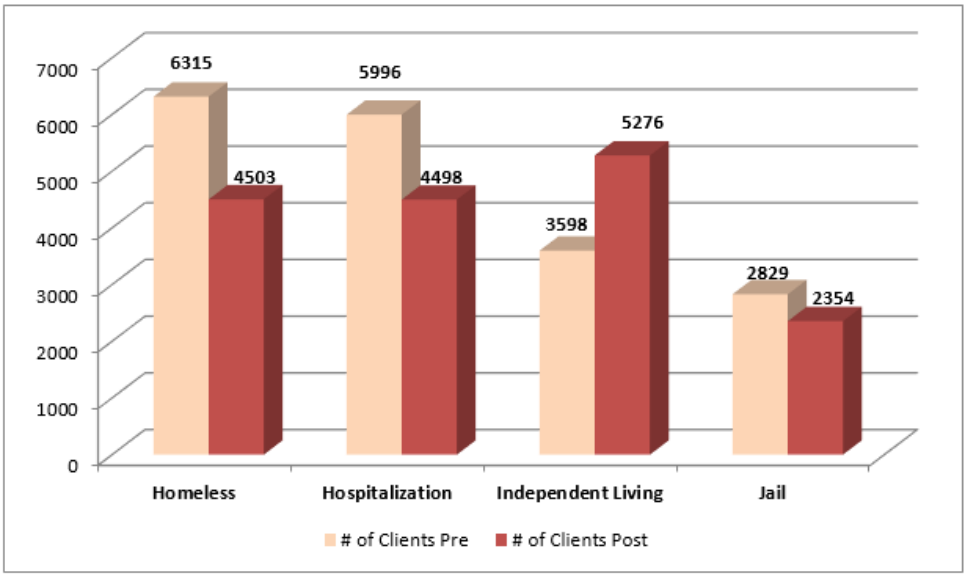


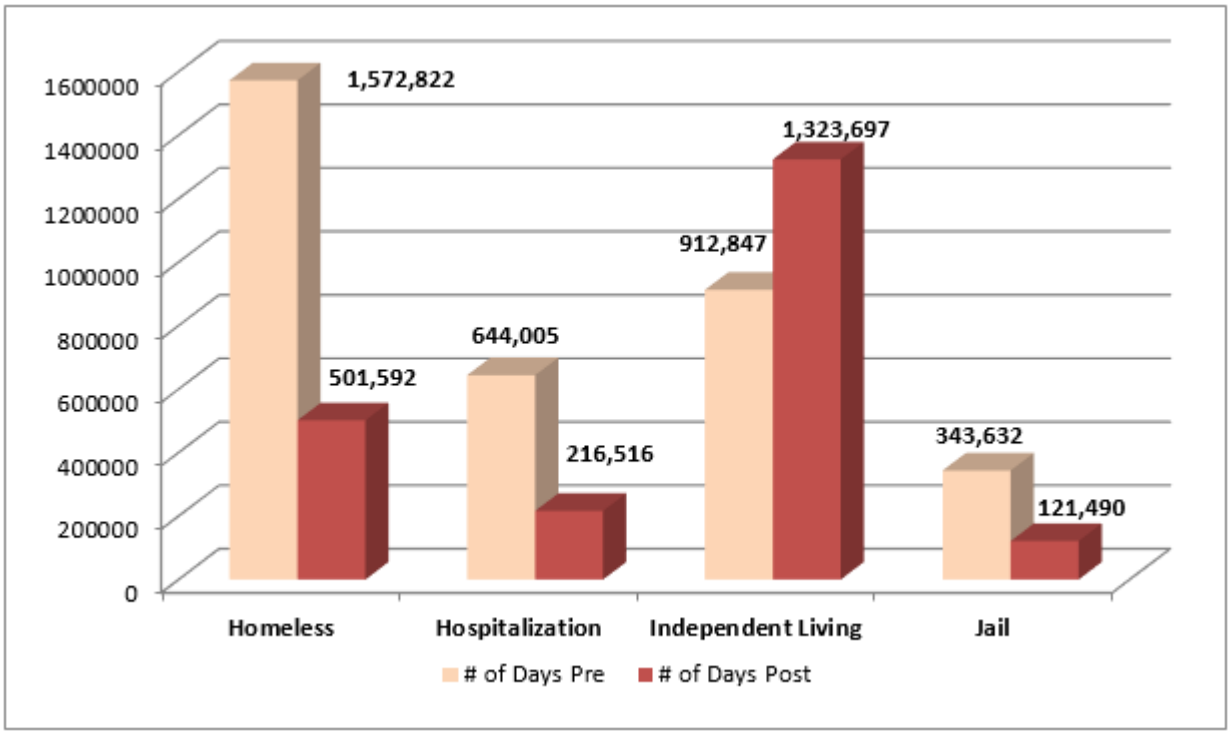


RESIDENTIAL OUTCOMES
CONTINUED

ADULT FSP
NUMBER OF BASELINES: 14,503
NUMBER OF CLIENTS: 13,713

- 68% reduction in days homeless
- 66% reduction in days hospitalized
- 65% reduction in days in jail
- 45% increase in days living independently
- 29% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently

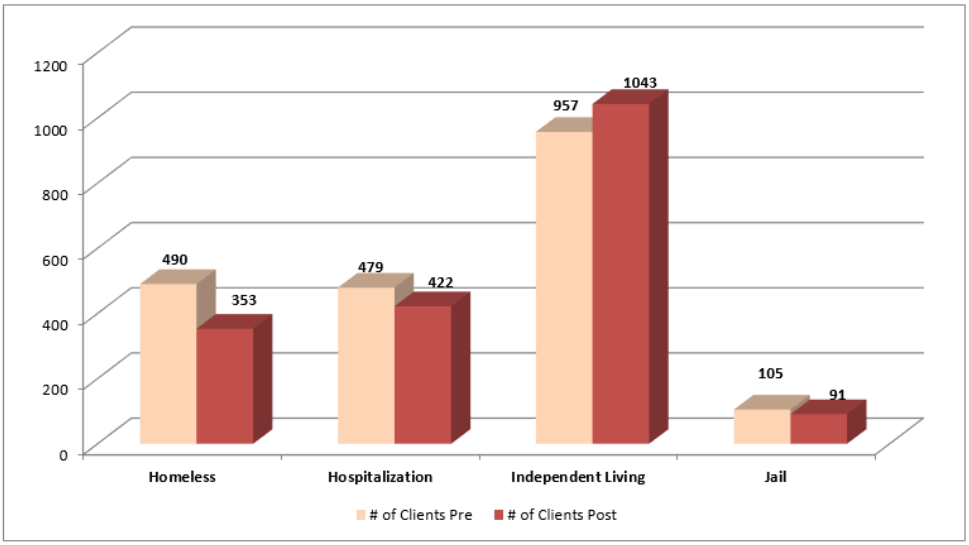


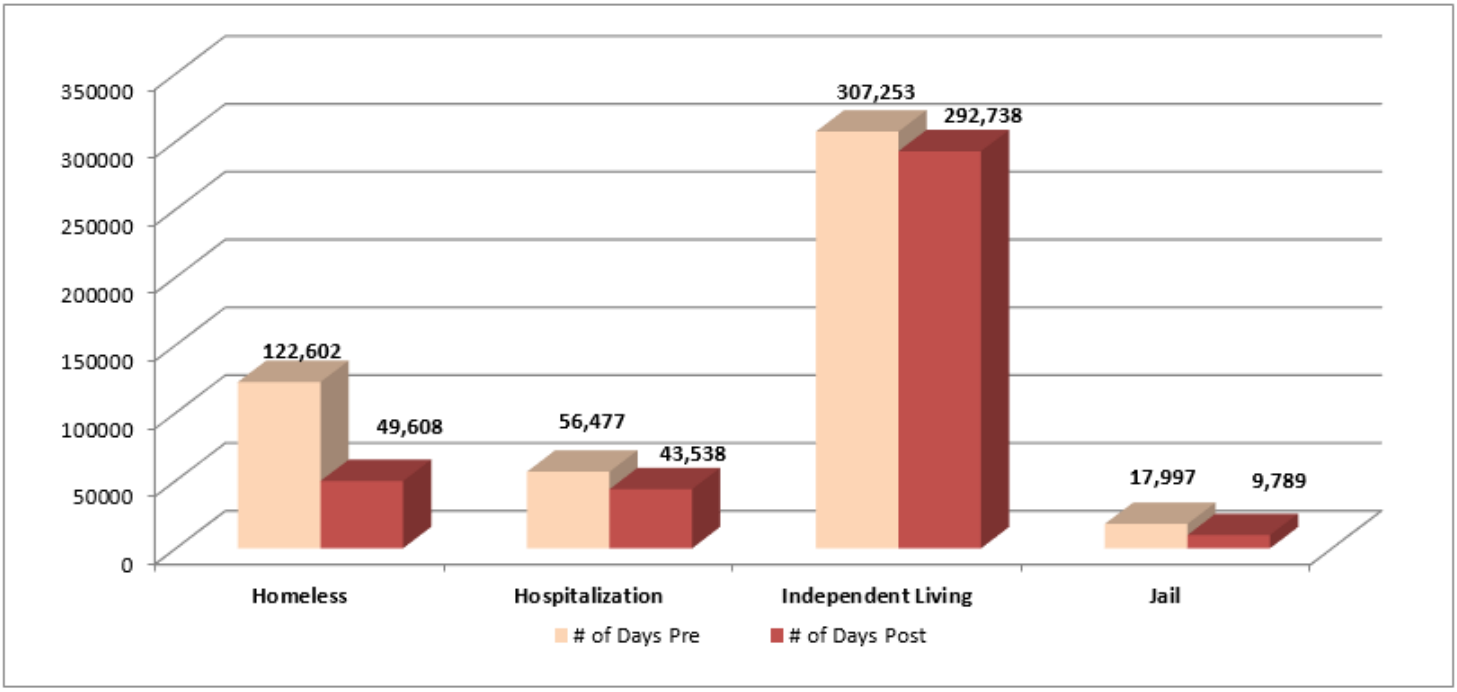


RESIDENTIAL OUTCOMES
CONTINUED

OLDER ADULT FSP
NUMBER OF BASELINES: 1,757
NUMBER OF CLIENTS: 1,715

- 60% reduction in days homeless
- 23% reduction in days hospitalized
- 5% reduction in days living independently
- 46% reduction in days in jail
- 28% reduction in clients homeless
- 12% reduction in clients hospitalized
- 8% increase in clients living independently
- 13% reduction in clients in jail

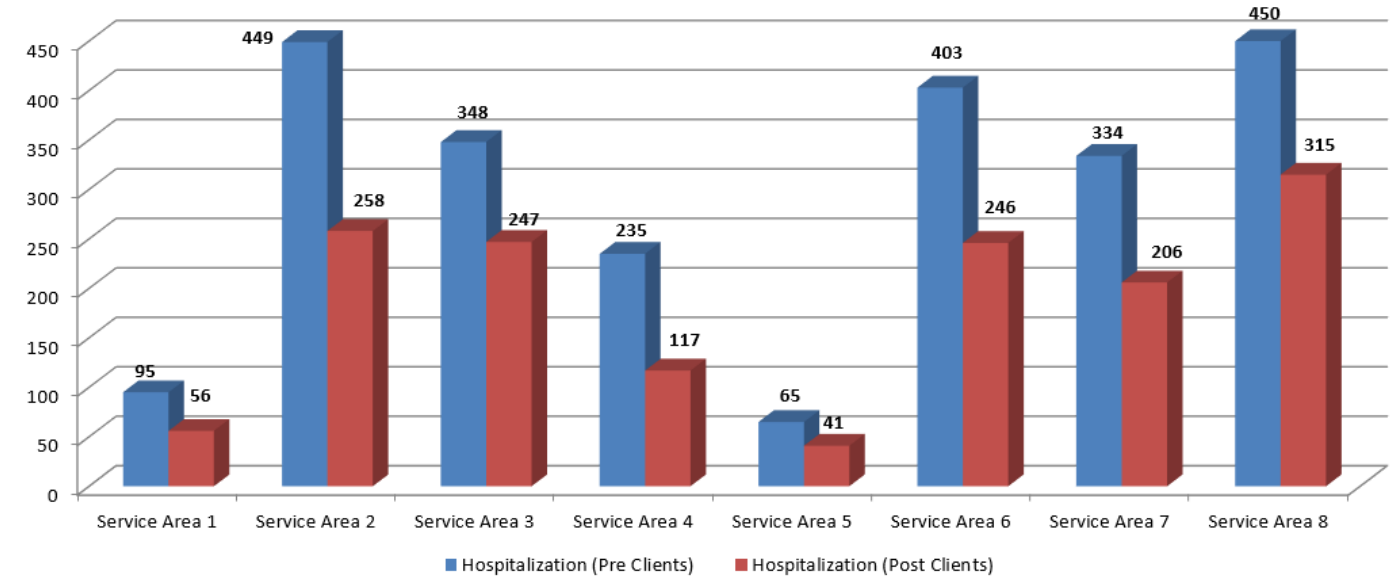


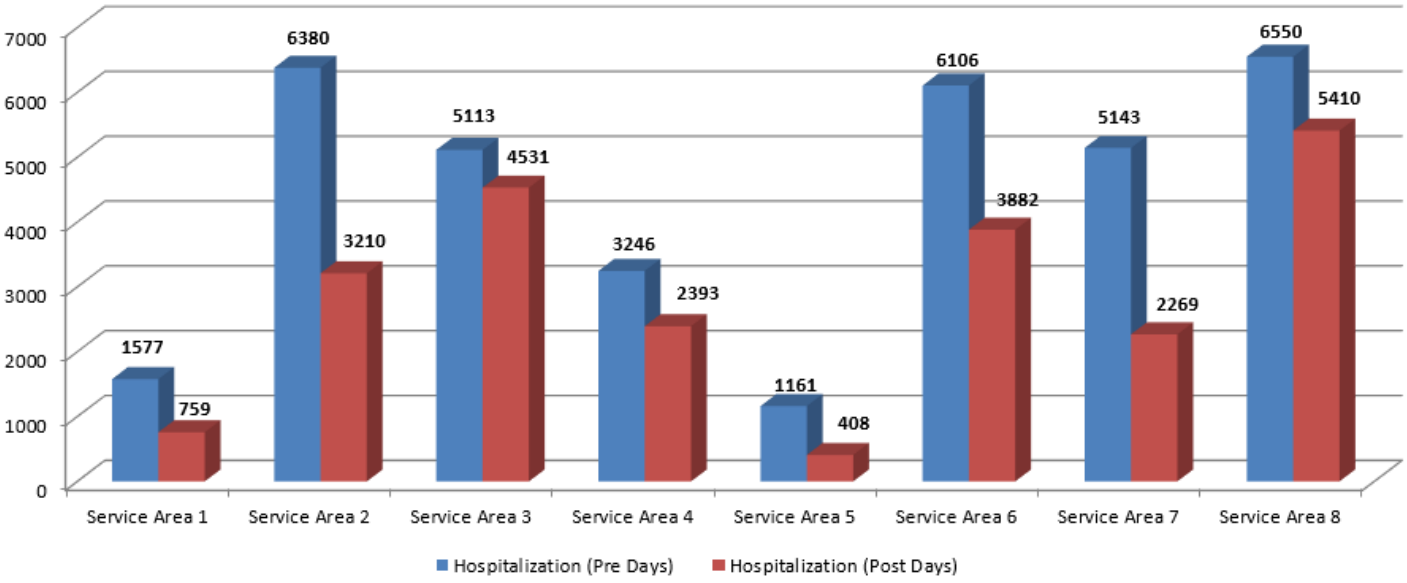


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 4 has the highest percent (50%) reduction in clients hospitalized post-partnership
- ◊ Service Area 5 has the highest percent reduction (65%) in hospital days post-partnership

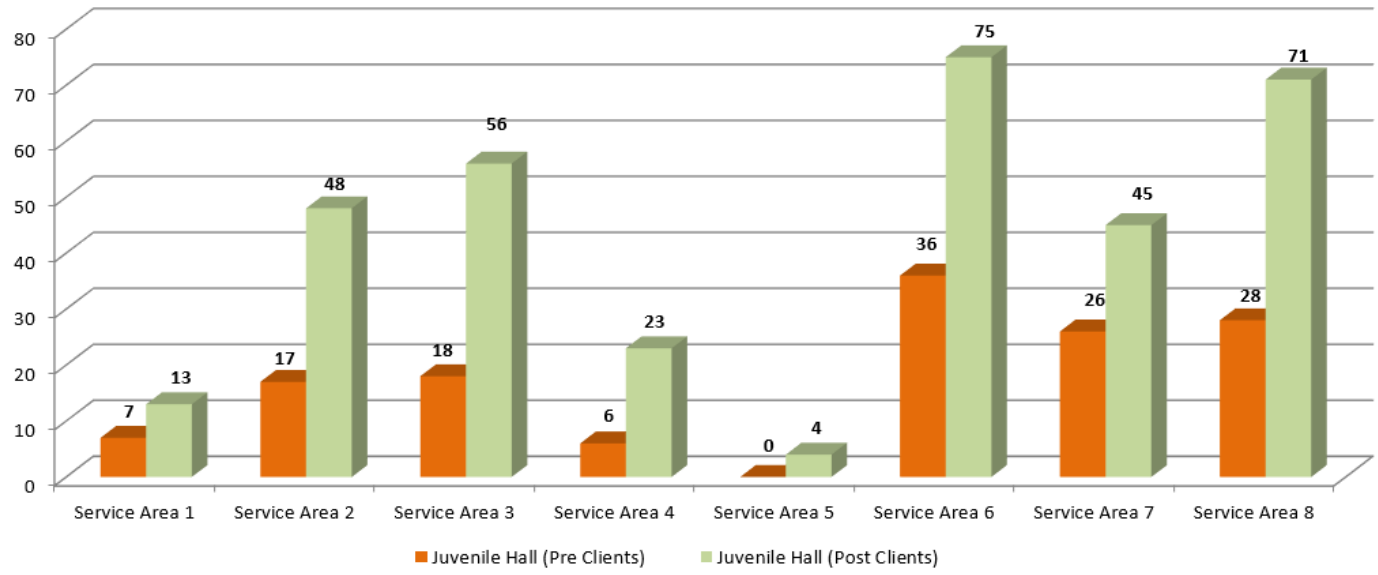


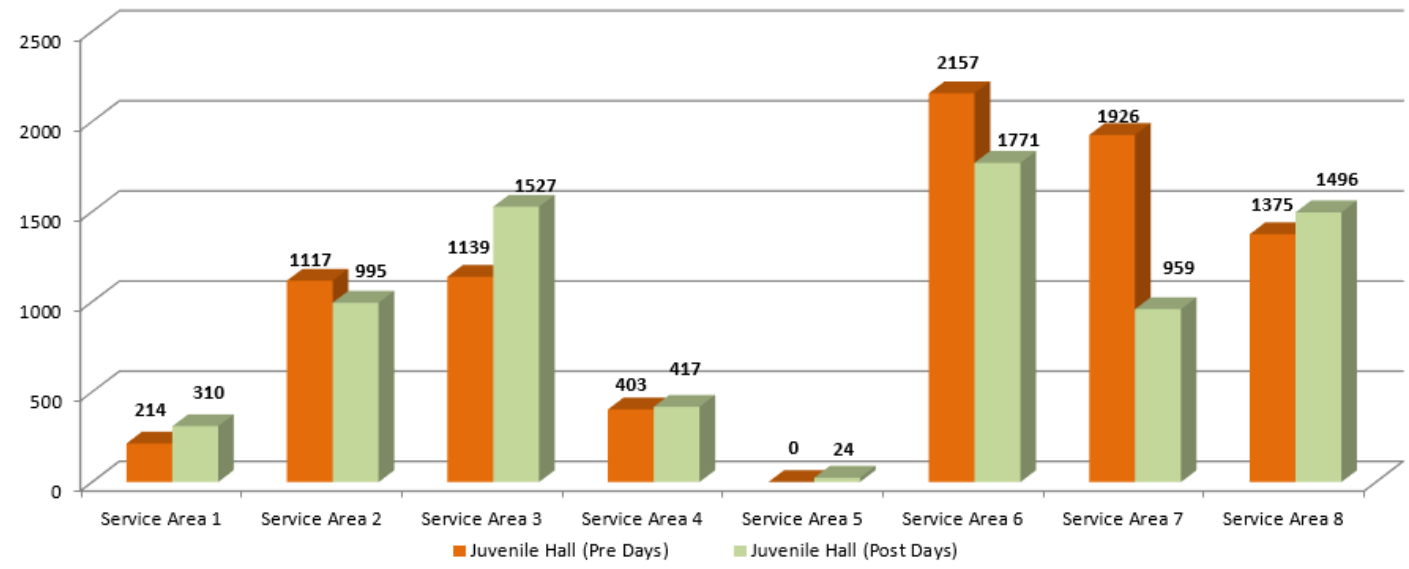


RESIDENTIAL OUTCOMES BY SERVICE AREA

CHILD JUVENILE HALL

- Service Area 8 has the most increase in the number of clients in juvenile hall from pre to post.
- Service Area 7 has the most reduction (50%) in the number of days in juvenile hall from pre to post.

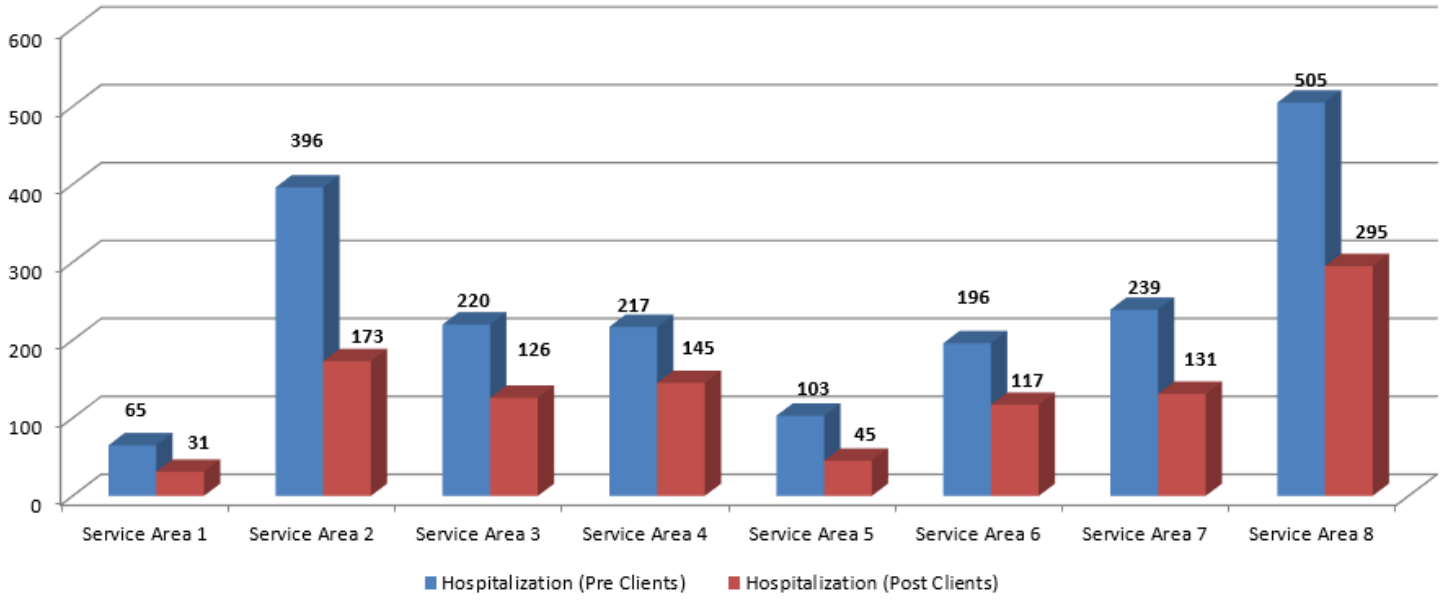


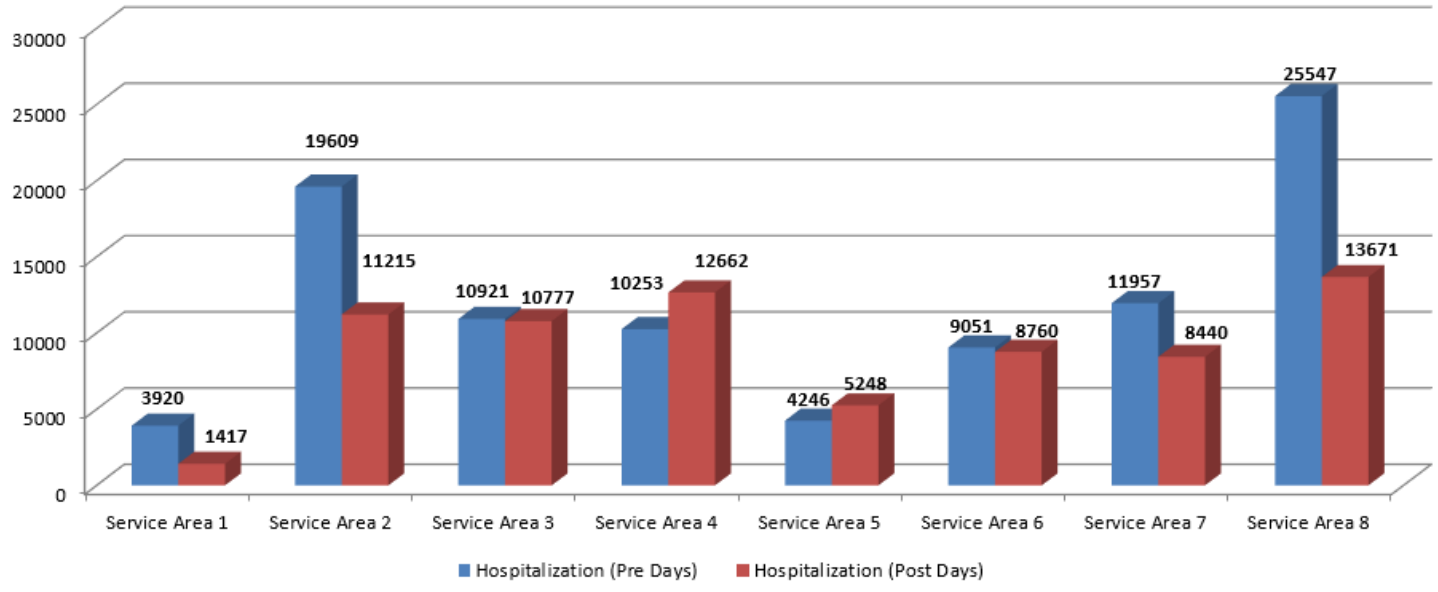


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients hospitalized post-partnership
- ◊ Service Areas 2 and 5 have the highest percent (56%) reduction in clients hospitalized post-partnership
- ◊ Service Area 8 has the most clients hospitalized pre-partnership (505) and post-partnership (295) with a 22% percent reduction
- ◊ Service Area 1 has the highest percent reduction (62%) in hospital days post-partnership
- ◊ Service Area 8 has the most days spent in hospitalized pre-partnership (25,547) and post-partnership (13,671) with a 46% percent reduction.

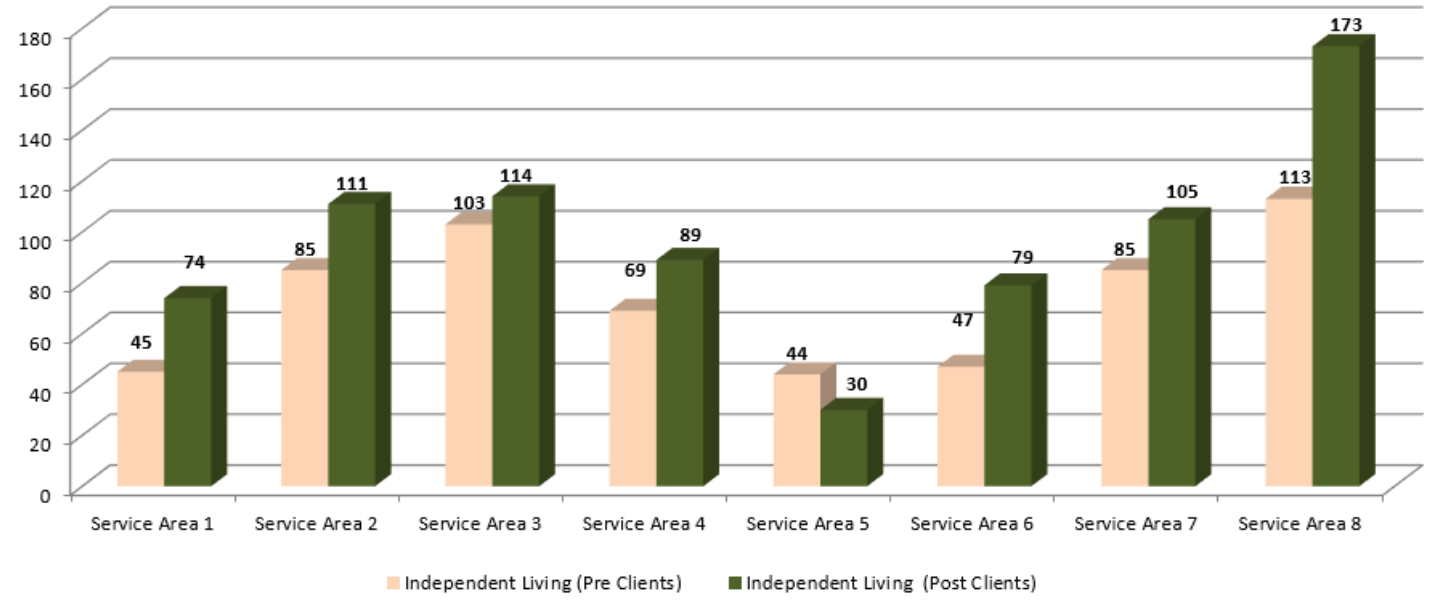


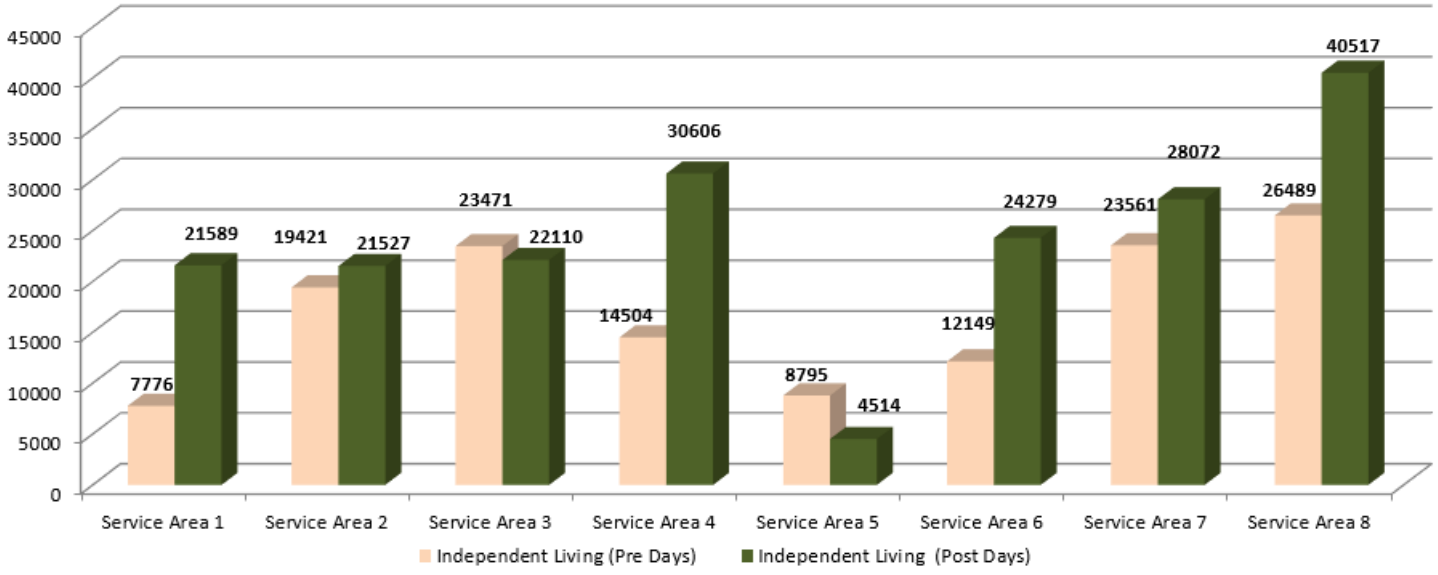


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY INDEPENDENT LIVING

- Service Area 8 has the highest number of clients living independently post partnership, 173
- Service Area 6 has the most percent increase in clients (68%) living independently post-partnership
- Service Area 1 has the most percent increase in days living independently, 178%

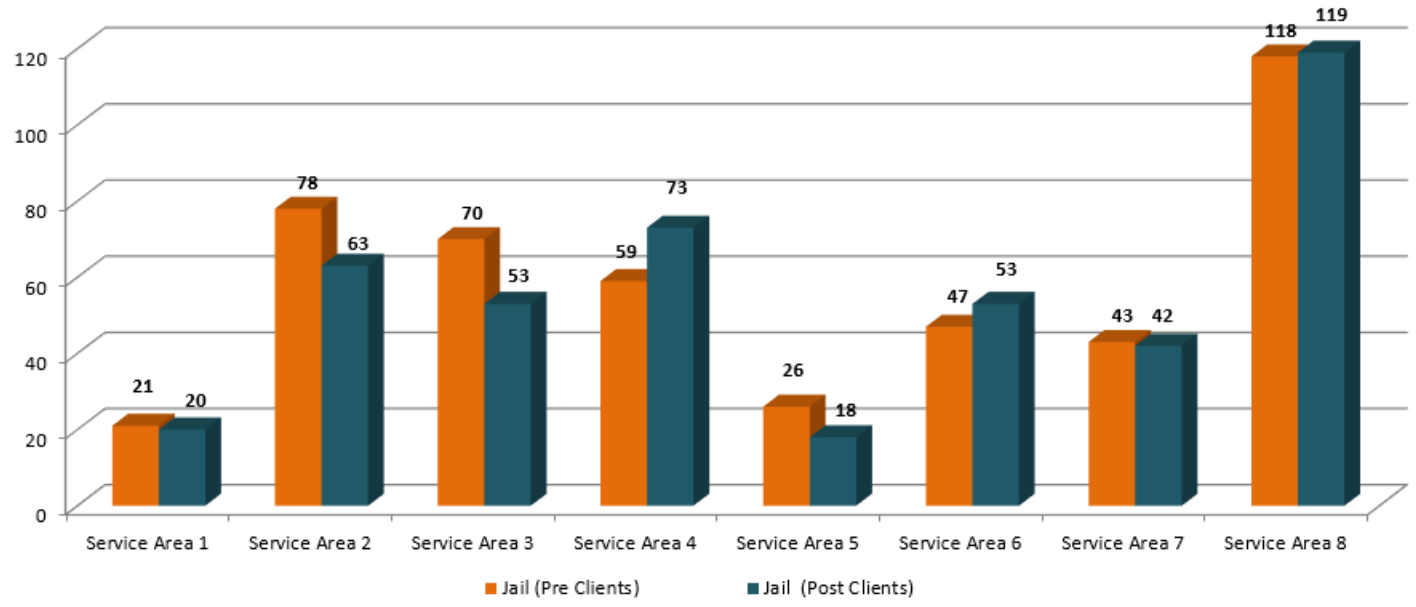


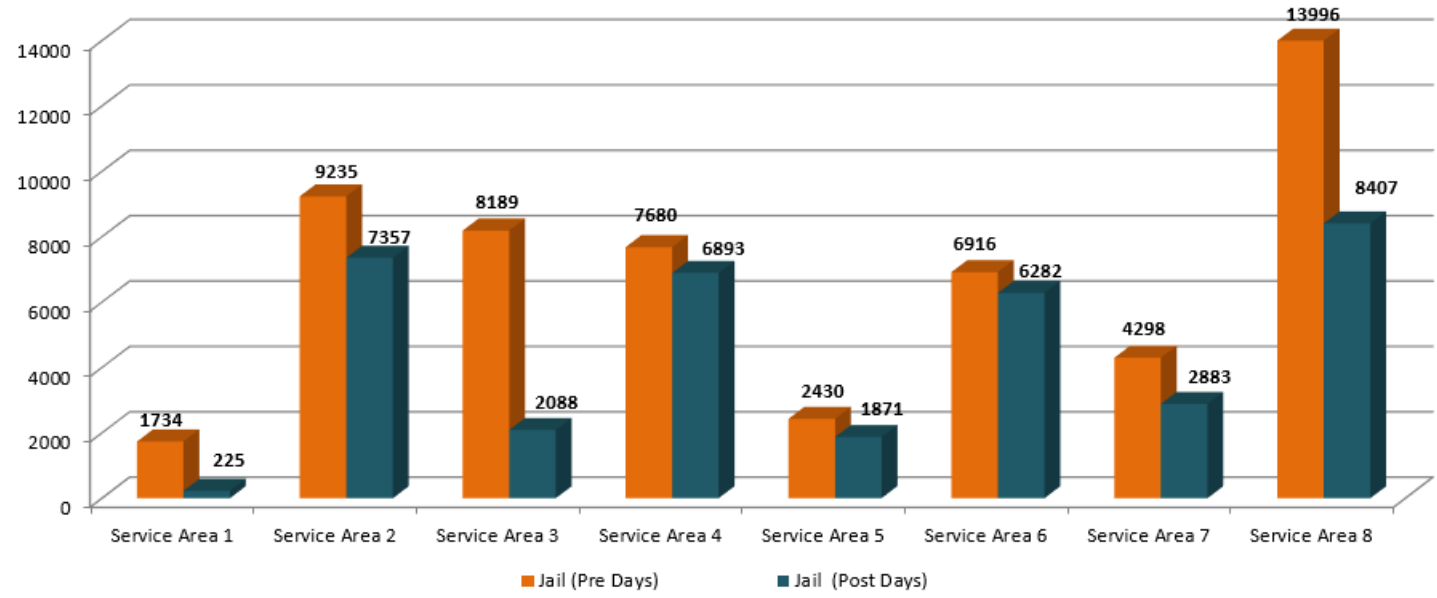


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY JAIL

- Service Area 5 has the highest percent (31%) reduction of clients in jail post-partnership
- Service Area 1 has the highest percent (87%) reduction of days spent in jail post-partnership

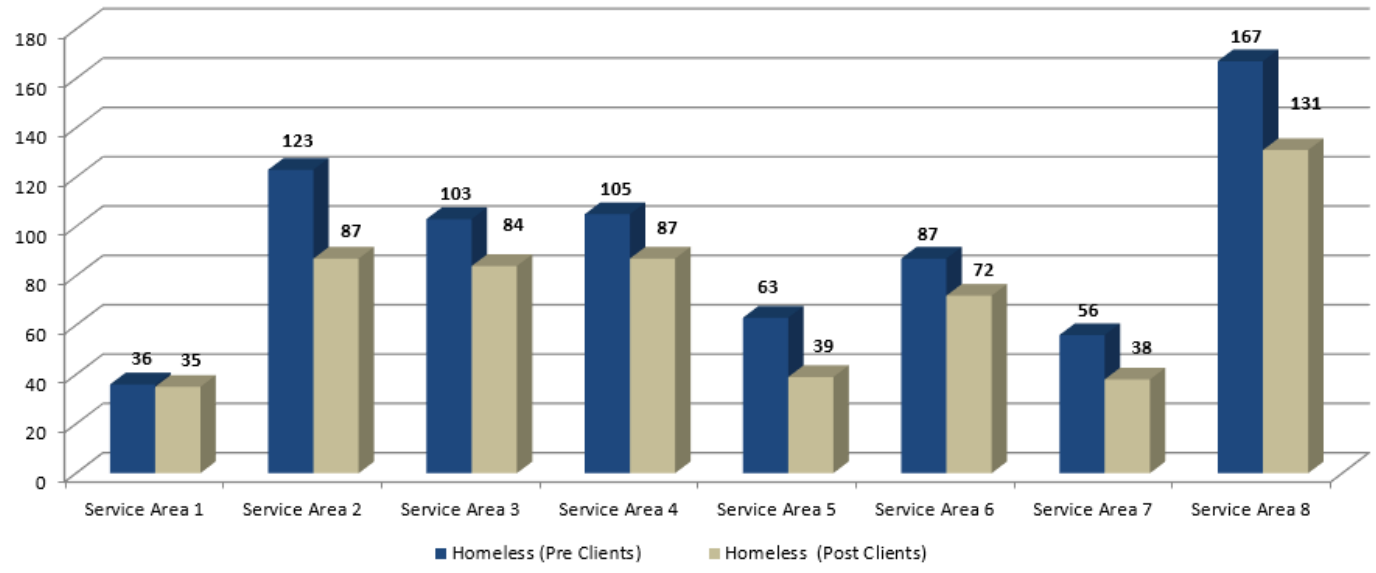


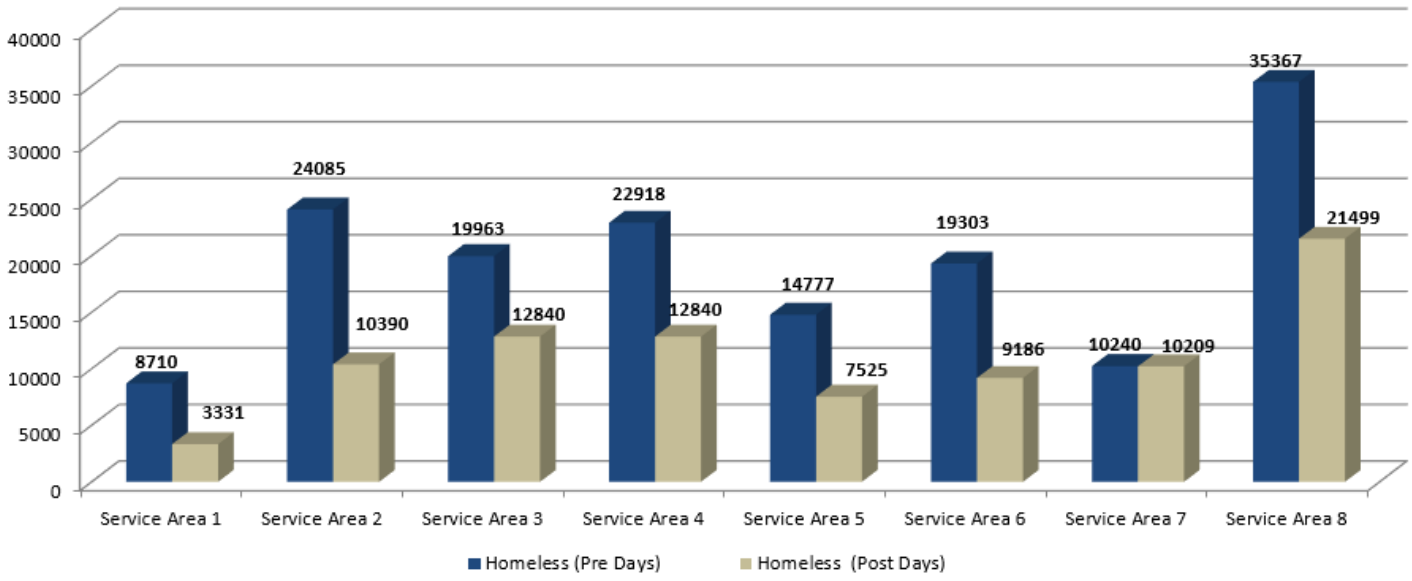


RESIDENTIAL OUTCOMES BY SERVICE AREA

TAY HOMELESS

- ◊ Service Area 5 has the highest percent (38%) reduction in clients homeless post-partnership
- ◊ Service Area 1 has the highest percent (62%) reduction in days homeless post-partnership
- ◊ Service Area 8 has the most clients homeless pre-partnership (167) and post-partnership (131) with a 22% percent reduction
- ◊ Service Area 8 has the most days spent homeless pre-partnership (35,367) and post-partnership (21,499) with a 39% percent reduction

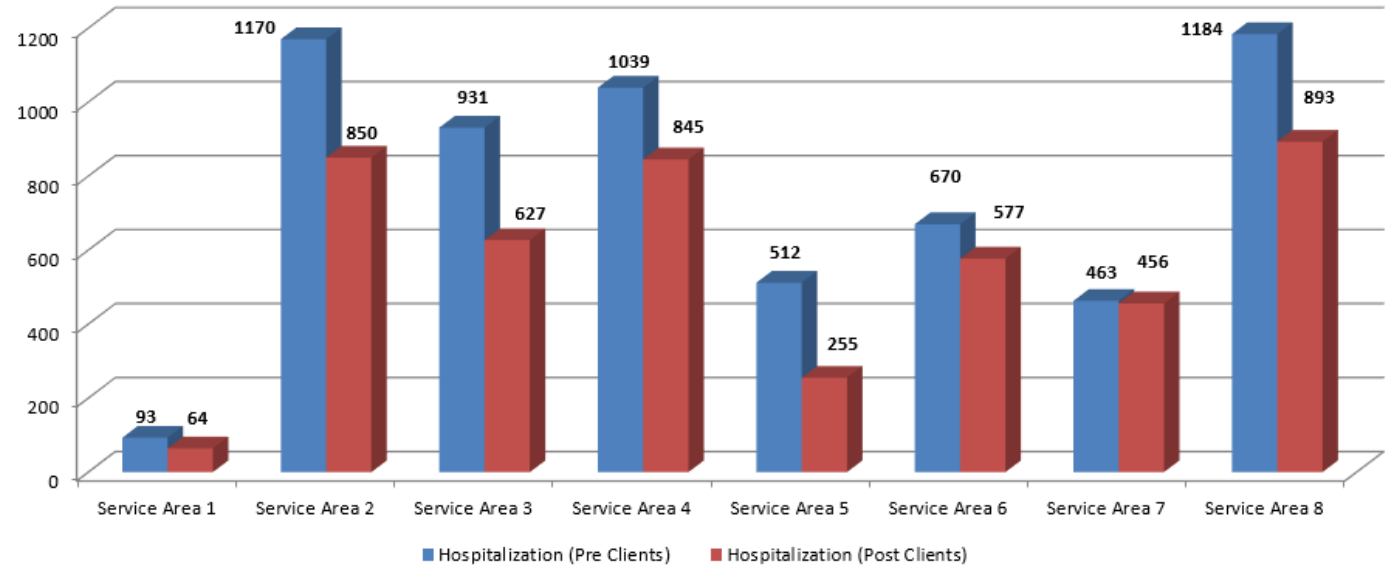


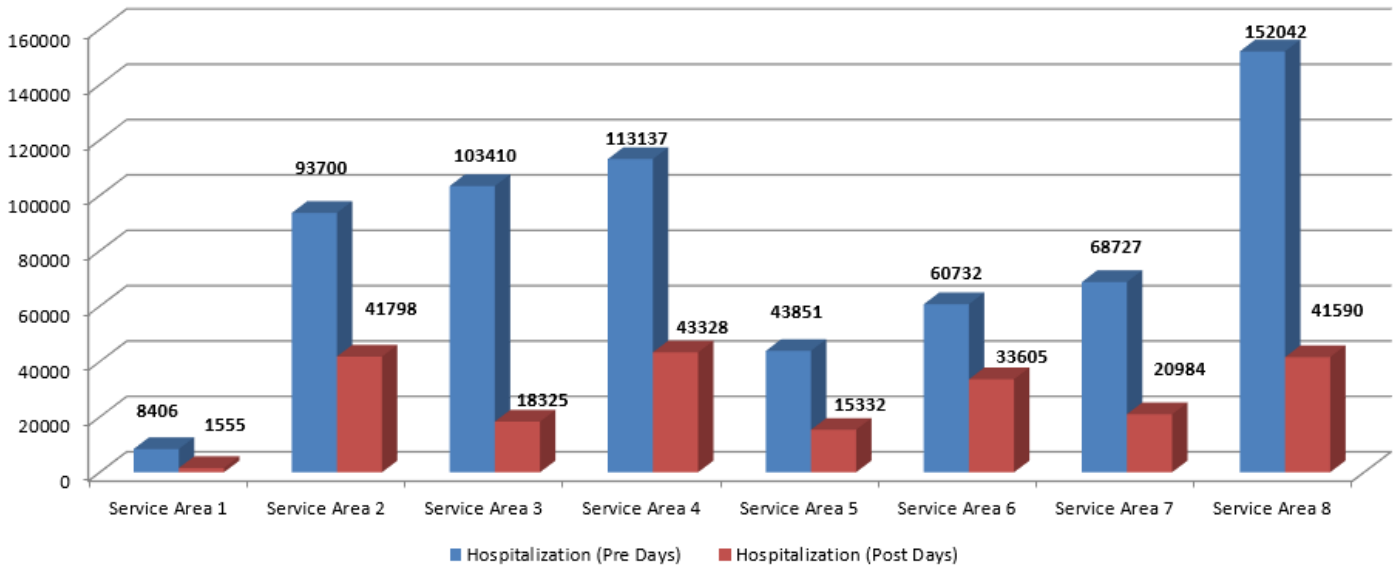


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT HOSPITALIZATIONS

- ◊ All Service Areas report a reduction in clients and days hospitalized post-partnership
- ◊ Service Area 5 has the highest percent (50%) reduction in clients hospitalized post-partnership
- ◊ Service Areas 1 and 3 have the highest percent reduction (82%) in hospital days post-partnership

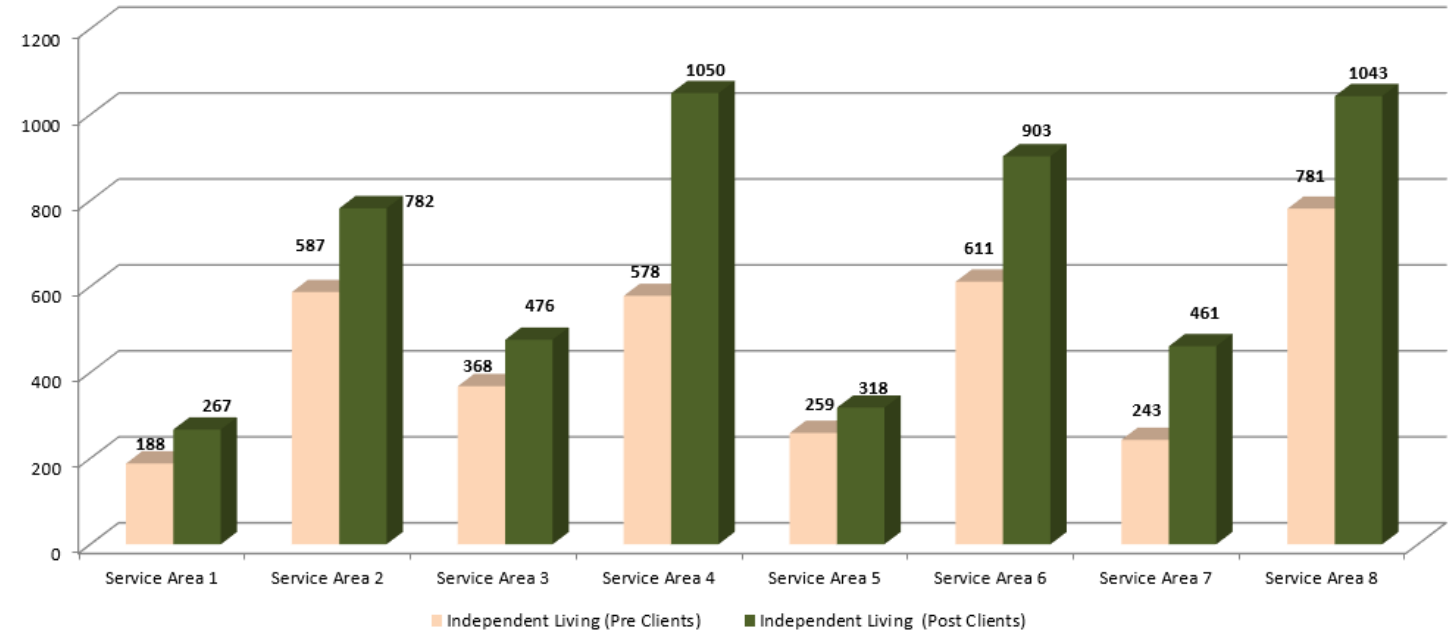


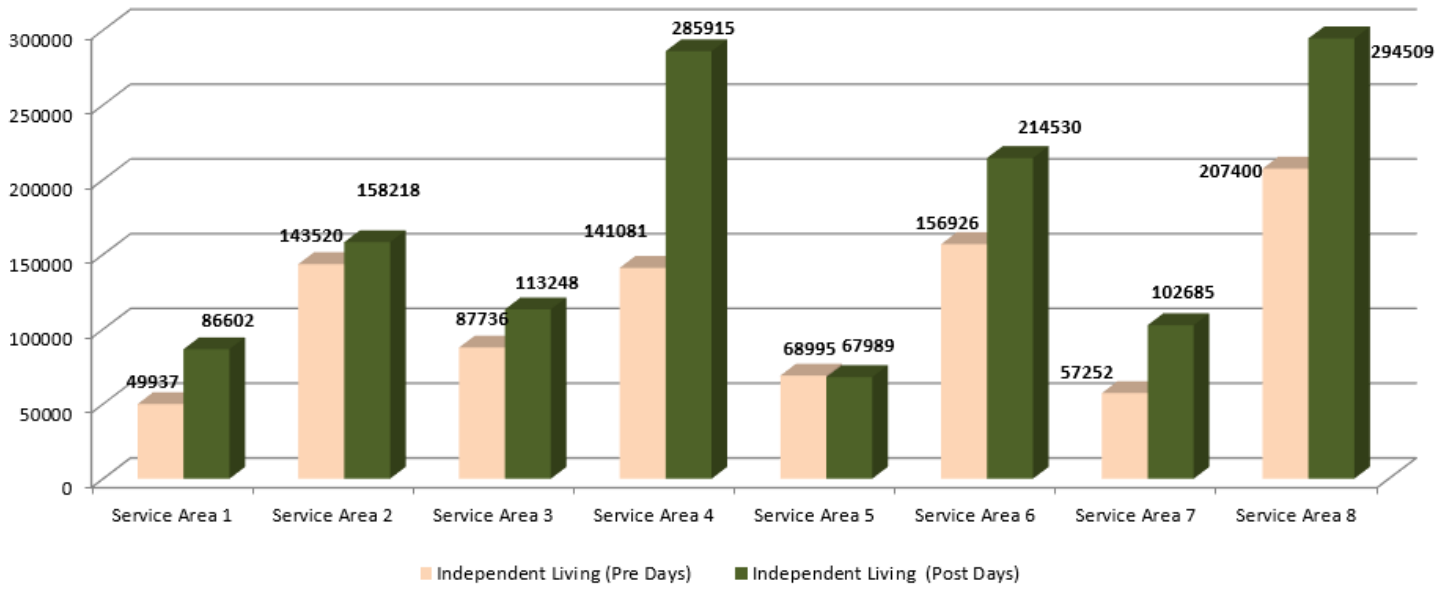


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT INDEPENDENT LIVING

- All Service Areas report an increase in clients and days living independently post-partnership
- Service Area 4 has the highest number of clients living independently post partnership, 1,050, and Service Area 7 has the most percent increase in clients living independently, 90%
- Service Area 4 has the most percent increase in days living independently, 125%

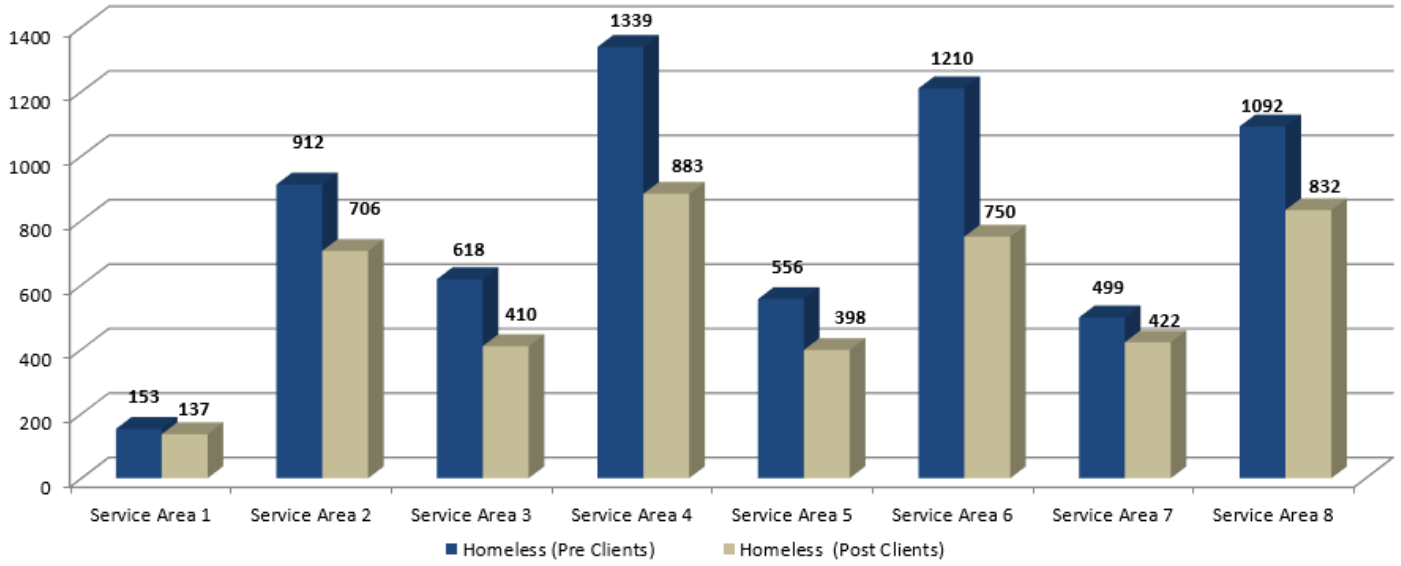


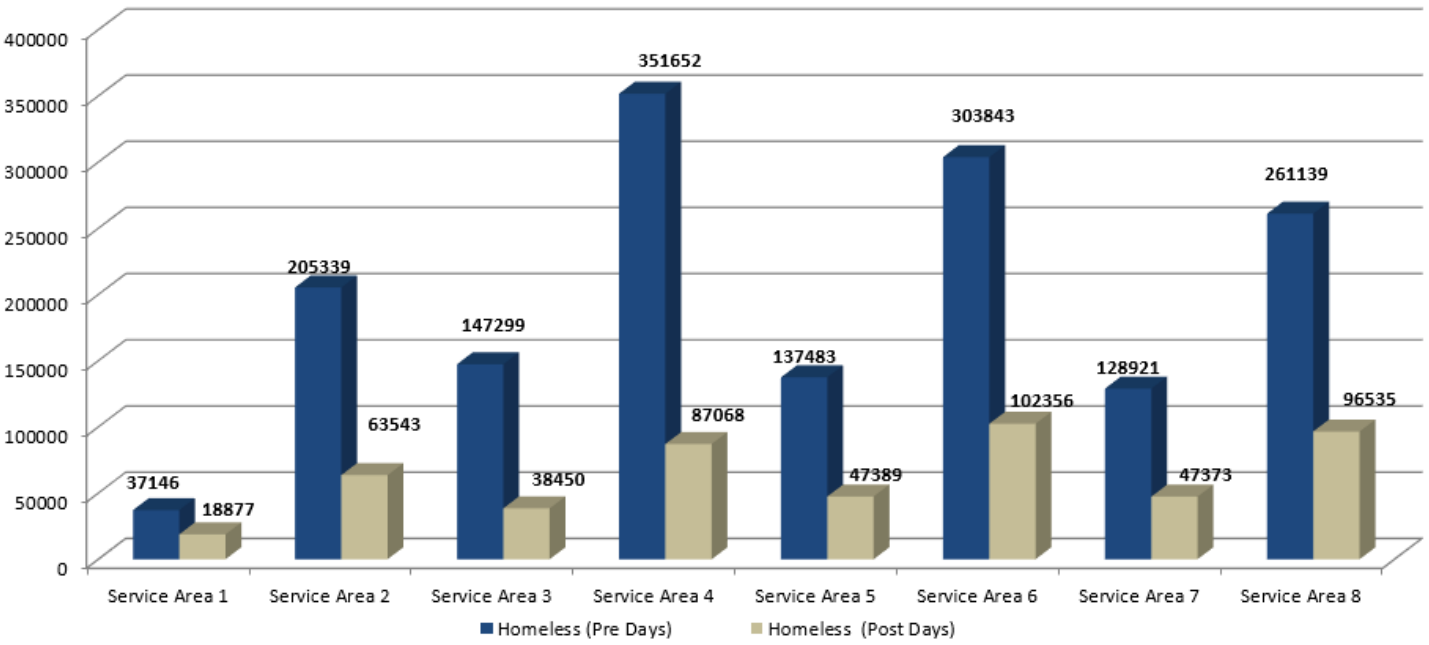


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT HOMELESS

- All Service Areas report a reduction in clients and days homeless post-partnership
- Service Area 6 has the highest percent (38%) reduction in clients homeless post-partnership
- Service Area 4 has the highest percent (75%) reduction in days homeless post-partnership

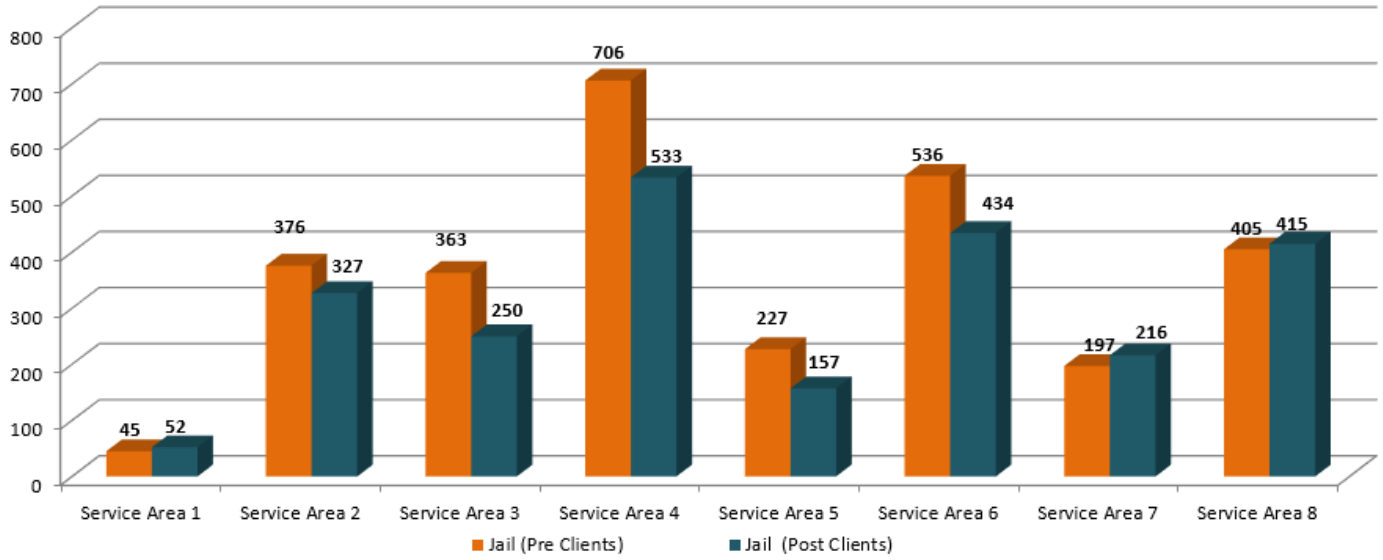


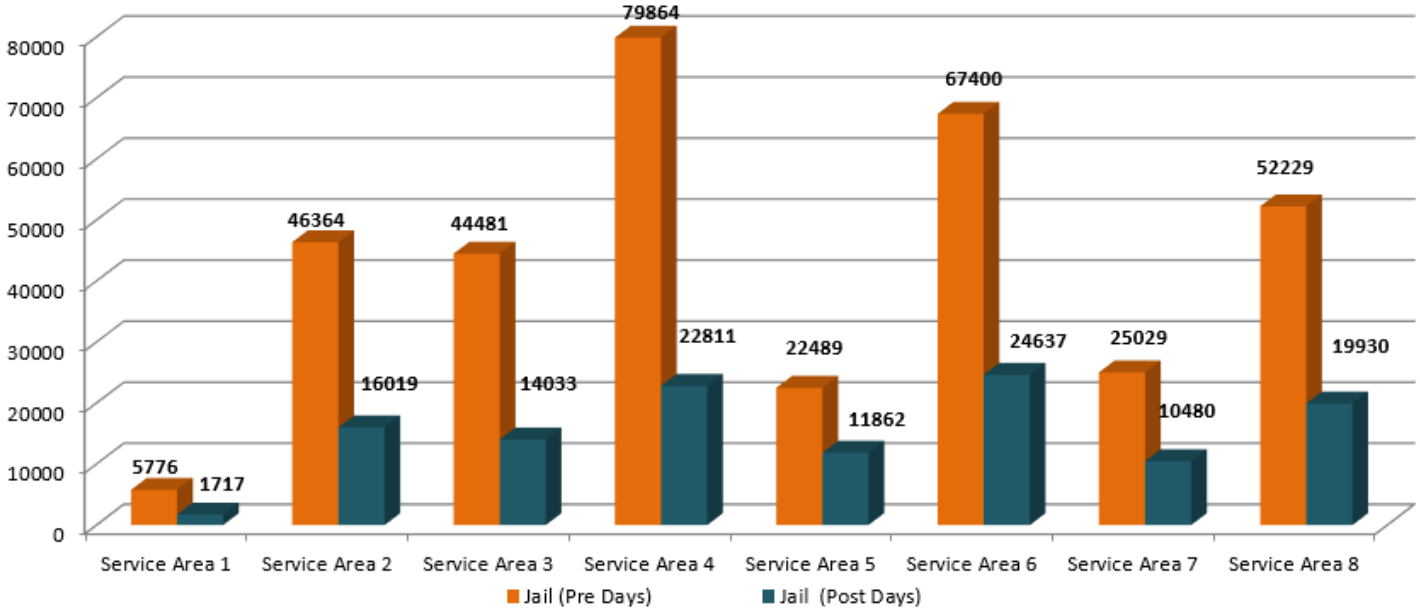


RESIDENTIAL OUTCOMES BY SERVICE AREA

ADULT JAIL

- ◊ All Service Areas report a reduction of days spent in jail post-partnership
- ◊ Service Areas 3 and 5 have the highest percent (31%) reduction of clients in jail post-partnership
- ◊ Service Area 4 has the highest percent (71%) reduction of days spent in jail post-partnership

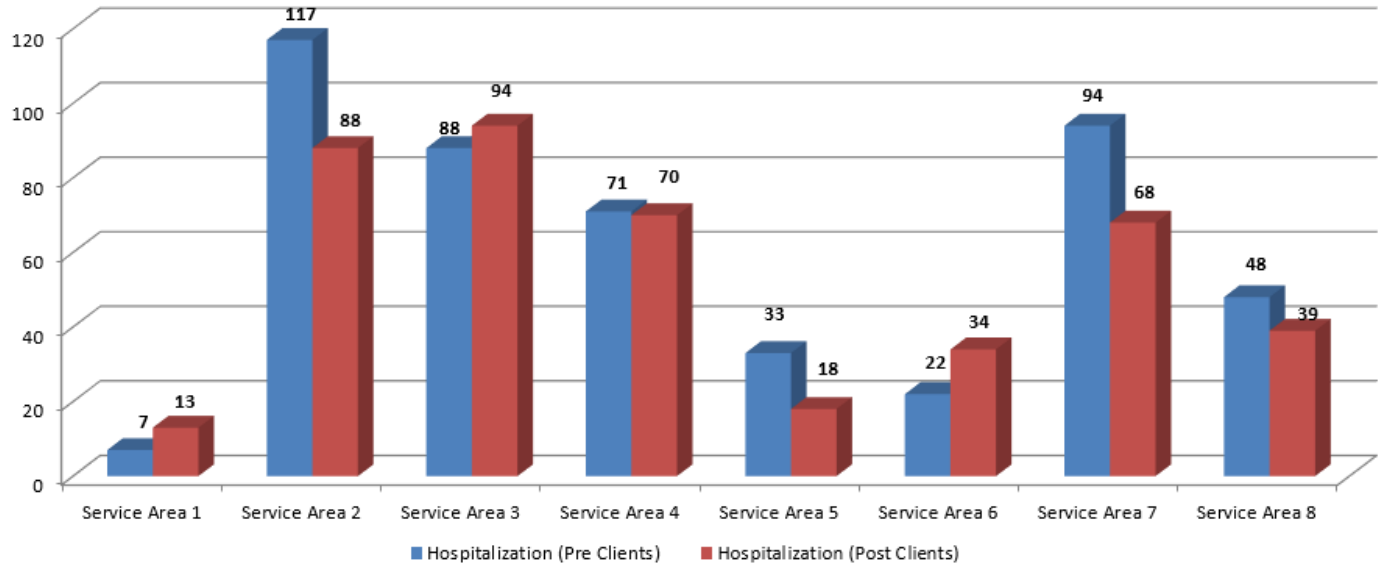


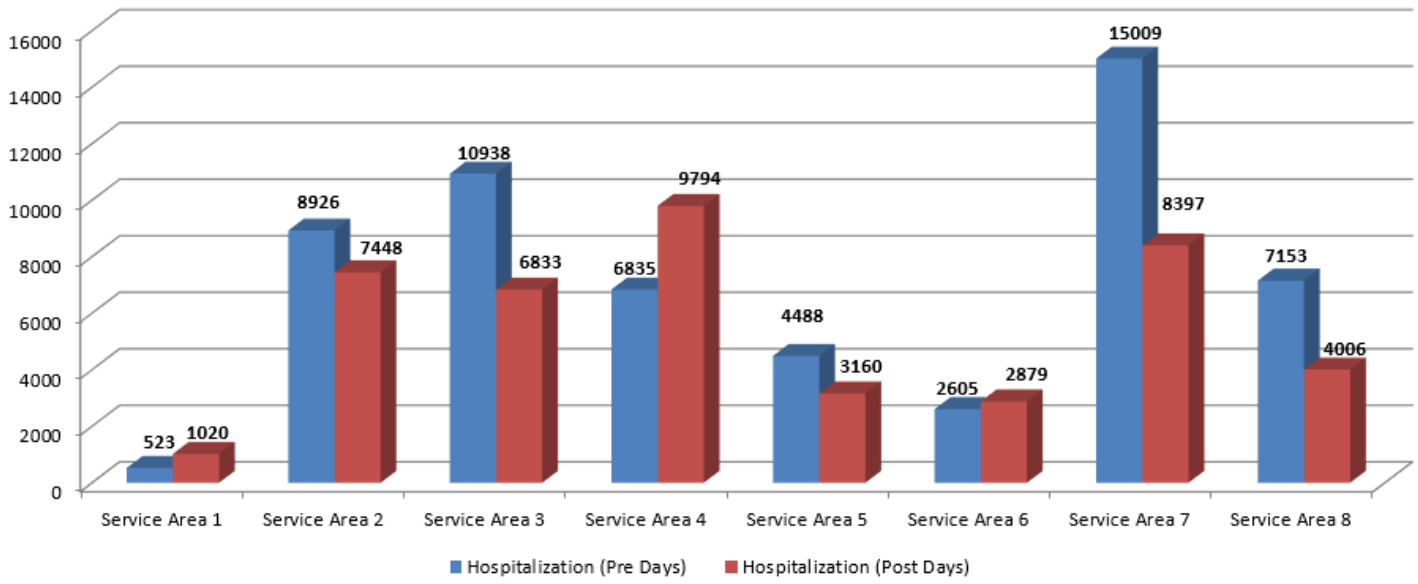


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOSPITALIZATION

◊ Service Area 5 has the highest percent (45%) reduction in clients hospitalized post-partnership
◊ Service Areas 7 and 8 have the highest percent reduction (44%) in hospital days post-partnership

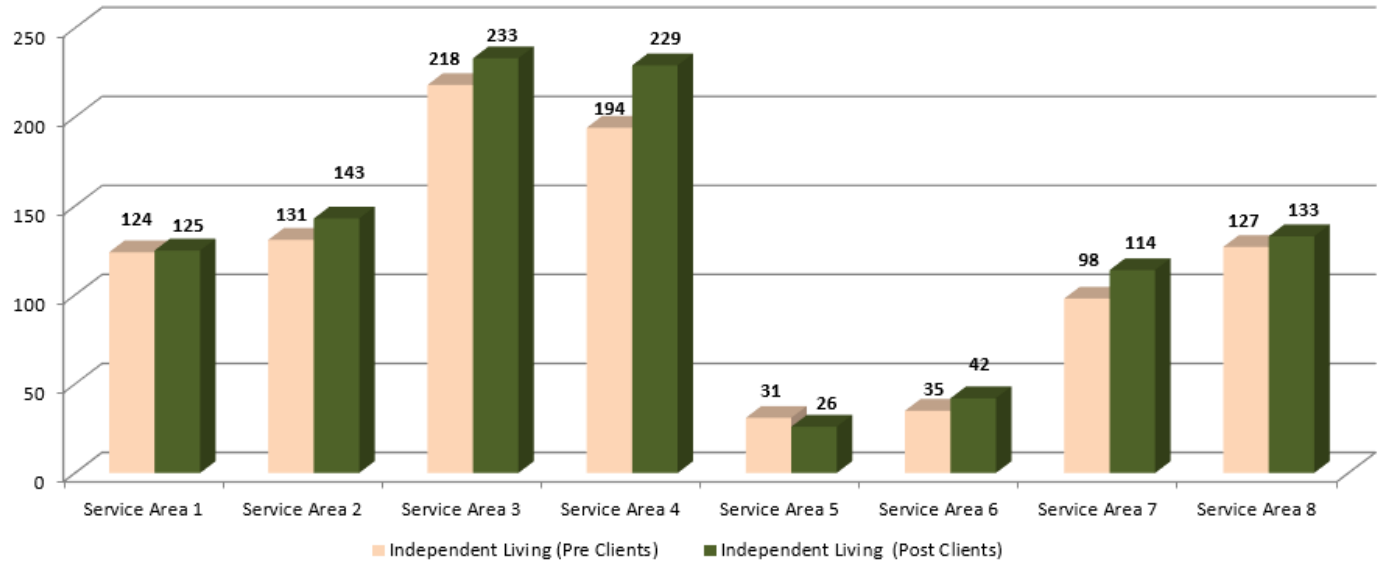


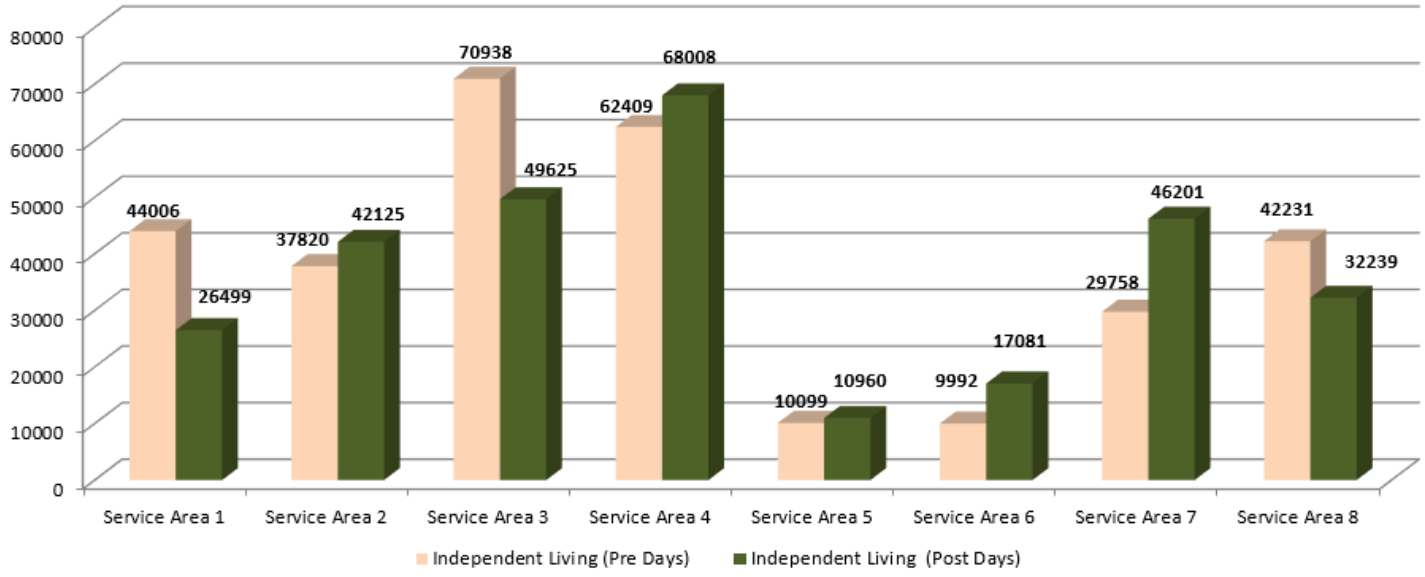


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT INDEPENDENT LIVING

- Service Area 3 has the highest number of clients living independently post partnership, 233
- Service Area 6 has the most percent increase in days (71%)and clients (20%) living independently

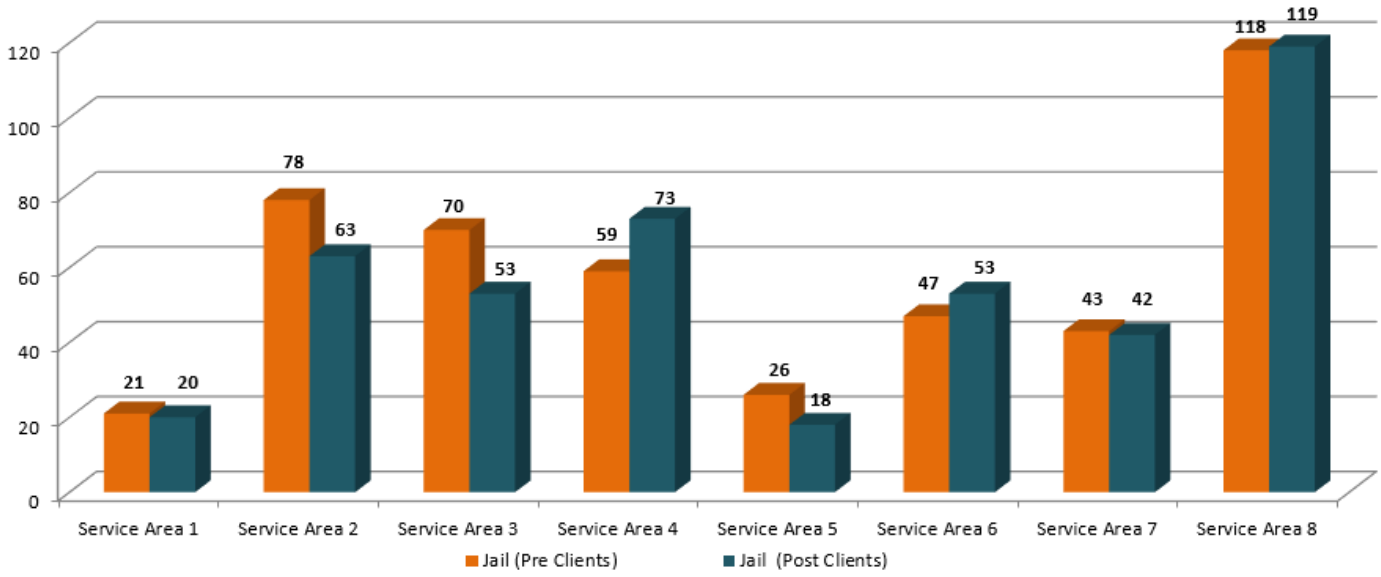


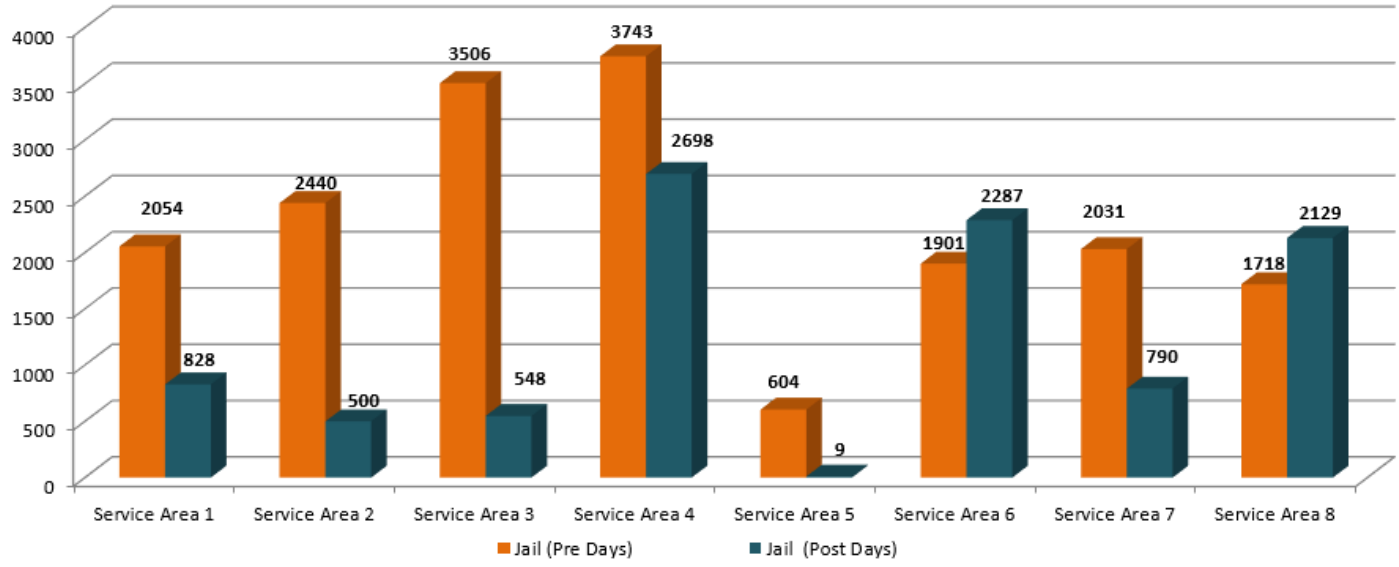


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT JAIL

◊ Service Area 5 has the highest percent (80%) reduction of clients in jail and highest percent (98%) reduction of days spent in jail post-partnership

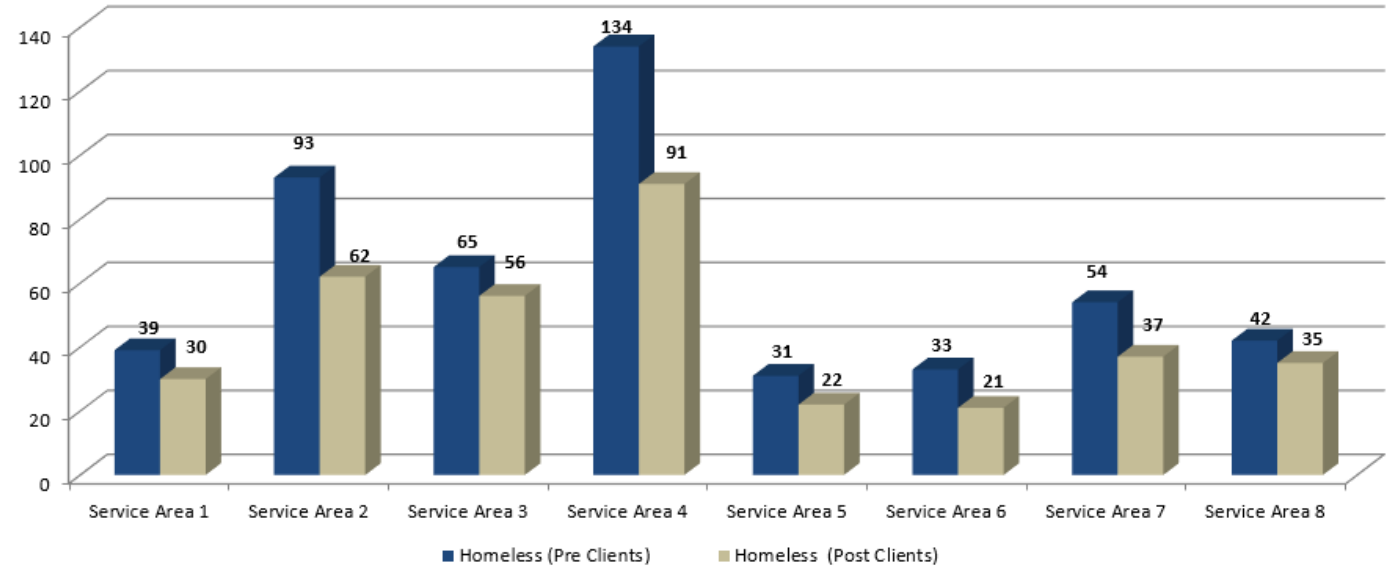


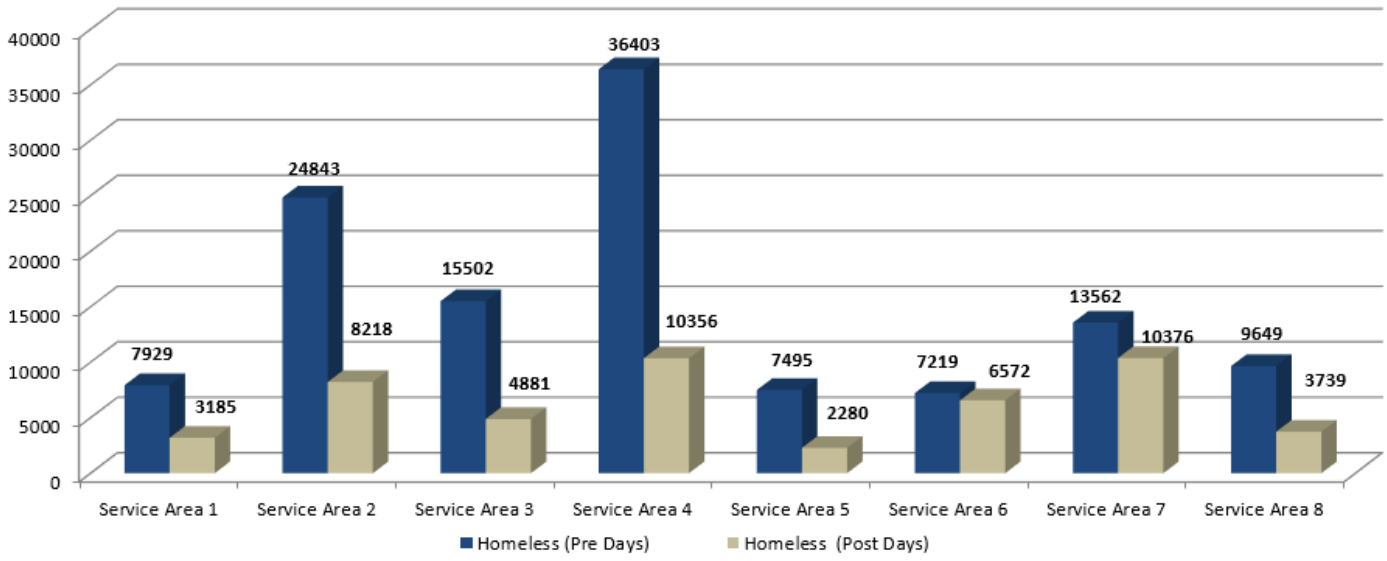


RESIDENTIAL OUTCOMES BY SERVICE AREA

OLDER ADULT HOMELESS

- ◊ Service Area 6 has the highest percent (36%) reduction in clients homeless post-partnership
- ◊ Service Area 4 has the highest percent (72%) reduction in days homeless post-partnership and has the most days spent homeless pre-partnership (36,403)
- ◊ Service Area 4 has the most clients homeless pre-partnership (134) and post-partnership (91) with a 32% percent reduction



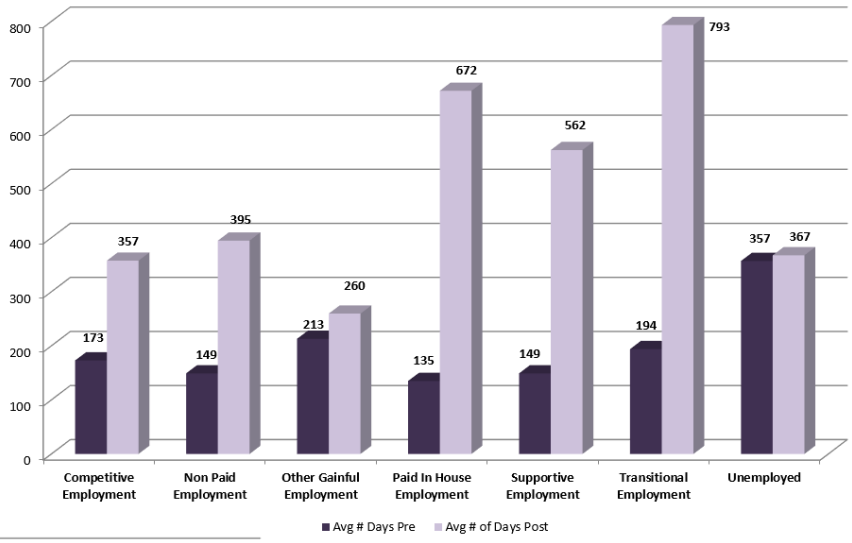


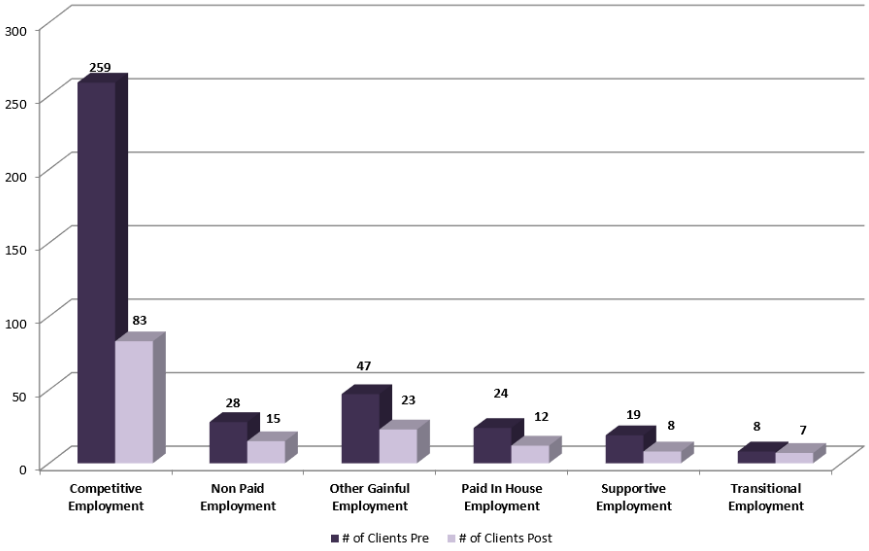
EMPLOYMENT OUTCOMES

ADULT FSP

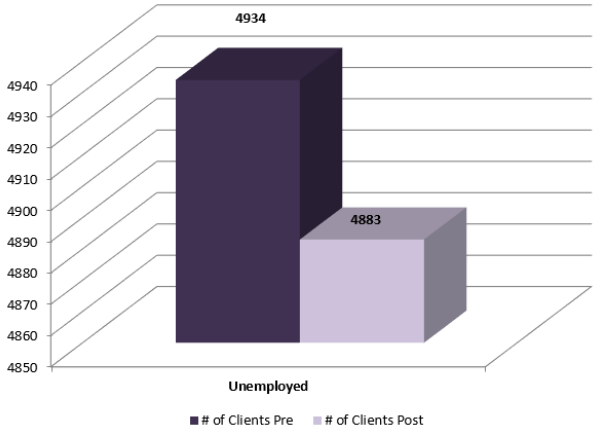
NUMBER OF BASELINES: 4,945

- 107% increase in the number of days spent in competitive employment
- 165% increase in the number of days spent in non-paid employment
- 22% increase in the number of days spent in other gainful employment
- 309% increase in the number of days spent in transitional employment





- 1% decrease in the number of clients unemployed
- 68% decrease in the number of clients in competitive employment
- 46% decrease in the number of clients in non paid employment
- 51% decrease in the number of clients in other gainful employment

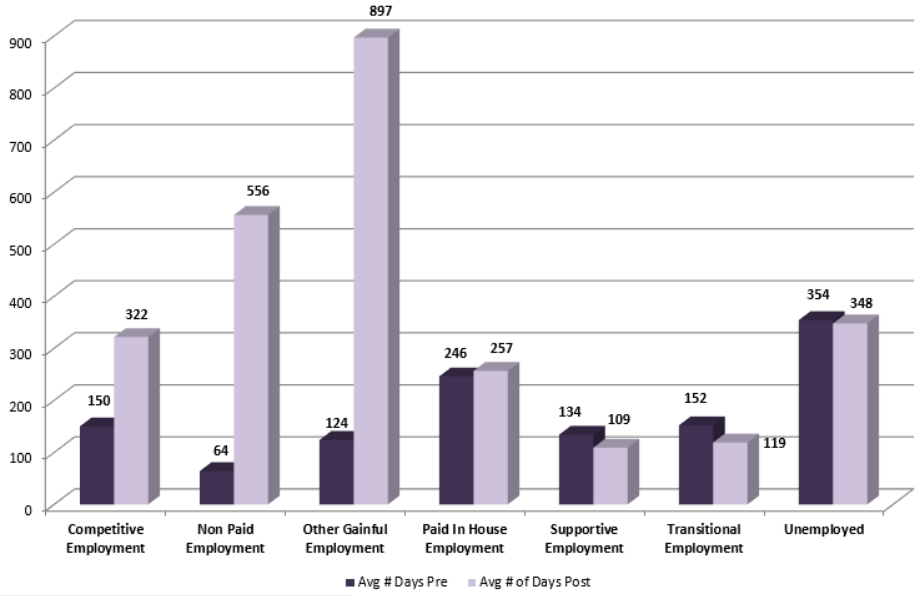


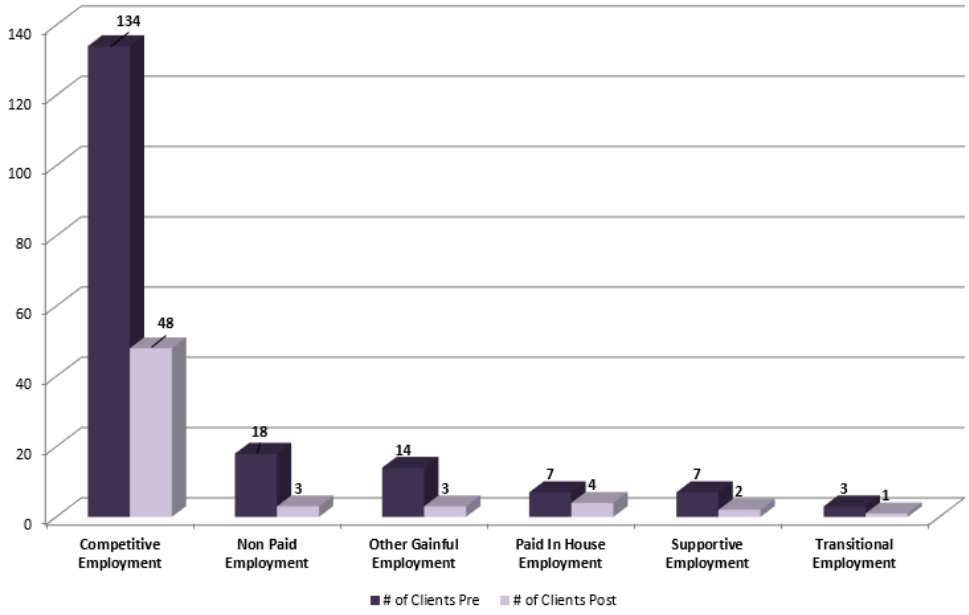
EMPLOYMENT OUTCOMES

TAY FSP

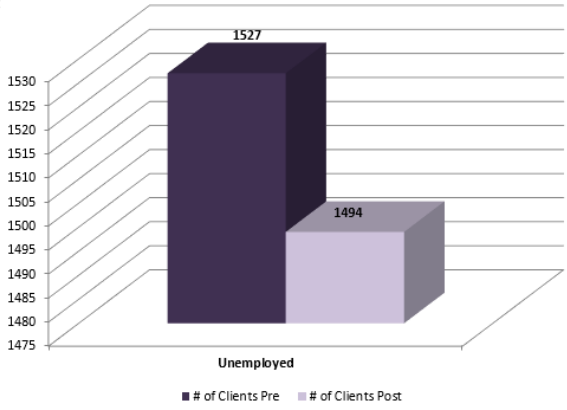
NUMBER OF BASELINES: 1,502

- 114% increase in the number of days spent in competitive employment
- 769% increase in the number of days spent in non-paid employment
- 623% increase in the number of days spent in other gainful employment
- 22% decrease in the number of days spent in transitional employment





- 2% decrease in the number of clients unemployed
- 64% decrease in the number of clients in competitive employment
- 83% decrease in the number of clients in non paid employment
- 79% decrease in the number of clients in other gainful employment



RECOVERY, RESILIENCE AND REINTEGRATION

UNIQUE CLIENTS SERVED

Children - 23,538
TAY - 15,195
Adult - 54,701
Older Adult - 13,236

AVERAGE COST PER CLIENT

Children - $5,740
TAY - $3,885
Adult - $2,879
Older Adult - $3,222

TARGET POPULATION

Infants, Children and Adolescents ages 0-18, who have a Serious Emotional Disturbance or Young Adults, Adults and Older Adults ages 18 and up, who have a Serious Mental Illness.

RRR provides a continuum of care so that clients can receive the care they need, when they need it and in the most appropriate setting to meet their needs.

RRR services are designed to meet the mental health needs of individuals in different stages of recovery. There are three Core Service Components including Community-Based Services, Clinic-Based Services and Wellbeing Services. Each program will provide each client with a combination of one or more of the core components to meet the client's individual needs. Within this continuum are Focused Service Models for specific populations, that were originally piloted through the MHSA Innovations work plan and includes the Peer Run Centers (PRC), Peer Run Respite Care Homes (PRRCH), Integrated Service Management (ISM) model and Integrated Clinic Model (ICM). Focused Service Models address the unique needs of their target population through more prescribed service approaches.

RRR services meet the needs of all age ranges from child to transitional age youth (TAY) to adults and older adults. While there may be some minor differences in the specific services provided to each population, there is more commonality across age groups than differences. All age groups will have access to assessments, traditional mental health services, crisis intervention, case management and medication support. The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each client and will likely change over time. While most clients will hopefully move from more intensive to less intensive services, some clients may need more intensive services for periods of time due to a variety of factors, which include, but are not limited to, the emergence or exacerbation of a severe mental illness, non-adherence to treatment recommendations, a substance use disorder, exposure to trauma or violence or external psychosocial stressors, such as housing, employment, relationship or legal problems.

Core Service Components

Focused Service Models

1. Peer Run Centers
2. Peer Respite Care Homes
3. Integrated Service Management Model
4. Integrated Clinic Model

PRRCH LOCATIONS

Hacienda of Hope in Long Beach

SHARE! in Monterey Park

Peer-Run Respite Care Homes (PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. PRRCH offers guests a short-stay voluntary opportunity to grow through distress in a warm, safe, and healing environment while engaging in recovery focused supportive services as desired.

Achievements and Highlights fro Fiscal Year 2017-18:

- 393 guest were served with an average length of stay of 10 days.
- 133 of these guest where homeless. (The thought of the PRRCH staff is that even those guest who disclose the housing status as homeless can benefit from respite, and with proper support could serve to assist the guest in managing their symptoms before they escalate and there was a need for hospitalization.
- Of the 133 only 63 remained homeless. This is due to some guests not disclosing their true housing nature until the day of departure, leaving the staff with no time to assist in linking to serves in the community. All guests are given resources when the depart.)
- 78% of guest reported making progress towards a personal goal and working towards it during their stay.
- 78% reported having family or friend involvement in their mental health treatment; 18% when things were serious, 18% when things started to go badly, 45% much of the time, with 16% reporting that family involvement helped.
- 88% of guests are involved in consumer run services, peer support groups, Alcoholics Anonymous; drop in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs.
- 49% of guests spend at least 3-6 hours per week in a meaningful role in their community (ex., working, volunteering, school, etc…); 13% spend at least 16-30 hour per week.

Even though the PRRCH is not to be used as shelter and the staff work diligently to with the guests who disclose they are homeless upon arrival to the PRRCH and connect them to housing services.)

TAY PROBATION CAMPS (T-04)

PROBATION CAMPS:

- Rockey
- Paige Afflerbaugh
- Scott-Scudder
- Gonzales
- Challenger
- Miller

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). MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

TAY DROP-IN CENTERS

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.

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	1230 Pine Avenue Long Beach, CA 90813

INTEGRATED CARE PROGRAM

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

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

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

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
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.
Community Diversion & Re-Entry Program for Seniors (CDRP): Training & Consultation Series.	OA Systems of Care conducted training and consultation series, as part of the Older Adult Training & Consultation Team, offered to mental health staff with professional expertise in geriatric medicine, gero-psychiatry, case management/community resources, substance use, and other resources. The training & consultation was designed to upgrade the training knowledge base and skills of all mental health staff through case presentation and consultation.
Older Adult Legal Issues/Elder Law Trainings and Consultation	OASOC as part of ongoing multi-disciplinary Older Adult Consultation team trainings, provided training and Elder Law consultation, curriculum training development and coordination on Elder Law for DMH and DMH-contracted clinical and non-clinical staff on best practices for working with Older Adult populations.
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.
Speaker Club Workshop Training Curriculum	This 7 week training session course provided peers with tools and skills to educate the community and advocate for hope, wellness and recovery.
The Use of Cognitive Screening Measures: The Mini Mental Status Exam (MMSE)	The purpose of this training is to provide an overview of cognitive screening tool using The Mini Mental State Exam (MMSE). 11-28-2018 and 1-28-2018
Medical Legal Pre-Elective	The purpose of this training is to educate participants on cognitive screening test, elements of decision-making capacity and legal report in the context of geriatric patients who requires evaluation for conservatorship, testamentary capacity, undue influence, and other relevant issues that involve the overlap between geriatrics and the law 11-2-2017.
Social Emotional Arts Part 2: Movement and Writing.	This 2-day curriculum also offers general guidelines on the use of each art form in therapeutic contexts, communication techniques for creating rapport and preventing resistance, and containment strategies for managing stress responses. Day 2 will focus on movement and writing. 3-29-2018.

Training	Description
Supervising Peer Providers in the Behavioral Health Workforce	The purpose of this training is to provide essential information and resources to supervisors overseeing peer providers 11-30-2017.
17th Annual Gero-Psychiatric Breakfast	L.A. County Department of Mental Health in collaboration with L.A. Care, and Health Net, provided the 16th Annual Gero-psychiatry Breakfast a free continuing medical education activity for primary care physicians and psychiatrists, focusing on adult behavioral health. 12-14-2017
The Use of Cognitive Screening Measures: The Montreal Cognitive Assessment	The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool. 12-21-2016
Milestones of Recovery Scale and Determinants of Care:	The goal of this training is to provide participants with a comprehensive understanding of the Milestones of Recovery Scale (MORS) and the Determinants of Care. 11-14-2017, 11-16-2017, 6-6-2018.
The Use of Cognitive Screening Measures: The Montreal Cognitive Assessment.	The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool. 12-7-2017.
Medical/Legal Aspects of Older Adults: Capacity, Undue Influence and Abuse:	This 2 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 & 1-8, 2018.
Introduction to Motivational Interviewing	This training will highlight Motivational Interviewing (MI) to promote change in individuals. This training will provide participants advanced understanding of MI and techniques for promoting behavioral change 2-28-2018.
Hoarding Disorder 102: Practical Intervention for your Consumers.	The training will address Hoarding Disorder diagnosis and provide mental health clinicians with strategies for assessment and intervention for willing consumers and harm reduction techniques for resistant consumers 3-8-2018.
Social Emotional Arts Part 1: Music and Art.	In this practical 2-day training program, participants will experience activities in art, movement, Day 1 will focus on music and art; Day 2 will focus on movement and writing music, and writing developed by UCLArts & Healing and its team of creative arts therapists 3-22-2018.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) for Older Adult Clients	This training provides a brief overview of the prevalence of substance use in older adults, criteria for risky use, and the effects of substance use on mental health 3-14-2018.
Older Adult Sexual Assault	The training will discuss the following topics: prevalence of sexual assault in the US, including factors that contribute to older adults heightened risk of sexual assault; victim impact, including common presentations; the influence of rape culture and intersectionality on issues of sexual violence; how to support a survivor; RTC services and how to refer to RTC 3-12-2018.
Hoarding Disorder 101: Introduction to Symptoms, Assessment and Treatment	The training will focus on diagnostic assessment including history, research, etiologies, and age of onset, prevalence, demographics, comorbidities, risk factors, hazards, treatments, and consequences of this disorder 2-28-2018.

ALTERNATIVE CRISIS SERVICES

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.

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.

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.

The following is a status on the development of five Urgent Care Centers. The UCCs will be located in the following areas:

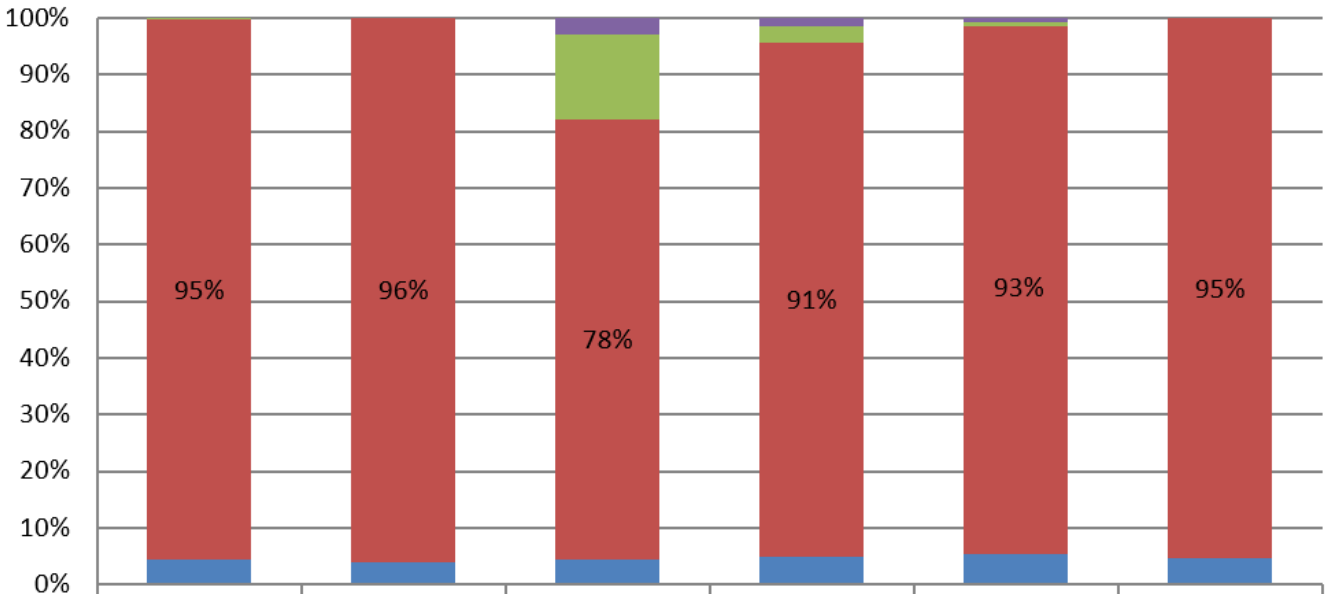
- Antelope Valley: Stars Behavioral Health Group (Stars) has been awarded a service contract to operate a UCC in the Antelope Valley. DMH and Stars are currently working collaboratively with the Supervisorial District to find an appropriate site to house the UCC.
- San Gabriel UCC: Stars was awarded a service contract to operate a UCC in the City of Industry and has obtained a Conditional Use Permit for their site. The UCC is projected to be operational in April of 2019.
- Long Beach UCC: Stars Long Beach Urgent Care Center. The UCC became operational on July 31, 2018.
- Long Beach UCC: Providence Little Company of Mary was awarded a service contract to operate a UCC in Long Beach. This UCC became operational in June 2018.
- Harbor-UCLA Medical Center UCC: Exodus Recovery, Inc. has developed a UCC on the campus of Harbor-UCLA Medical Center in Torrance in close proximity to the Psychiatric Emergency Services (PES) to provide PES decompression and increased capacity for community-based crisis care. The UCC became operational June 12, 2018.

ALTERNATIVE CRISIS SERVICES

The following is a status on the development of 21 new Crisis Residential Treatment Programs (CRTP) that will increase capacity by 336 beds Countywide:

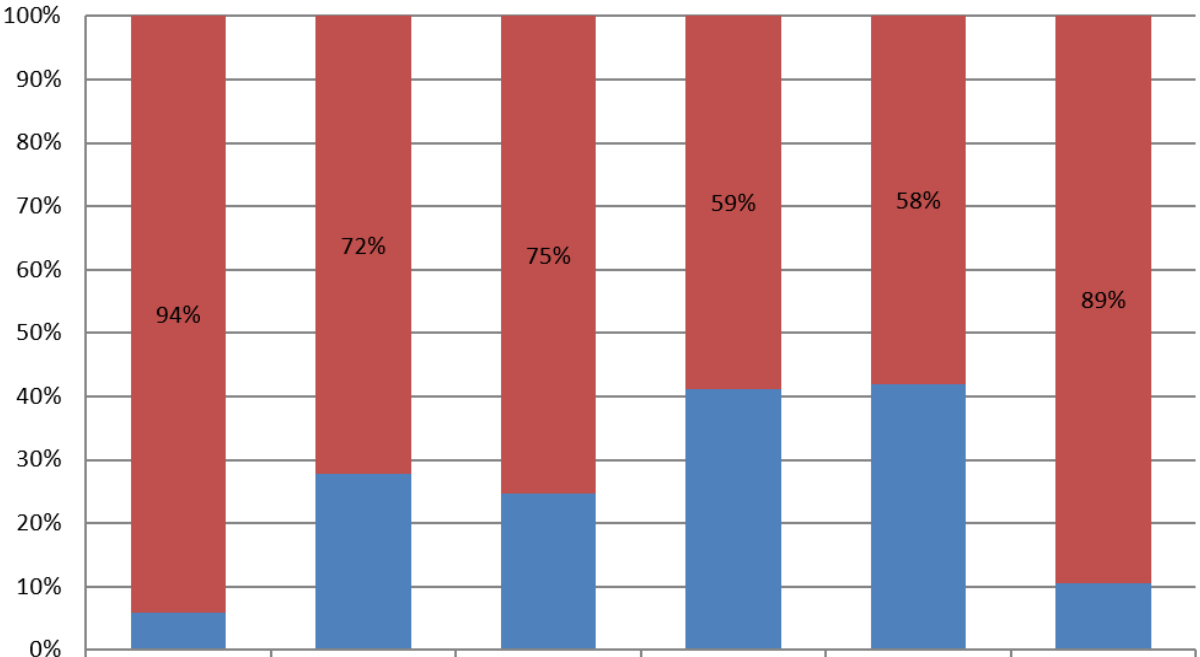
- DMH has implemented two (2) CRTPs. Exodus opened on December 20, 2017 and operates in Service Area 5. They have a total of twelve (12) beds. Gateways became operational on April 12, 2018. Currently, they have a total of sixteen (16) beds. Individuals are referred from hospitals, UCCs, and community programs.
- DMH has opened a CRTP this FY in Santa Monica and will be implementing 3 additional CRTPs in the San Fernando Valley, south central Los Angeles and east Los Angeles. In addition, DMH intends to develop fifteen (15) unique CRTPs for a total of 240 beds on the grounds of four County-operated hospitals: LAC+USC Medical Center, Olive View-UCLA Medical Center, Rancho Los Amigos National Rehabilitation Center, Martin Luther King (MLK) Jr. Medical Campus in the near future. The CRTPs are a critical component of the Intentional Communities the Health Agency is building that will support behavioral health initiatives.

NEW ADMISSIONS AT URGENT CARE CENTERS (UCCS) BY AGE CATEGORY



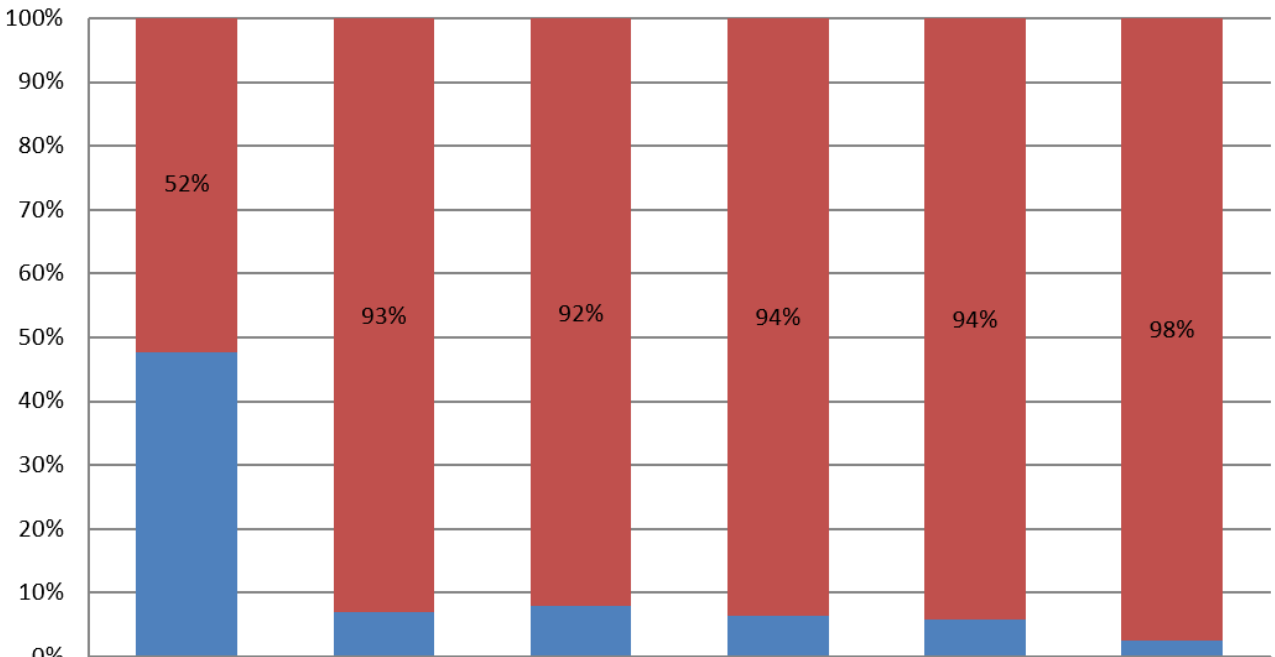
	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
Child	2	0	371	203	32	0
TAY	16	0	1863	445	35	0
Adult	4862	1479	9786	13629	4584	2173
Older Adult	224	61	541	739	269	109

NEW ADMISSIONS AT UCCS WHO WERE HOMELESS UPON ADMISSION



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	4802	1125	9447	8839	2853	2042
Yes	302	432	3087	6177	2067	240

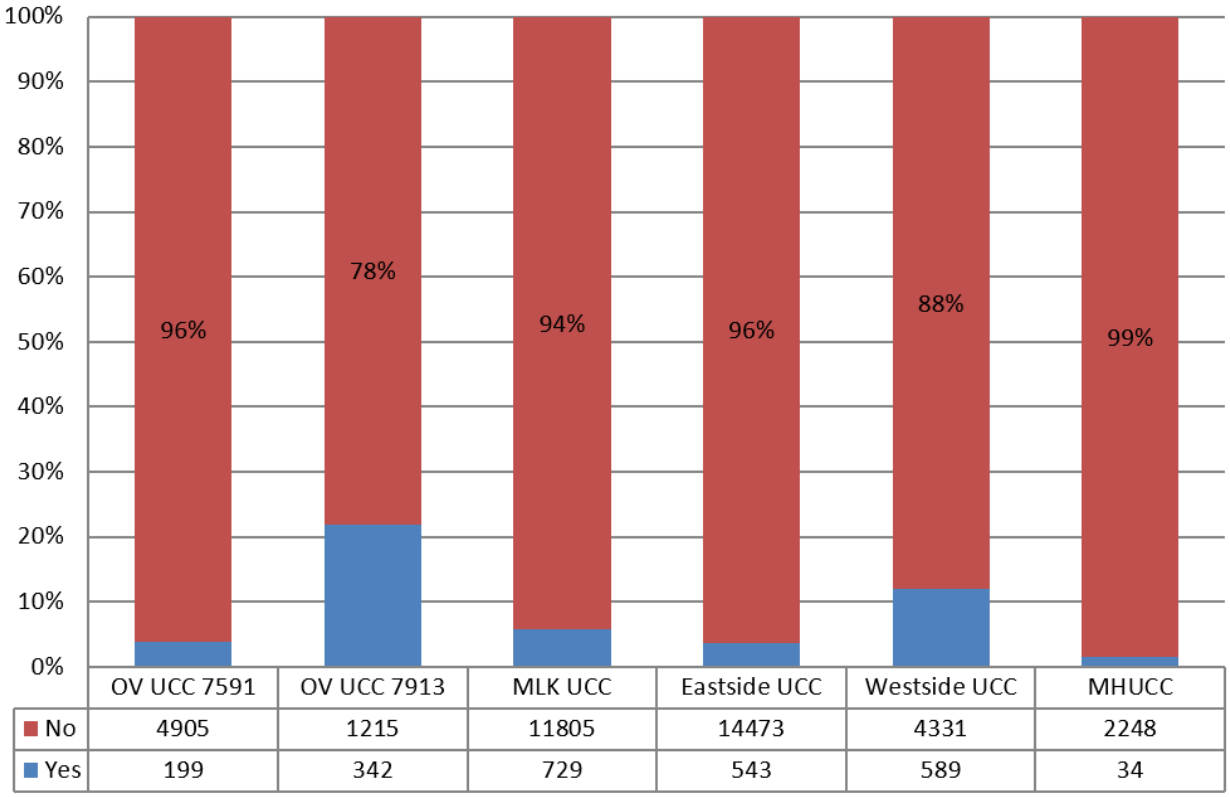
PERCENT OF THOSE WITH AN ASSESSMENT AT A PSYCHIATRIC EMERGENCY ROOM WITHIN 30 DAYS OF A UCC ASSESSMENT



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	2667	1449	11542	14058	4634	2225
Yes	2437	108	992	958	286	57

ALTERNATIVE CRISIS SERVICES

PERCENT OF THOSE WHO RETURN TO A UCC WITHIN 30 DAYS OF A UCC ASSESSMENT



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	4905	1215	11805	14473	4331	2248
Yes	199	342	729	543	589	34

ENRICHED RESIDENTIAL SERVICES

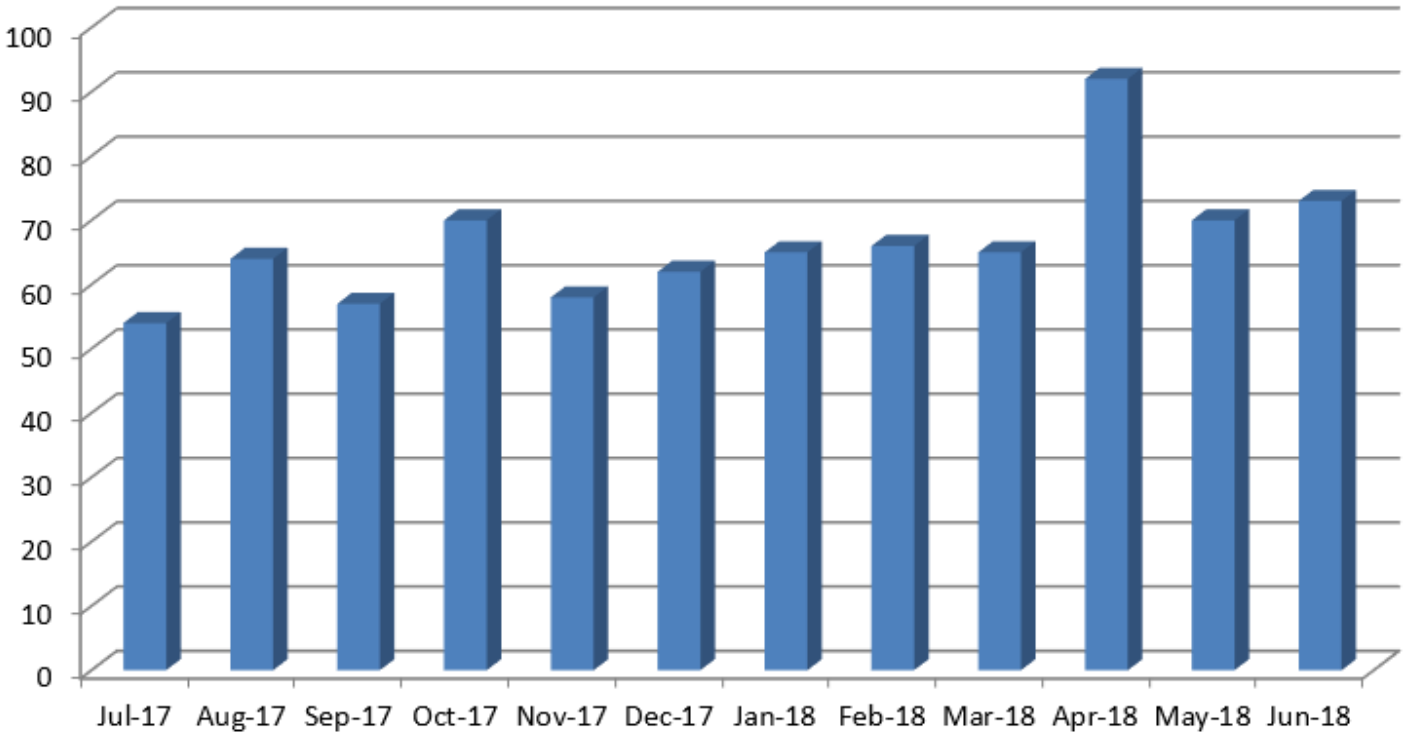
Enriched Residential Services are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from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

ENRICHED RESIDENTIAL SERVICES ADMISSION SOURCES FY 2017-18

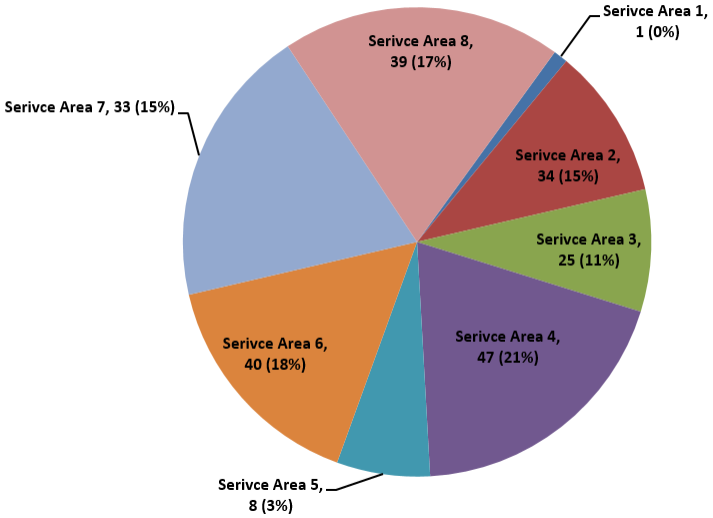
Source	# of Clients	%
State Hospital	9	1%
IMDs	222	26%
County Hospitals	106	13%
Fee for Service Hospitals	223	26%
Psychiatric Health Facilities/Skilled Nursing Facilities	11	1%
DMH Jail/Outpatient Programs	138	16%
Urgent Care Centers	20	2%
Mental Health Outpatient Providers	6	1%
Lateral Transfers/Rollover/Re-admits	80	10%
Emergency Outreach Bureau	16	2%
Crisis Residential Treatment Program	20	2%
Total	**851**	**100%**

ALTERNATIVE CRISIS SERVICES

ENRICHED RESIDENTIAL SERVICES DISCHARGES FY 2017-18



FSP REFERRALS FROM ENRICHED RESIDENTIAL SERVICES BY SERVICE AREA, FY 2017-18 N=202



⇒ Service Area 6 receives the most FSP referral from IMD Step-down services.

⇒ Service Area 1 receives the least amount of FSP referral from IMD Step-down services.

ALTERNATIVE CRISIS SERVICES

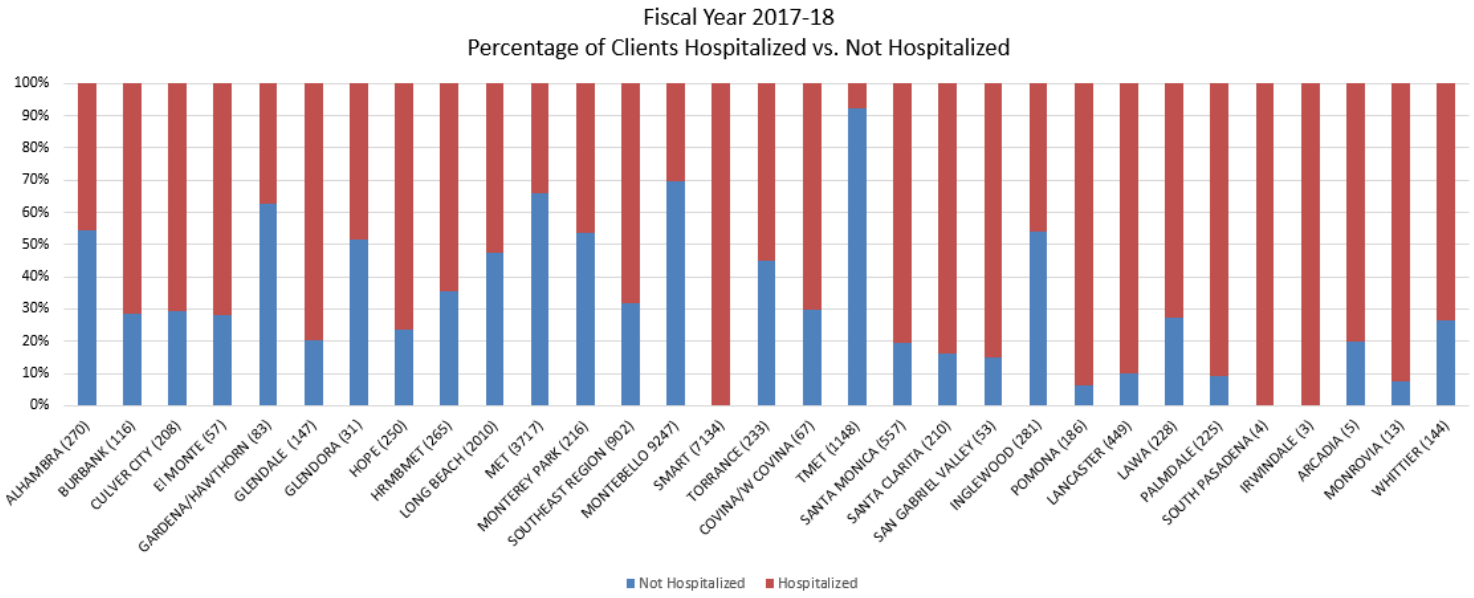
LAW ENFORCEMENT TEAMS (LET) FISCAL YEAR 2017-18

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

TOTAL NUMBER OF CALLS: 19,728

OF CLIENTS HOSPITALIZED: 13,404
OF ARRESTS: 347
OF CLIENTS HOMELESS: 9,708

The number of calls increased from FY 2016-17, 14,115 to FY 2017-18, 19,728 by 40%



SMART continues to take the lead in linkage to psychiatric hospitals (7128) , followed by MET (1270), Long Beach MET (1059), Southeast Region (616), Santa Monica (448), Lancaster (404), and remaining providers ranged from 3 to 191

HOUSING SERVICES

MHSA FUNDED HOUSING SERVICES

Under System Development, Adult Housing Services include 14 Countywide Housing Specialists that, as part of a Service Area team, provide housing related services to individuals and families that are homeless or at risk of homelessness in their assigned Service Area. The housing related services include but are not limited to assisting consumers complete required paperwork such as housing applications, federal rental subsidies, housing assistance for security deposits, household goods, and/or utility deposit; obtaining third party verifications of income; accompanying consumers to housing interviews with property owners and local housing authorities. An important function of their work is to avert evictions by working closely with property owners or property management companies to resolve the presenting issues. In addition, they conduct community outreach to identify housing resources within their Service Area.

TAY Housing Services include 8 Countywide Housing Specialists that are assigned to designated Services Areas as part of TAY Administration. TAY Countywide Housing Specialists perform similar responsibilities as staff assigned to Adult Housing Services. They focus a significant amount of time on monitoring and coordinating services for individuals who are living in permanent housing in order to break the cycle of homelessness. In addition, the Enhanced Emergency Shelter Program (EESP) (previously Motel Voucher Program) provides 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.

MHSA FUNDED CAPITAL INVESTMENTS

During FY 2017-2018, the Department continued its investment in the development of supportive housing for individuals and families living with serious mental illness or a severe emotional disorder, who are homeless or chronically homeless. Through these efforts, DMH invested an additional $63,480,000 in the development of 21 new MHSA funded developments adding 366 units to the county's overall total. These newly funded housing developments will target various age groups as indicated below.

TARGETED POPULATION	NUMBER OF DEVELOPMENTS	NUMBER OF UNITS
ADULTS	9	148
FAMILIES	3	77
OLDER ADULTS	5	85
TAY	4	56
TOTAL	21	366

HOUSING SERVICES

MHSA FUNDED CAPITAL INVESTMENTS (CONTINUED)

Overall, the Department has invested $197.1 million in the development of supportive housing across Los Angeles County providing capital funding for 70 MHSA funded housing developments and 13 of 70 with capitalized operating subsidies.

TARGETED POPULATION	NUMBER OF DEVELOPMENTS	NUMBER OF UNITS
ADULTS	30	615
FAMILIES	15	407
OLDER ADULTS	12	250
TAY	13	167
TOTAL	70	1,439

As of June 30, 2018, 37 of the 70 MHSA funded housing developments were occupied by formerly homeless or chronically homeless individuals or families living with serious mental illness or severe emotional disorder residing in 837 units including studios and/or 1 to 4 bedroom apartments. In addition, DMH committed onsite supportive services funding to 9 housing developments, including single site and scattered site housing developments, that provided 369 units of supportive housing. For calendar year 2018, DMH housed 1,277 individuals and/or families across its various MHSA funded housing developments with 191 new residents, 1,097 residents remaining housed, and 109 residents exiting housing reflecting a 91% retention rate.

In 2017-18, DMH also transitioned its Temporary Shelter Program for adults and families to an Interim Housing Program (IHP) in which DMH contracted for a specific number of IHP beds rather than buying beds as needed, increasing the bed capacity across the system and increasing the bed rate to include funding for supportive services. By the end of 2018, DMH had 401 beds for single adults and 79 units for families of all sizes.

PLANNING, OUTREACH & ENGAGEMENT

UNDERSERVED CULTURAL COMMUNITIES (USCC)

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

AFRICAN/AFRICAN AMERICAN (AAA) USCC SUBCOMMITTEE

Black Male Mental Health Awareness Campaign: This project increased mental health awareness and spread learning through community presentations in Los Angeles County. The project outreached to Black males 16 years old and older via community presentations. It targeted those who are not currently involved in the public mental health system, but who might benefit from learning more about mental health.

Outcomes:

- A total of 144 community members attended a community Town Hall meeting to discuss the mental health needs of Black males ages 16 and older.
- Of those who attended the Town Hall meeting, 19 Black males were recruited and trained on basic mental health education. After their training, they became Community Advocates for Mental Health.
- Once trained, the Community advocates for Mental Health conducted a total of 12 different countywide community presentations between February 20, 2017 and May 19, 2017.
- A total of 318 community members attended the mental health presentations conducted by the Community Advocates and learned about basic mental health issues affecting Black males and how to access mental health services.

African American Women Leadership and Wellness Mental Health Outreach Project: The objective of this project was to engage and empower African American women to seek mental health services. This is a countywide advocacy, leadership, holistic wellness, spirituality and mental health outreach project for African American women ages 18 years and older. It aimed to break down stigma related to mental health services among African American women.

Outcomes:

- A total of 24 countywide community workshops were conducted on basic mental health education and wellness activities that incorporated spirituality & traditional cultural practices.
- A total of 128 community members participated in the workshops.
- A Mental Health Resource Guide was distributed during the workshops to encourage community members to access mental health services.
- The workshops took place in schools, churches, counseling agencies, universities, and community based organizations.

AAA Mental Health Informational Brochures: This project was initiated in FY 2015-16 and it was implemented in FY 2016-17. Brochures were 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 were used to educate and inform these ethnically diverse communities on the benefits of utilizing mental health services and provided referrals and contact information. The informational brochure were translated into two (2) different African languages: Amharic and Somali.

Outcomes:

- 5000 Brochures were printed.
- 4700 have been distributed as of May 2018.

AFRICAN/AFRICAN AMERICAN (AAA) UsCC SUBCOMMITTEE (CONT)

African Immigrants and Refugees Mental Health Outreach Projects: This was a mental health outreach project for African immigrants and refugees from Nigeria, Somalia, Ethiopia, Liberia, and Ghana. The purpose of this project was to outreach and provide mental health awareness, education, linkage and referral services to these underserved groups in a non-stigmatized manner using culturally sensitive techniques designed to improve and sustain their quality of life.

Outcomes:

- By implementing grassroots outreach and engagement methods, 15 community mental health workshops were completed.
- A total of 400 community members, who identified as Nigerian, Somali, Ethiopian, Liberian, and/or Ghanaian were outreached to as a result of this project.
- Overall, this project engaged and empowered African immigrants and refugees, who may have a history of pre and post migration trauma as a result of political conflicts in their country of origin.
- The project enabled underserved and marginalized African immigrant groups to access mental health service for themselves and empower other members of their communities to access services.

Life Links: Resource Mapping Project: This project has been continued for four consecutive years since the initial implementation. 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 directory, 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 4 times and the fifth reprint is scheduled for June 2018.

Outcomes:

- 7000 booklets were printed.
- Over 6670 booklets have been distributed as of May 2018.

AMERICAN INDIAN/ALASKA NATIVE (AI/AN) UsCC SUBCOMMITTEE

AI/AN TV and Radio Media Campaign: The AI/AN UsCC subcommittee funded a TV and Radio Media Campaign for FY 2016-2017. The campaign was launched on May 4, 2017 and was completed on July 2, 2017. The AI/AN commercials were aired on CBS, KCAL, and KNX 1070.

Outcomes:

- KCAL and CBS ran a total of 542 commercials, Billboards and Snipes
- These commercials reached 85.7% of the Los Angeles Households with 37,742,000 Impressions
- These Households saw the TV exposure with a frequency of 2.9 times
- KNX 1070 ran a total 671 commercials and 260 streaming commercials
- Of these, 98 were included as added value
- The radio commercials delivered 21,668,000 Impressions and reached 2,870,400 unduplicated adults an average of 9.7 times during the campaign period
- The digital ad banners and streaming on the companion cbsla.com website provided 611, 296 exposure with a frequency of 2.5 times
- The advertisements that ran on KNX 1070 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 to an estimated **61,000** additional listeners

AMERICAN INDIAN/ALASKA NATIVE (AI/AN) UsCC SUBCOMMITTEE (CONT)

AI/AN Bus Advertising Campaign: The bus advertising campaign took place during 12 weeks in March-May, 2017. It included the following: 40 taillight bus displays, 10 king-size bus posters, and 400 interior bus cards. It also included an additional 400 interior bus cards for 12 weeks from June-August, 2017 at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in Los Angeles County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members.

Outcomes:

- A total of 28,128,300 impressions were delivered
- Advertising took place primarily in the following cities: Bell, Bell Gardens, Cerritos, City of Commerce, Downtown Los Angeles, Gardena, Long Beach, Los Angeles, Santa Fe Springs, South Gate, and Whittier.

AI/AN Mental Health Conference: One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2017 American Indian / Alaska Native Mental Health Conference: "Bridging the Gaps – Systems, Cultures, and Generations."

Outcomes:

- The purpose of the conference included the following: to inform participants of mental health issues unique to the AI/AN community, to improve participants ability to recognize when to refer an AI/AN community member for mental health services, to provide participants with useful information on available mental health resources for AI/AN community members, and to improve participants ability to provide culturally appropriate mental health treatment to AI/AN consumers. A survey was handed out to all participants at the start of the conference. The survey was anonymous and voluntary. In total, 265 individuals attended the conference and of those, 119 completed surveys.
- 95% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community.
- 88% agreed or strongly agreed that the conference improved their ability to recognize when to refer an AI/AN community member for mental health services.
- 95% agreed or strongly agreed that they received useful information on mental health resources for AI/AN community members.
- 97% agreed or strongly agreed that as a result of the conference, they had a better understanding of where to refer AI/AN community members to mental health services.
- 95% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to AI/AN consumers.

ASIAN PACIFIC ISLANDER (API) USCC SUBCOMMITTEE

The Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities: This project was implemented on September 1, 2016 and was completed on September 30, 2017. The Multimedia Mental Health Awareness Campaigns included linguistically and culturally appropriate mental health education and engagement workshops and an ethnic media campaign, including mental health awareness Advertisements (Ads) on Television and Radio and Newspaper Articles, that targeted the Cambodian and Vietnamese communities in Los Angeles County. The purpose of this project was to increase awareness and knowledge of the signs and symptoms of mental illness, and for improved access to mental health services for the Cambodian and Vietnamese communities in Los Angeles County.

Outcomes:

- 22 mental health education workshops were held, 11 in Khmer for the Cambodian community and 11 in Vietnamese for the Vietnamese community.
- Of the 238 participants surveyed, 58% were female and 42% were male
- Of the 238 participants surveyed, 55% were older adults, 37% were adults, and 8% were TAY (16-25)
- Of the 238 participants surveyed, 45% were Cambodian, 29% were Vietnamese, and 26% were Chinese
- 238 Pre-Test and 238 Post-Test surveys were collected by workshop participants to assess the impact on their knowledge about the risk factors related to mental illnesses and the importance of prevention.
- Before the workshops, 42% of participants were aware of risk factors that can affect a person's mental health. After the workshops, 97% of participants were aware of the risk factors that can affect a person's mental health, which is an increase of 55%.
- Before the workshops, 36% of participants were aware of how biological factors can affect a person's mental health. After the workshops, 98% of participants were aware of how biological factors can affect a person's mental health, which is an increase of 62%.
- Before the workshops, 39% of participants understood how a person's mood can affect their mental health. After the workshops, 98% of participants understood how a person's mood can affect their mental health, which is an increase of 59%.
- Before the workshops, 38% of participants understood how a person's environment can affect their mental health. After the workshops, 95% of participants understood how a person's environment can affect their mental health, which is an increase of 57%.
- Before the workshops, 35% of participants were aware of how they can help prevent mental health problems. After the workshops, 98% of participants were aware of how they can help prevent mental health problems, which is an increase of 63%.
- A Cambodian Mental Health Radio Ad and a Vietnamese Mental Health TV Ad were developed. The Cambodian Ad was aired 257 times on FM 106.3, which airs a Khmer Radio program. The Vietnamese TV Ad was aired 5,320 times on Saigon TV, which targets the Vietnamese community.
- Four (4) newspaper articles were published in local newspapers. Two articles were published to target the Cambodian community using the Khmer Post and Khmer Voice newspapers. The other two articles were published targeting the Vietnamese communities using the Viet Bao newspaper.

ASIAN PACIFIC ISLANDER (API) USCC SUBCOMMITTEE (CONT)

The Samoan Outreach and Engagement Program: In 2017, LACDMH utilized CSS funds to continue the Samoan Outreach and Engagement Program in order to increase awareness of mental illness, knowledge of mental health resources and decrease stigma related to mental health in the Samoan community. LACDMH contracted with Special Services for Groups (SSG) who partners with two Samoan community-based agencies to conduct individual and group outreach and engagement activities with the Samoan community in Service Area 8, which has the largest concentration of Samoans within the County of Los Angeles. This program completed its second year of implementation on June 30, 2017 during which 483 mental health education workshops were conducted and 2,182 individuals were reached. Workshop activity topics included mental health awareness, stress management, depression, peer pressure, grief and loss, mental health myths and facts, mental health stigma, mental health resources, and suicide. Most of the activities were provided in Samoan (51%). Activities were held at various community locations including: churches (61% of activities), community member homes (18%), Samoan agency offices, community centers, and other community locations (parks, etc.). Attendees were mostly adults (84%), females (59%) and Samoans (94%) who speak English as their primary language (55%).

Outcomes:

- For FY 16-17, all workshop attendees were given a survey to complete to assess the impact of the workshops.
- 100% strongly agree or agree that their knowledge of mental health issues in the community has increased as a result of the activity.
- 100% strongly agree or agree that their knowledge about mental health services available for the Samoan community has increased as a result of the activity.
- 100% strongly agree or agree that they can better recognize the signs of mental health issues as a result of the activity.
- 99% strongly agree or agree that they know where to go for help with mental health issues (for themselves or others) as a result of the activity.
- 99% strongly agree or agree that they can be more accepting of someone with mental health issues (themselves included) as a result of the workshop.
- 98% strongly agree or agree that Samoan culture can influence how one views mental health.
- 99% strongly agree or agree that stigma (shame) can keep individuals from getting help for mental health issues.
- 99% strongly agree or agree that stigma (shame) can keep individuals feeling bad about themselves if they experience mental health issues.
- 99% strongly agree or agree that seeking help for mental health issues is important.
- Starting FY 17-18, enrollment data was collected instead of survey data. There were two individuals enrolled into mental health services, as a result of the workshops as of August 2017.

DISABILITIES USCC SUBCOMMITTEE

The Physical Disabilities UsCC was established January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018. The goal of this subcommittee is to reduce disparities and increase mental health access for those affected by Physical Disabilities. This group will work closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery oriented services specific to the Physically Disabled community, and to develop capacity building projects. As of March 1, 2018 this subcommittee is actively recruiting new members and exploring future capacity building project ideas.

EASTERN EUROPEAN/MIDDLE EASTERN (EE/ME) UsCC SUBCOMMITTEE

Mental Health Education and Stigma Reduction Project for Arabic Speaking College Students: This project was funded to increase mental health awareness, and reduce disparities among Arabic-speaking community members in the County of Los Angeles. It was implemented on September 15, 2016 and continued until June 19, 2017. The project included presentations conducted at local colleges and universities, with the goal to increase awareness and educate Arabic speaking college students (ages 18-30) about mental health, recognition of mental health signs and symptoms and how to access services from Los Angeles County Department of Mental Health. These presentations were conducted by college students (using a Peer-to-Peer model), who were trained by a mental health expert. Some of the topics presented in the project were the following: anxiety, depression, mental health awareness, and stigma to mental health. This project educated Arabic speaking college students who may need mental health services, but are unable or unwilling to access these services due to stigma, lack of education and awareness, and/or cultural/religious barriers.

Outcomes:

- In total, seventeen (17), one (1) hour mental health presentations were conducted at local colleges and universities across Los Angeles County.
- Eight (8) Arabic speaking college students were recruited and trained on basic mental health education. The students were provided with a total of 6 hours of training.
- The presentations took place at University of Southern California, Cal Poly Pomona, University of California, Los Angeles, and Glendale Community College. There were also presentations conducted at a local mosque.
- Attendees of these presentations were asked to complete a pre and posttest survey to capture the level of knowledge gained and if their attitude towards mental health changed.
- A total of 103 matched pair (pre and post) surveys were collected.
- The post-test results indicated that the participants had an increase in knowledge about mental health issues and there was a positive improvement in their attitude toward mental health.
- The post-test results indicated that after attending a mental health presentation, most students reported that they would feel more comfortable living next door to a person with a mental illness.
- The results of the pre and posttest indicated a positive shift in the attitude toward receiving psychotherapy among all those students who participated and completed the surveys.
- In general, the presentations had a positive impact on the Arabic Speaking Students. Many of the participants were grateful to have learned about the most prevalent mental health issues. Due to the knowledge gained from the presentations, participants reported an understanding of some basic mental health symptoms, and ability to recognize when to ask for mental health assistance for themselves and/or someone else.
- A total of 112 students participated in the community presentations and their age ranged from age 14 to age 42.

EASTERN EUROPEAN/MIDDLE EASTERN (EE/ME) UsCC SUBCOMMITTEE (CONT)

The Armenian Talk Show Project Part II: This project consisted of forty-four (44) DMH approved mental health TV talk shows to inform the Armenian community about common mental health issues and how to access services in the County of Los Angeles. The media project was an expansion of a similar project that was funded in FY 2014-2015. The Armenian Talk Show Project Part II included mental health topics such as eating disorders, terminal illness and mental health, intergenerational conflict, mental illness and family support and caregiver stress. These mental health topics provided an opportunity for the Armenian Community to be further educated and informed of the mental health issues that are currently impacting their community. These shows also provided the viewers with linkage and information about mental health services in the County of Los Angeles, including the LACDMH 24-hour ACCESS line phone number. In addition, the most popular 44 episodes of the Armenian Mental Health Show from two seasons were re-aired from April 15, 2017 to September 9, 2017. The shows were broadcasted in areas in the County of Los Angeles with the largest concentration of Armenians such as La Canada, Burbank, North Hollywood, Glendale, Pasadena, Los Angeles, and Montebello).

Outcomes:

- The mental health shows had great success within the Armenian community living in Los Angeles County.
- Between September 16, 2016 and April 5, 2017, a total of 44 half an hour mental health shows aired on the local Armenian television station.
- Based on the feedback provided by T.V. viewers, Armenian community members felt that the talk shows were culturally relevant, educational and thought-provoking.
- The community expressed gratitude for airing the reruns of this show and reported that it expanded their knowledge regarding mental health, how these issues present within the Armenian Community, and how community could access services from LACDMH.
- It was reported by LACDMH's 24/7 ACCESS line that Armenian community members were calling and asking to speak with the clinical psychologist who served as a co-host of these shows.

Farsi Peer-Run Outreach Project: This project trained Farsi speaking volunteers to conduct mental health presentations and provide linkage and referral services. The purpose of the project was to assist Farsi speaking community members in need of mental health services; since they were unable or unwilling to obtain the information and resources due to stigma, lack of education or awareness, and/or language barriers. The project included a 20-hour training curriculum to train Farsi speaking volunteers to conduct the mental health presentations. These volunteers were trained to become Peer Outreach Workers. Their primary role was to educate Farsi speaking community members on basic mental health information and available resources. Due to this training, the community members had the opportunity to work with and learn from someone (peer) from their community, who speaks the Farsi language and has an understanding of the cultural barriers to accessing mental health services.

Outcomes:

- A total of sixty (60) presentations were completed by the volunteers
- The pre and post survey questionnaires were provided at the beginning and at the end of the presentations. It included 5 closed ended questions
- A total of 407 matched pair (pre and post) surveys were collected
- The pre-tests indicated that the majority of the community members (56%) either "disagreed," "strongly disagreed" or had "no opinion" in regards to therapy being as beneficial for healthy, stable, successful people, as much as it is for people suffering from serious mental illness.
- In contrast, the post tests indicated a high number of participants (96%) who "strongly agreed" or "agreed" with this same statement.
- The pre-tests also indicated that a large number of community members (97%), did not know the difference between psychologists, therapists, psychiatrists, and social workers. Additionally, they were not aware of two places where they can find affordable mental health services that are culturally and linguistically appropriate for them (97%).

EASTERN EUROPEAN/MIDDLE EASTERN (EE/ME) UsCC SUBCOMMITTEE (CONT)

Farsi Peer-Run Outreach Project: (CONT)

Outcomes:

- In contrast, the post-tests indicated that the majority of participants (90%) had gained knowledge about the differences between mental health professionals. Also, 98% had gained knowledge on where to access culturally and linguistically appropriate mental health services.
- In regards to "accessing mental health services is not a sign of weakness," again, the pre-tests indicated that only 16% of participants either "agreed" or "strongly agreed" with this statement; while the post-tests indicated that the overwhelming majority (98%) either "agreed" or "strongly agreed" with this statement.
- The pre-tests indicated that the majority of participants (66.5%), either had "no opinion," "strongly disagreed," or "disagreed" with the statement that "problems like depression and anxiety can get better if a person attends therapy;" while the vast majority (90%), indicated in post-tests that they "strongly agreed" or "agreed" with this statement.
- The results indicated that the majority of Farsi-speaking community members had little information about mental health, and there is cultural stigma related to mental illness and accessing mental health services. However, after the peer-run presentations were completed, majority of participants had a better understanding about mental health services and where to access these services in their communities.
- Participants gained a new awareness of how mental health services can benefit everyone and how they can access services and resources.
- A total of 415 community members participated in the presentations.

Mental Health Farsi Language Radio Media Campaign: This project consisted of three (3) different Public Service Announcements (PSA) in the Farsi language. The PSAs aired on a Farsi radio station 5 times – 8 times daily, from May 4, 2017 to July 30, 2017. The PSAs targeted Iranian/Persian communities of Los Angeles County. Each PSA provided culturally sensitive information, education, and resources about a specific mental health topic. The topics presented in the project were the following: mental health awareness, and domestic violence. The purpose of this Farsi language PSA project was to provide mental health education and information to the Farsi speaking community on how to access mental health services as stigma, lack of education and language barriers continue to be obstacles for this underserved community.

Outcomes:

- The PSAs had a large impact on the Farsi speaking community
- According to the ACCESS Center Language Line report, there was a significant increase in calls from Farsi speaking community members during the months of May 2017, June 2017, and July 2017, which was when the PSAs were aired.
- For example, there were a total of 31 Farsi speaking calls for the first four months of 2017 (January – April) and for May 2017 alone, there were 49 calls, 44 calls in June of 2017, and 25 calls in July of 2017.
- The PSAs offered the Farsi speaking community members the opportunity to learn of the services offered by Los Angeles County Department of Mental Health and it helped to increase awareness about several mental health issues within this community.

EASTERN EUROPEAN/MIDDLE EASTERN (EE/ME) UsCC SUBCOMMITTEE (CONT)

Mental Health Russian Language Television Media Campaign: This project consisted of four (4) different PSAs in the Russian language. The PSAs helped educate the Russian community and increase awareness of the signs and symptoms of mental illness, as well as reduce the stigma associated with mental health conditions with this underserved subgroup. The PSA's aired in a rotation and one PSA aired at least six times a day for three months, from April 25, 2017 to July 29, 2017, between the hours of 7 a.m. and 11 p.m. The PSAs included mental health education and information on topics such as general mental health information, depression, and anxiety. The PSAs informed consumers of existent mental health issues in the Russian community and resources available within the LACDMH.

Outcomes:

- As reported by the television station, the airing of the Russian PSAs had a great impact on the Russian and Russian-Armenian community.
- Four PSAs aired 6 times day between April 25, 2017 and July 29, 2017.
- As reported by the television station, they received many calls from viewers requesting information and referrals regarding the services offered by LACDMH.

LATINO UsCC SUBCOMMITTEE

Latino 2017 Mental Health Awareness Media Outreach Campaign: For FY 2016-2017, the Latino UsCC subcommittee funded an additional Television and Radio Media Campaign. Univision Communications, Inc. was contracted to launch the Media Campaign that included TV, Radio and Digital elements. The project was launched on May 1, 2017 and completed on July 16, 2017. The commercials were aired on KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran a total of 138 television commercials, a 2-day Homepage takeovers and Univision.com geo-LA/Local Los Angeles Rotation – in banner video, and Social Media. KLVE, KRCD, and KTNQ radio stations ran 501 commercials, and a 2-day Homepage takeovers and social media. In addition, a 3- minute interview with DMH's Ethnic Service Manager (ESM) was aired weekly on Dr. Navarro's program at KTNQ – 1020 Radio Station for nine (9) weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview was aired on four (4) radio stations on June 12, 2017 and June 25, 2017.

Outcomes:

- The KMEX report shows that the television campaign delivered a total of 14,501,956 Impressions (the total number of times households were exposed to the commercials)
- The KLVE, KRCD, and KTNQ reports show that the radio campaign delivered a total of 12,200 impressions.
- Digital campaign delivered 1,106,234 impressions.
- A gross total of 15,620,390 Impressions were delivered from viewers and listeners.
- The media campaign reached millennials via digital, KLVE Motivational Monday social media posts and homepage takeovers via Univision.com and at the same time personally touched the 25-54 age group with their message on KMEX news and novellas.
- KTNQ 1020 AM live interviews on Tuesdays with DMH's Ethnic Service Manager aired weekly on Dr. Eduardo Navarro's program were considered by Univision Communications, Inc., "jewels for the community" as it offered advice on topics of importance to the functioning of a happy family.

LATINO UsCC SUBCOMMITTEE (CONT)

Latino UsCC Bus Advertising Campaign: For FY 2016-2017, the Latino UsCC subcommittee funded a Bus Advertising Campaign to promote mental health services, increase the capacity of the public mental health system, and reduce stigma. The campaign began on February 27, 2017 and ended on October 8, 2017. It includes the following: 172 taillight bus displays, 56 king-size bus posters, and 4,000 interior bus cards for a total of 32 weeks (that includes an additional 2,000 interior bus cards for 12 weeks at no additional cost).

Outcomes:

- 43 Bus tails, 16 weeks = 3,832,332 impressions
- 14 Bus kings, 16 weeks = 4,410,672 impressions
- 500 Interior bus cards, 32 weeks = 13,676,000 impressions
- The campaign delivered a total of 21,919,004 impressions

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING INTERSEX, TWO-SPIRIT (LGBTQI2-S) UsCC SUBCOMMITTEE

LGBTQI2-S Radio Media Campaign: The LGBTQI2-S UsCC subcommittee funded a Radio Media Campaign for Fiscal Year 2016-2017. The campaign was launched on May 4, 2017 and was completed on July 2, 2017. The LGBTQI2-S commercials were aired on KNX 1070, KRTH 101, KCBS FM 93.1, KROQ 106.7, KAMP 97.1, and 94.7 The Wave.

Outcomes:

- In total, 878 commercials were aired
- KAMP 97.1 ran 136 commercials, KCBS 93.1 ran 132 commercials, KNX 1070 ran 161 commercials, KROQ 106.7 ran 129 commercials, KRTH 101 ran 136 commercials, and 94.7 The Wave ran 184 commercials
- The combined radio campaign reached an estimated 7,664,200 people
- 73.8% of the Los Angeles County population was reached an average of 4.3 times
- Total radio Impressions were 32,244,000
- The digital display banners on the companion websites to the radio stations delivered approximately 1,530,607 Impressions
- The audio streaming commercials delivered an additional 1,000,576 Impressions (2,531,183 digital Impressions total)

Community Mental Health Needs Assessment: The objective of the LGBTQI2-S Community Mental Health Needs Assessment Project was to outreach and engage people of color within the LGBTQI2-S population into a discussion regarding the needs of the community, as well as reduce stigma associated with mental health services. Additionally, this project aimed to increase awareness of the mental health needs of LGBTQI2-S individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. This project targeted both leaders and providers within the LGBTQI2-S community, as well as community members. The project included two components: a Community Leaders Forum made up of leaders and providers who were brought together into a learning collaborative to discuss the needs of the community, as well as seven focus groups made up of people of color within the LGBTQI2-S community with the purpose of assessing the needs of LGBTQI2-S individuals, identifying gaps in access to mental health services, and identifying how to engage community members into mental health services provided by Los Angeles County Department of Mental Health.

Outcomes:

- Individuals were recruited from the following six communities: African-American, American Indian/Alaska Native, Armenian, Asian Pacific Islander, Iranian, Latinx
- Seven focus groups were conducted in total

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING INTERSEX, TWO-SPIRIT (LGBTQI2-S) USCC SUBCOMMITTEE (CONT)

Community Mental Health Needs Assessment (CONT)

Outcomes:

- 61 people participated in the focus groups – 10 African-American participants, 10 American Indian/Alaska Native, nine Armenian, 12 Asian Pacific Islander, 11 Iranian, and nine Latinx
- The participants ranged in age from 18 to 60 and were representative of a broad gender spectrum
- The Community Leaders Forum took place on 8/24/2017 and was attended by 20 community leaders, providers, and community members
- As a result of the focus groups, numerous barriers were identified with regards to access to mental health services: stigma, transgenerational trauma, and limited availability of resources
- Recommendations were given related to engagement and marketing including developing culturally relevant materials, marketing on cultural and ethnic television stations and networks, marketing on social media for younger generations, conducting outreach at universities and schools, and attending culturally significant events such as pow wows
- Additionally, recommendations were given for the upcoming LGBTQI2-S Mental Health Conference being hosted by LACDMH. These recommendations included making the conference free to attend for community members, conducting intergenerational panels, providing information on how to address and treat transgenerational trauma, addressing homelessness, and many others.

Speak Your Mind Academy: The objective of the LGBTQI2-S Youth Speak Your Mind Academy Mental Health Outreach Project was to engage, empower, enlist, and enlighten the LGBTQI2-S Youth community, as well as to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. The project included two components: training of 50 LGBTQI2-S Youth Advocates and, once trained, the Advocates conducted two community mental health presentations. The Youth Advocates were to be aged 18-25 years and from all eight Service Areas. The LGBTQI2-S Youth Advocates were individuals who identified as LGBTQI2-S and who had limited or no experience with LACDMH mental health services. The Academy covered basic mental health education including common diagnoses and symptoms, the power of advocacy, storytelling and public speaking, crisis identification/resolution, and outreach and engagement.

Outcomes:

- 23 LGBTQI2-S Youth were trained to become Mental Health Advocates and graduated from the Speak Your Mind Academy
- A total of 38 community presentations were completed by 10 of the Advocates
- The presentations took place in all eight Service Areas
- A total of 259 community members attended the presentations
- Participants of the presentations were asked to complete a survey/evaluation at the end of the presentation. In total, 132 surveys were completed and were overall very favorable
- Resources were provided at the presentations and included mental health resources, social support resources, and physical health resources

SERVICE AREA OUTREACH & ENGAGEMENT HIGHLIGHTS

Outreach and Activities As Reported by the Service Areas

SERVICE AREA 1
ANTELOPE VALLEY

Attended multiple joined and planned activities with over 4,000 attendees. The population consisted of African American, Latino, White, Families, Children, Consumers and individuals with various disabilities.

1. **The Desperately Seeking Attachment: Understanding How Trauma & Neglect Disrupt Attachment** - Participants were provided with an overview of identifying attachment theory, understanding types of attachment patterns and how a crisis in the attachment relationship is an opportunity for change and healing. Skills and tools to effectively engage the child who has experienced trauma. As a result of this training, parents and professionals should have an increased understanding with attachment-based interventions and how attachment therapy empowers the family system to become the healing mechanism for the child. Participating agencies and attendees were Parents, DCFS, Penny Lane Centers, Children's Bureau, LAC DMH, Antelope Valley Partners for Health, Grace Resources and Equip Day Care.
2. **Suicide Prevention Campaign** School-based Mental Health providers put together a campaign focused on suicide prevention in May of 2018. Over 1000 flyers were distributed throughout the community at large The goal was to provide information to the public regarding resources related to suicide prevention. Five billboards were also placed around the Antelope Valley.
3. **H.O.P.E. (Homeless, Outreach, Partnership, Event)** The 3rd annual H.O.P.E (Homeless Outreach Partnership Event) consisted of various services provided to the homeless population such as vaccinations, dental examinations, vision screenings, application for reduced bus fees, identification cards, information and advocacy about how to navigate the social security system, assistance with medi-cal enrollment, haircuts and tangible items such as clothing, food, hygiene kits, and blankets. The following service providers participated and provided resources at the event, Mental Health America, Bartz-Altadonna, Antelope Valley Community Clinic, Lancaster School District-Welcome Center, Operation Blankets of Love, Department of Motor Vehicles, San Joaquin College, Various Faith-Based organizations/ministries, Social Security, Department of Health Services, Department of Public Social Services, Department of Public Health.
4. **Implicit Bias Forum** the Antelope Valley Health Neighborhood held its first Implicit Bias Forum. The training included a module on implicit bias as well as cultural competency. This training introduced resources and an individualized development plan to help learners mitigate implicit biases and improve cultural competence. The forum was attended by 85 individuals representing 25 agencies and programs as well as community members from all over the Antelope Valley.

SERVICE AREA 2
SAN FERNANDO VALLEY

Attended multiple joined and planned activities with 7,956 attendees. The population consisted of Latino, African American, Armenian, and White, Asian Pacific Islanders, Russian, Arabic, Iranian and etc.

1. **1st Annual Armenian Genocide Event** focused on Transgenerational Effects on Trauma and Healing. Engaging with the Armenian community, collaborating with professionals from the Glendale Police Department, Glendale Public Library, Glendale Unified School District, Private Armenian Schools, Armenian Clergy and Faith organizations, agencies that provide mental health services to the Armenian population to start conversations about the effects of trauma and how to heal.

SERVICE AREA 2
SAN FERNANDO VALLEY

continued

2. **1st NAMI Armenian Support Group** started in May 2018. The Support Group is held at Didi Hirsch in Glendale on a monthly basis
3. **Clergy Breakfasts/Roundtable/Faith Based Advocacy Council Meetings** Outreach and Engagement teams engaging with health professionals and clergy and faith organizations. Clergy leaders and mental health professionals meet to provide information, updates on their organizations and collaborate with each other to help mutual consumers and congregants.
4. **May is Mental Health "Reaching Out" Private Screening Event** The team assisted outreach, engagement, coordination and promotion of the event
5. The team helped, organized and attended an array of Community Resource Fairs:
    - NAMI Pathway Annual Recovery Fair
    - School/Head Start Resource Fairs
    - Annual Government Day Event
    - LGBTQI
    - Homeless Connect Day Event
    - Summer Fest Health Fair/Child 306
    - EXP Earth Day
    - DCFS Resource Fair

The team also delivered educational presentations in Spanish and English to unserved and underserved ethnic populations, parents, foster parents, and caregivers of children who are at risk of experiencing depression and anxiety.

SERVICE AREA 3
SAN GABRIEL VALLEY

Attended multiple joined and planned activities with over 2,000 attendees. The population consisted of Latino, Asian, Pacific Islanders, Veterans and the community at large.

1. **Peer Support Subcommittee** which serves a planning group for the larger body (SAAC 3). The recruitment of consumers required extensive community grassroots outreach to local mental health clinics and consumer groups.
2. **May is Mental Awareness Poster Campaign** an all consumer band named the River Band provided the entertainment and volunteers served the food and refreshments. T-shirts and posters were designed by the peers and were disseminated into the local neighborhoods in the San Gabriel Valley.
3. Participated in multiple events in the community by providing resource booths with information on Mental Health at:

    - Los Angeles County Veterans and Resource Expo 2017
    - Parks After Dark
    - East San Gabriel Valley Mental Health Clinic Open House
    - Supervisor Hilda L. Solis 1st Anniversary East San Gabriel Valley District Office
    - Los Angeles County Fair
    - Salvation Army Homeless Connect Day
    - The 2nd Annual Disability and Aging Resource Fair
    - Miles Conference
    - Asian American Mental Health Conference
    - Mental Health Conference: Pornography Addiction
    - Adelante Young Men Conference 2017
    - La Fentre Center Annual Health and Information Fair
    - Mountain View High School Community Resource Fair/Open House
    - 17th Annual Conference on Mental Health & Spirituality
    - 21st Annual Tribute Veterans Military Families Resources Fair
    - Boys & Girls Clubs Wellness Fair

SERVICE AREA 4
METRO

Attended multiple joined and planned activities with 5,863 attendees. The population consisted of Latino, African American, Homeless Population, LGBTQ, and the community at large.

1. Mexican, Salvadorian and Guatemalan Consulates Service area 4 provides weekly information booths at each consulate disseminating mental health informational material
2. Interfaith Roundtable/Health Neighborhood/SAAC Meetings consist of local police presentations, Department of Mental professionals providing educational information on mental health, linkage and how to access services. Attendees are able to participate in case vignettes and discussion. These meeting bring a variety of individuals, consumers and the community at large together to collaborate and discuss Mental Health Programs, activities and future goals.
3. Participated in multiple events in the community by providing information on Mental Health at:
    - Various LAUSD Schools Parents/Family Resource Fairs
    - The Wellness 4th Anniversary
    - Pico-Union Resource Fair
    - Archdiocesan Catholic Center
    - Frank D. Lanterman Regional Center Resource Fair
    - USC School of Social Work Immigration Conference
    - Cal State LA 2nd Annual Mental Health & Behavioral Health Conference

SERVICE AREA 5
WEST

Attended multiple joined and planned activities with over 2,000 attendees. The population consisted of the community at large from underserved cultural communities.

1. The Winter Celebration the focus of this event was Self Help. A panel of speakers and representatives from Recovery International, Depression Bipolar Support Association, NAMI Peer Support, Support Groups in Spanish Project and Share. Discussed the importance of Self Help, how to celebrate and encourage opportunities that promote well-being, as well as sharing of success stories.
2. The Summer Celebration the focus was celebrating Health Neighborhoods. This event provided hands on activities to explore what neighborhoods can do to increase well-being within their neighborhood.
3. Participated in multiple events in the community by providing information on Mental Health at:
    - Quarterly Breakfast at churches in Service Area 5
    - City Libraries in Service Area 5
    - Community Resource Fairs
    - Garifuna International Indigenous Film Festival and Mental Health Awareness
    - Women Infant and Children Office (WIC)
    - Winter Shelter

SERVICE AREA 6
SOUTH

Attended multiple joined and planned activities with 5,904 attendees. The population consisted of Latino, African American, White, and the community at large.

1. **17th Annual Conference on Mental Health and Spirituality** the conference theme was "Connected You Are Not Alone"
2. **Dealing with Teen Depression Presentation** focused on a variety of subtopics such as signs and symptoms of depression in adolescent males and females.
3. **The Impact of Domestic Violence Exposure on Children Presentation** focused the emotional toll Domestic Violence has on children, the link between poor academic performance and the PTSD aspect.
4. **Nutrition and Mental Health Presentation** focused on the importance of ingesting a variety of foods that have a positive effect on one's emotional well-being.
5. **Mental Health and Spirituality Presentation** focused on raising awareness on conscious living, increasing inspiration, meaning and purpose to help decrease depression, anxiety, and stress.
6. **Anti-Bullying Presentation** focused on different types of bullying. The attendees were educated on topics such as cyber bullying and how they can help the person being bullied.
7. **Mental Health and Drugs Presentation** attendees were given description of what is considered a drug, how drugs can induce emotional instability and a discussion on physical and emotional changes .
8. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - Parks After Dark
    - Victory Baptist Church Resource Fair
    - Compton Unity Festival
    - LAPD National Night Out
    - Family and Back to School Resource Fair
    - Transitional Age Youth Resource Fair
    - Back to School Night and Resource Fair
    - Job and Resource Fair
    - Hands Around Locke Resource Fair
    - FAME Church 2nd Chance Fair
    - Teen Young Parent Holiday Event Health and Resource Fair
    - Foster Young Resource Fair
    - Celebrating Fatherhood Father's Day Event
    - Each Mind Matters Wellness Fair

SERVICE AREA 7
EAST

Attended multiple joined and planned activities with 3,117 attendees. The population consisted of the community at large from underserved cultural communities.

1. **May is Mental Health 2nd annual health fair "Spring Fling"** co-led by Service Area 7, Child 306 and Best Five LA. Hundreds of participants enjoyed entertainment, food, information and education about health, mental health, substance abuse, free dental and vision screenings.
2. **We Rise Event** Service Area 7 provided both clinicians and case managers to man a resource table at the event, Rio Hondo Mental Health Clinic transported clients and volunteers to the event.
3. **American Indian Counseling Center Resource Fair** The event included traditional dance, singing, music, including drumming, and speeches by both clients and members of DMH. A free, hot lunch was served to all participants. There were booths with culturally appropriate arts and crafts activities, and Wellness themes such as Reiki massage, and the use of bells and sound to heal.
4. **Clergy Breakfasts** These meetings allow networking between our Mental health directly operated programs and Providers, with members of local churches, synagogues, temples and mosques, who are often the first to encounter community members experiencing mental health difficulties. Each meeting included a presenter on a mental health topic relevant to the clergy, such as: Spirituality and Psychotropic Medication, Understanding the Needs of Older Adults and the Benefits of Faith, Homelessness on our Doorstep: Mental Health and Harm Reduction; and Rituals in Healing: A Native American Perspective.
5. **Youth Mental Health First Aid training:** Provided by clinician Kelly Brignoni, offered to Rio Hondo College Kinder Care program and twice to the SA 7 Interfaith Coalition. Teaches parents, family members, teachers caregivers, health and human service workers how to help an adolescent who is experiencing mental health or addictions crisis.
6. **Case Management Symposium** Co-sponsored by PIH, SA 7 Health Action Lab and the Southeast Los Angeles Health Neighborhood, this was a four-hour symposium to build skills, create connections and strengthen the community. Panel discussion facilitated by Kelly Brignoni, included speakers from One Degree, 211, Enki, and Whittier First Day, with a keynote address by the Director of Social Work for Whittier College.
7. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - Law Enforcement Resource Fair
    - Parks After Dark
    - Ribbon Cutting Ceremony for Supervisor Hilda Solis's Health Center
    - Annual Stepping In Conference with Law Enforcement
    - Annual Spirituality Conference
    - Annual Resource Fair at Rio Hondo Mental Health Clinic "Nuestra Salud"
    - Probation Department's resource fair
    - CORE Resource Fair
    - Senior Centers
    - Rio Hondo College Fair: Suicide Prevention booth with Power 106 FM Radio

SERVICE AREA 8
HARBOR

Attended multiple joined and planned activities with over 4,000 attendees. The population consisted of the community at large from underserved cultural communities.

1. The Long Beach Career, Community & Wellness Fair Expo 2018
2. The coalition was awarded the grant from Cal MHSA. The purpose of the community partnerships is to improve conditions physically, mentally, spirituality, and economically, in the North Long Beach Community. With support from Senator Kamala Harris Office, they recruited several employers, to offer career opportunities to those attending. There were 30 tables for vendors staffed with workers, a DJ and Photographer to document this event also providing information on Community resources including mental health topics, physical wellness topics, as well as government resources.
3. **Client Turkey Basket & Gift Cards for the Holidays event** SA 8 and community churches delivered gift cards, food boxes and wish list gifts to consumers.
4. **San Pedro Mental Health** hosted its annual May is Mental Health Awareness Month Community Health and Resource Fair There where volunteers from Women in Non-Traditional Employment Roles (WINTER), not including consumers, volunteers and staff. Service providers such as Providence Club conducted blood glucose and pressure screenings, Lions Club conducted hearing and vision testing independence Scan conducted carotid artery screenings for strokes assessments, DMV and DPSS and Cal Fresh process applicants.
5. **San Pedro Mental Health hosted a Primeros Auxillos Para Salud Mental (Mental Health First Aid training in Spanish)** Facilitating educational workshops promotes inclusion and reduces stigma associated to mental health in the community. Continuously disseminating information also assists clients to successfully reintegrate in to their community.
6. **San Pedro Mental Health hosted a Suicide Prevention Awareness Workshop Facilitating** educational workshops promoting inclusion and reduces stigma associated to mental health in the community. Continuously disseminating information to the community at large also assists clients to successfully reintegrate into their community.
7. Participated in multiple events in the community by providing resource booths with information on Mental Health at:
    - San Pedro Mental Health participated in the Wilmington Housing and Health Fair
    - Tri-Cities League of Woman Voters Mental Health Form
    - First Ladies Health Initiative

LINKAGE SERVICES

JAIL LINKAGE & TRANSITION AND SERVICE AREA NAVIGATION

JAIL LINKAGE & TRANSITION

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.

Report on Jail Linkage Program services conducted by MHSA-funded staff:

The table below shows clients served per quarter by self-reported race/ethnicity. The final column shows the annual number of unduplicated clients for Fiscal Year 2017-2018.

Ethnicity	Q1 July-Sept 2017	Q2 Oct-Dec 2017	Q3 Jan-Mar 2018	Q4 Apr-June 2018	Unduplicated Client Total FY 2017-2018
African American	96	50	62	84	254
Latino	81	78	46	72	223
Asian Pacific Islander	2	1	1	11	12
Native American/ American Indian	0	0	0	0	0
Caucasian	52	39	31	48	134
Middle Eastern/ Eastern European	2	0	0	0	2
Unknown	9	5	1	1	14
Total	**242**	**173**	**141**	**216**	**639**

Mental Health Outpatient Treatment - Linkage Outcomes

From the unduplicated client count of 639, we created a sample of clients with referrals to mental health outpatient services. Clients were excluded who declined linkage services, were released after July 1, 2018, were transferred to state prisons, state hospitals or other county jails, or were referred to inpatient treatment programs, residential bridging services, Enriched Residential Services (ERS), IMDs, IMD step downs, FSPs and residential SUD treatment programs.

We randomly selected 20% of the remaining individuals, resulting in a sample of 73 clients who received referrals to community mental health outpatient treatment. We searched the financial records section of IBHIS for documentation of billing from outpatient MH clinics in the period following clients' release from jail, to capture "showed up" or successful linkages where the client received treatment services.

In our sample of 73 individuals, 33 (43.4%) had documented visits after release at community MH outpatient providers, including both DMH-contracted agencies and DMH directly operated clinics throughout LA County. Among these 33 individuals, 21 (28.8% of the 73 sampled) received outpatient MH services within 2 months of release.

Outpatient Referral Sample	73
Post-release MH outpatient visit (per billing shown in IBHIS)	33 (43.4%)
MH outpatient visit within 2 months of release (per billing shown in IBHIS)	21 (28.8 %)

MENTAL HEALTH COURT PROGRAM

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

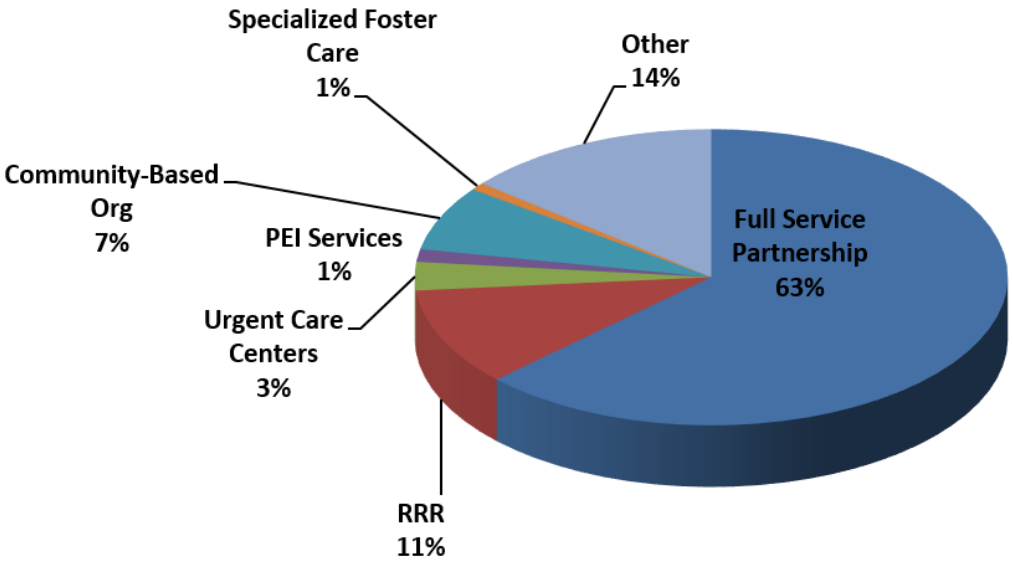
1) The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery based program serves adults 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

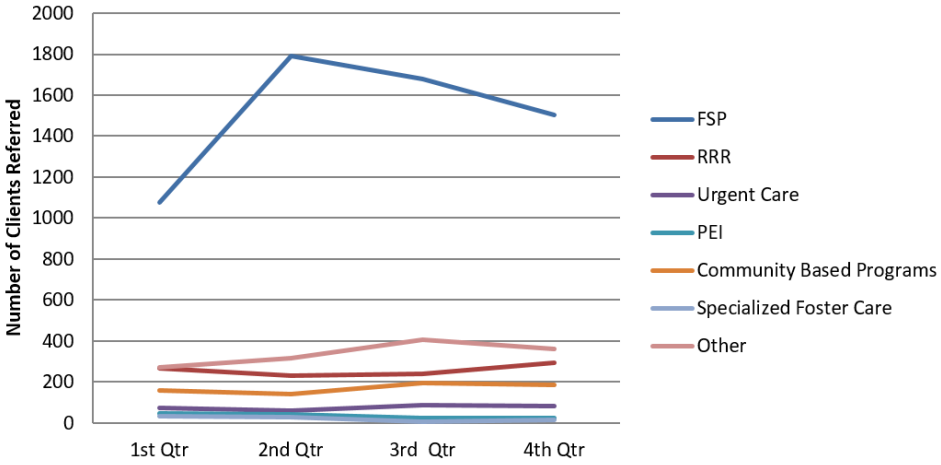
Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry 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.

Referrals by Program
Countywide Fiscal Year 2017-18
N=12,273

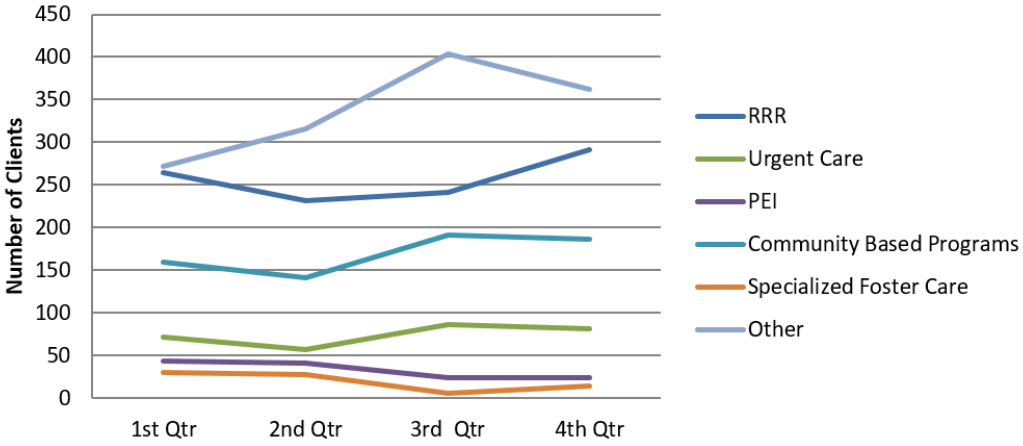


Clients Referred to Services in FY 17-18



Referrals to the Full Service Partnership program steadily decreased at the start of the 2nd quarter.

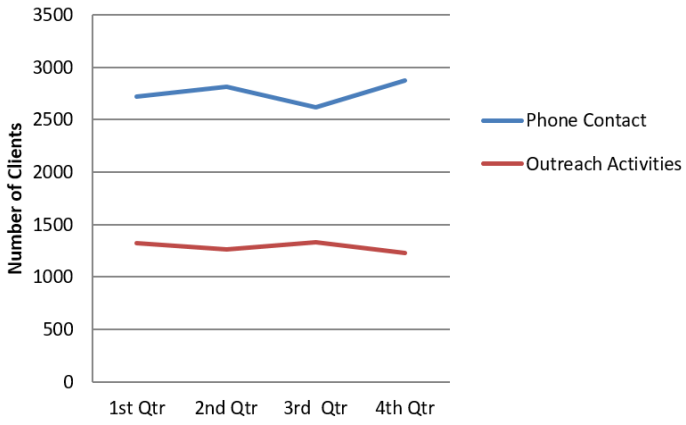
Clients Referred to Services other than FSP in FY 17-18



Referrals to RRR Services decreased 2nd quarter but gradually increased over the 3rd and 4th quarter.

Phone contacts and outreach activities remained constant through the fiscal year.

Phone Contacts and Outreach Activities in FY 17-18



PREVENTION & EARLY INTERVENTION

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

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

The prevention strategies involve, at a minimum, a combination of training, resource infusion at the site of the access platform, partnership development and consultation to educators. The Department, through a contract with RAND Corporation, developed a prevention outcome measure that went into use on July 1, 2018.

Prevention and Early Intervention

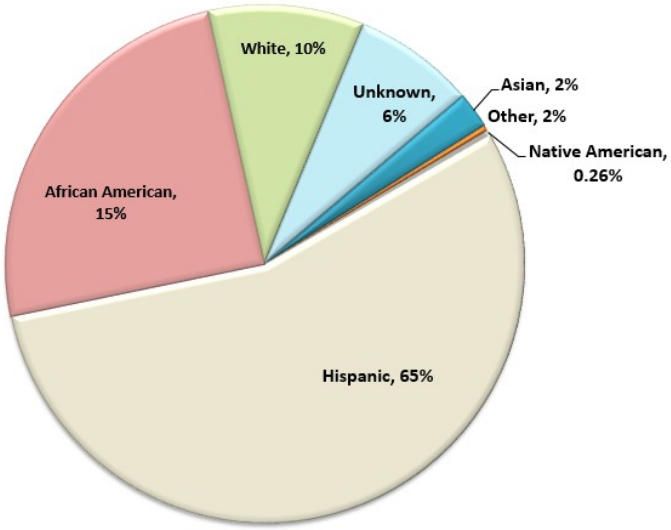
Prevention - Early Intervention - Stigma & Discrimination - Suicide Prevention

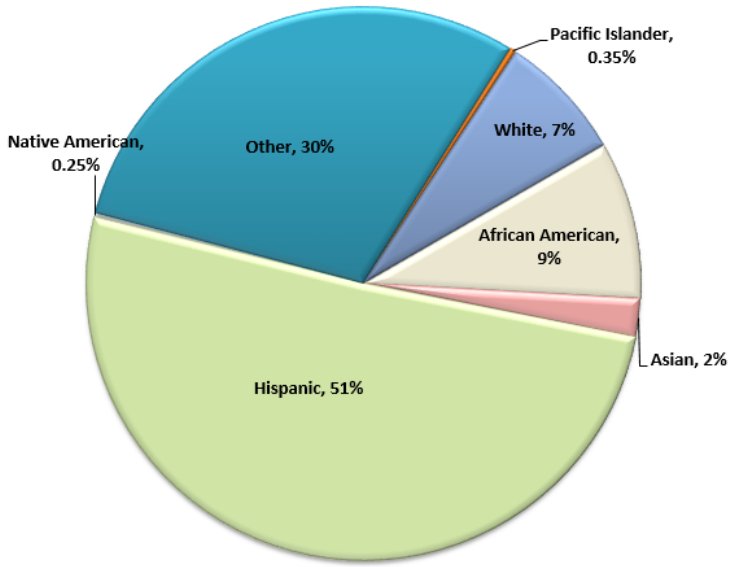
CLIENTS

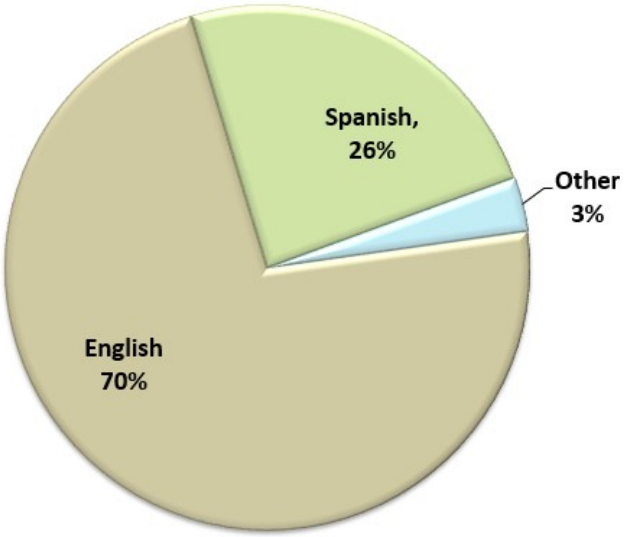
- 44,212 clients received a direct mental health service
- 69% of the clients are children
- 19% of the clients are TAY
- 10% of the clients are Adult
- 2% of the clients are Older Adult
- 55% are Hispanic
- 73% have a primary language of English

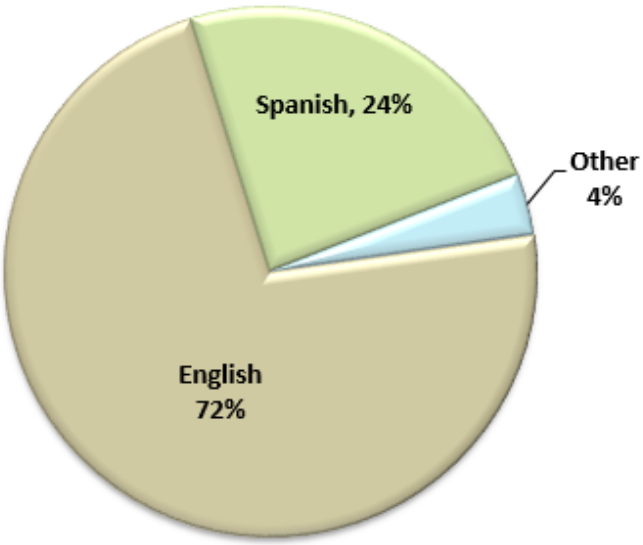
NEW CLIENTS

- 27,341 new clients receiving PEI services Countywide with no previous MHSA service
- 51% are Hispanic
- 72% have a primary language of English

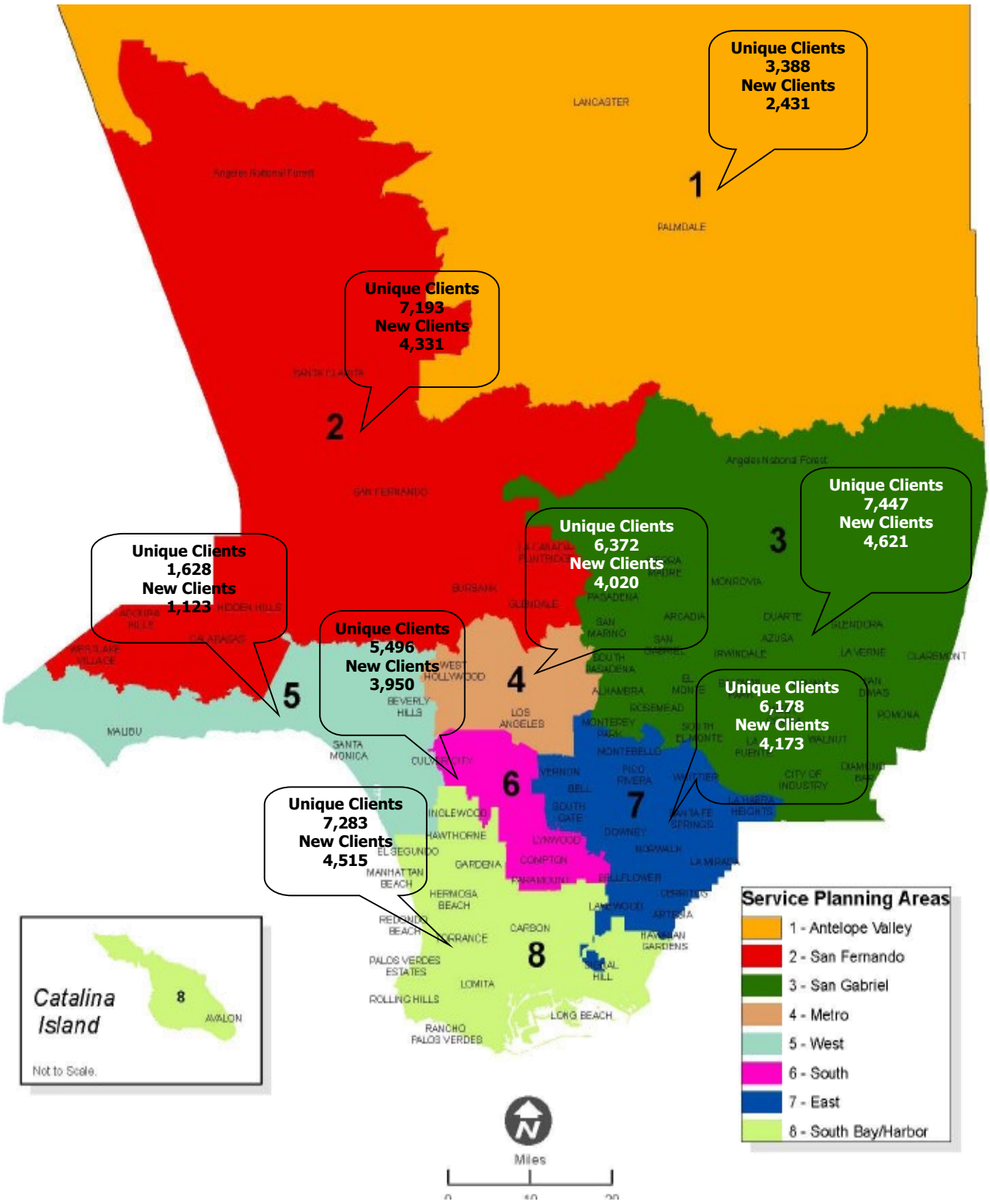






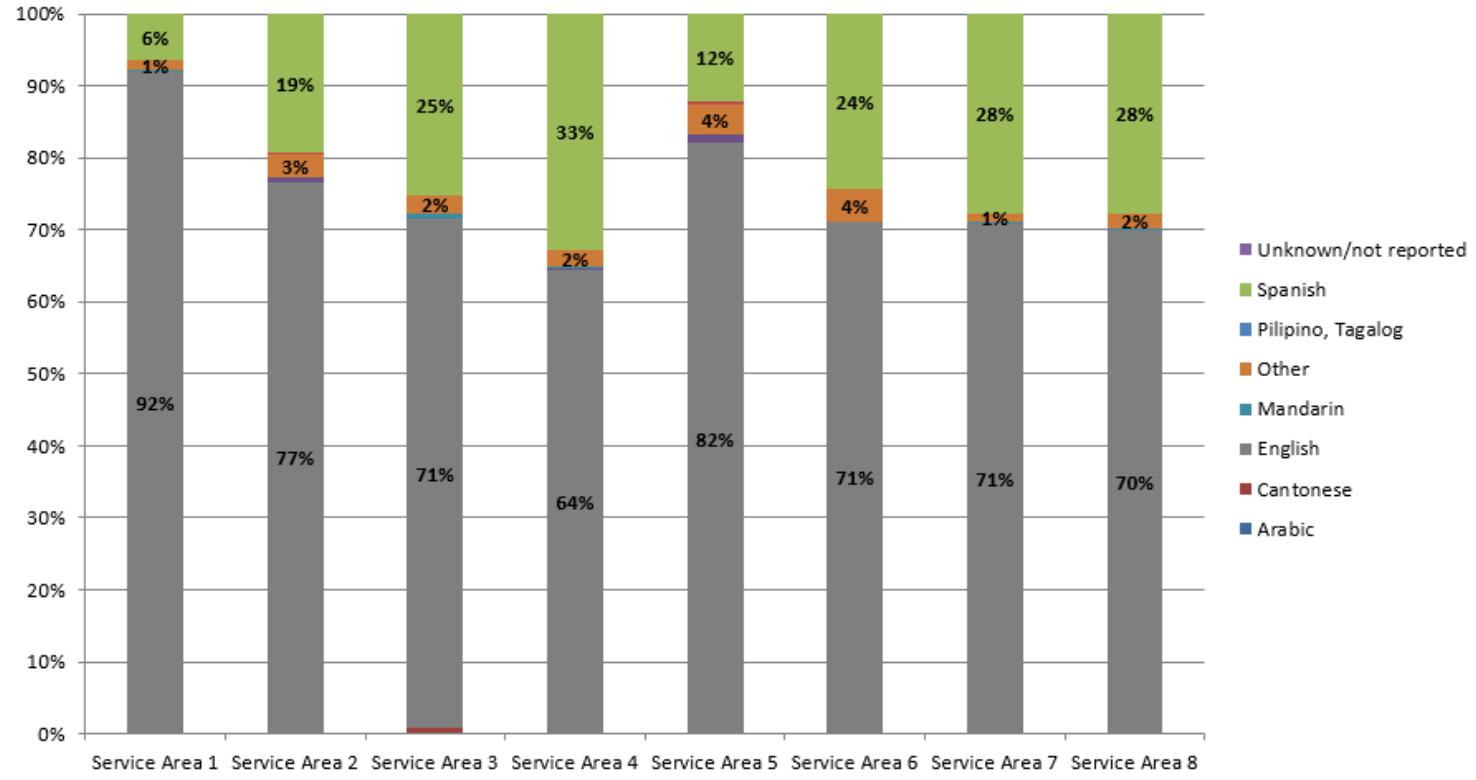


Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2017-18

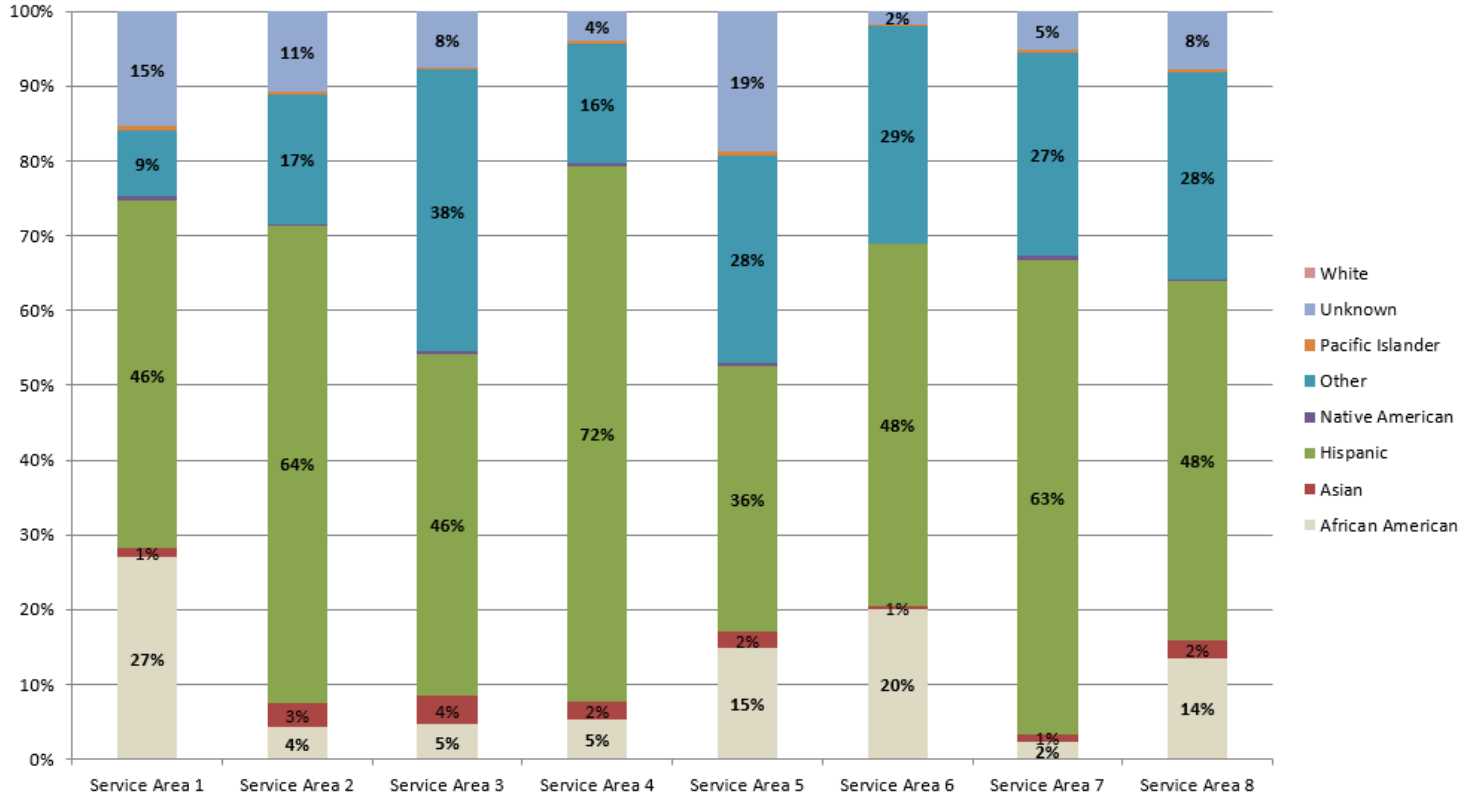


Los Angeles County Clients Served Through PEI by Service Areas Fiscal Year 2017-18

Primary Language by Service Area



Ethnicity by Service Area



EARLY INTERVENTION

AGRESSION REPLACEMENT TRAINING (ART)

Children (ages 5-12) –Skill Streaming Only
Children (ages 12-15), TAY (ages 16-17)

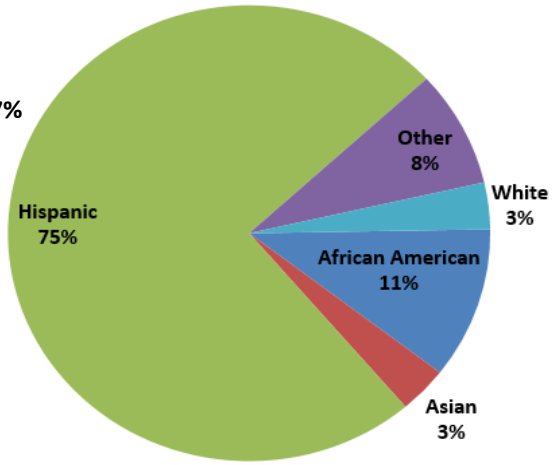
ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs

OUTCOMES

* 3,375 Treatment Cycles
* 42% reported completing the EBP
* 25% Improvement in mental health functioning

ETHNICITY & GENDER

N= 121
Male: 63%
Female: 37%



Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)

Children (ages 4-15), TAY (ages 16-17)

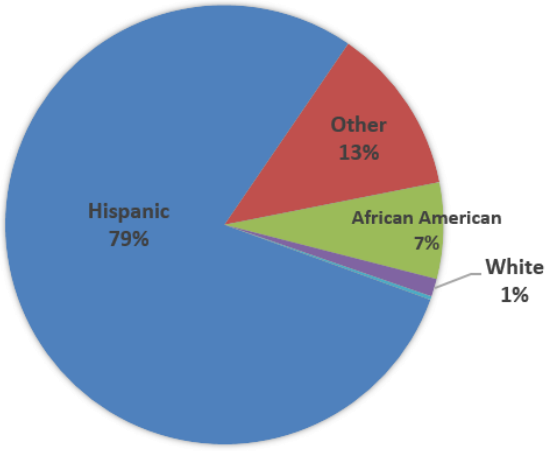
AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.

OUTCOMES

* 1,332 Treatment Cycles
* 49% reported completing the EBP
* 50% Improvement in mental health functioning
* 53% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=381
Male: 60%
Female: 40%



*Data as of 4/4/2018. Outcomes entered July 2011 through April 2018. Percentage of clients completing the EBP was determined by what was entered in the PEI

Asian American Family Enrichment Network (AAFEN)

Children (ages 12-15), TAY (ages 16-18)

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.

Brief Strategic Family Therapy (BSFT)

Children (ages 10-15), TAY (ages 16-18)

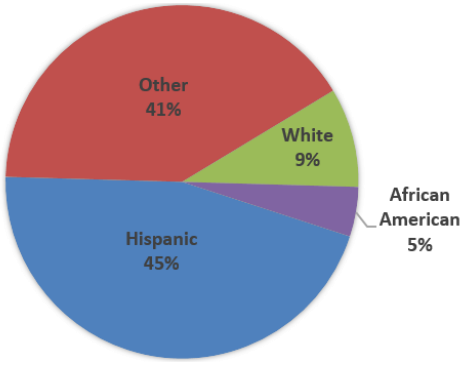
BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

OUTCOMES

* 185 Treatment Cycles
* 66% reported completing the EBP
* 50% Improvement in mental health functioning
* 50% Reduction in behavioral problems

ETHNICITY & GENDER

N=22
Male: 50%
Female: 50%



Caring for Our Families (CFOF)

Children (ages 5-11)

Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.

OUTCOMES

* 732 Treatment Cycles
* 68% reported completing the EBP
* 23% Improvement in mental health functioning
* 30% Reduction in disruptive behaviors

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

TAY

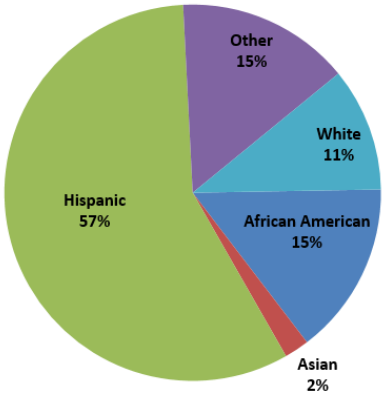
The focus of CAPPS is to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.

OUTCOMES

* 189 Treatment Cycles
* 44% reported completing the EBP
* 31% Improvement in mental health functioning
* 60% Reduction in prodromal symptoms

ETHNICITY & GENDER

N=
Male: 60%
Female: 40%



Child-Parent Psychotherapy (CPP)

Young Children (ages 0-6)

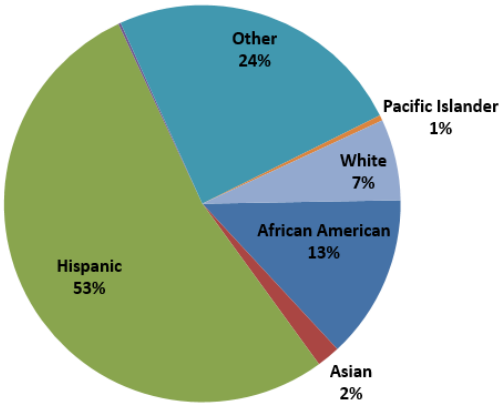
CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged 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.

OUTCOMES

* 5,039 Treatment Cycles
* 48% Reported completing the EBP
* 55% Improvement in mental health functioning
* 19% Reduction in child's mental health functioning following a traumatic event

ETHNICITY & GENDER

N= 1,572
Male: 52%
Female: 48%



Cognitive Behavioral Intervention for Trauma in School (CBITS)

Children (ages 10-15), TAY

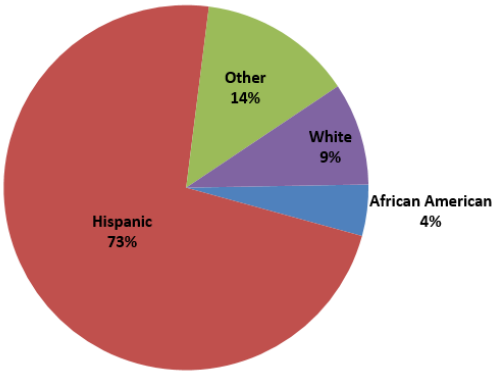
CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school 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 .

OUTCOMES

* 121 Treatment Cycles
* 68% reported completing the EBP
* 31% Improvement in mental health functioning
* 28% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=22
Male: 32%
Female: 68%



Coordinated Specialty Care Model for Early Psychosis (CSC-EP)

Children (ages 12-15) & TAY (ages 16-25)

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.

Crisis Oriented Recovery Services (CORS)

Children , TAY, Adults,, Older Adults

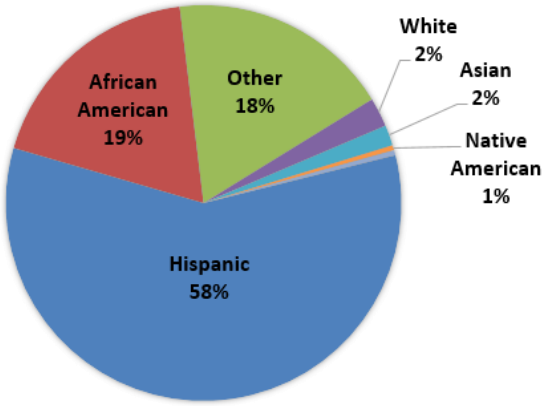
CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.

OUTCOMES

* 3,898 Treatment Cycles
* 59% reported completing the EBP
* 28% Improvement in mental health functioning

ETHNICITY & GENDER

N=716
Male: 50%
Female: 50%



Depression Treatment Quality Improvement (DTQI)

Children , TAY , Adults , Older Adults

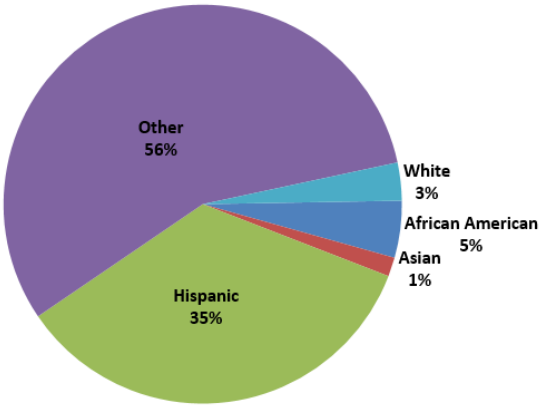
DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.

OUTCOMES

* 1,118 Treatment Cycles
* 62% reported completing the EBP
* 47% Improvement in mental health functioning
* 62% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=100
Male: 41%
Female: 59%



Dialectical Behavior Therapy (DBT)

Children (ages 12-15) TAY (ages 16-20)

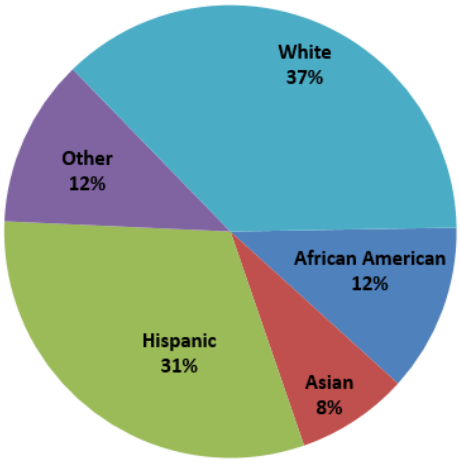
DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.

OUTCOMES

* 109 Treatment Cycles
* 47% reported completing the EBP

ETHNICITY & GENDER

N=100
Male: 29%
Female: 70%



Families Over Coming Under Stress (FOCUS)

Children , TAY , Adults

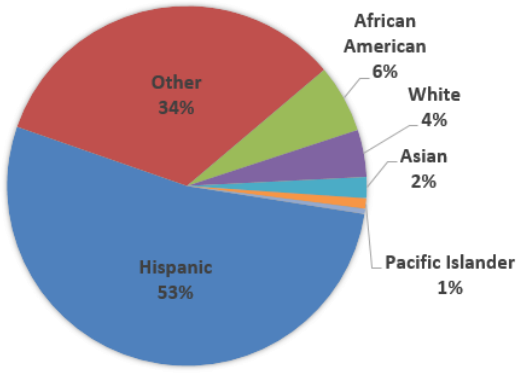
Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.

OUTCOMES

* 414 Treatment Cycles
* 71% reported completing the EBP
* 43% Improvement in mental health functioning
* 50% Improvement in family functioning

ETHNICITY & GENDER

N=212
Male: 53%
Female: 47%



Family Connections

Children (ages 0-17), TAY (ages 16-17)

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.

Functional Family Therapy (FFT)

Children (ages 11-15) TAY (ages 16-18)

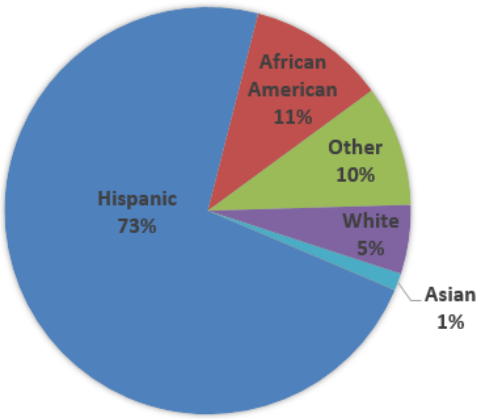
FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.

OUTCOMES

* 1,637 Treatment Cycles
* 65% reported completing the EBP
* 31% Improvement in mental health functioning

ETHNICITY & GENDER

N=73
Male: 55%
Female: 45%



Group Cognitive Behavioral Therapy for Major Depression (Group CBT)

TAY (ages 18-25), Adults, , Older Adults

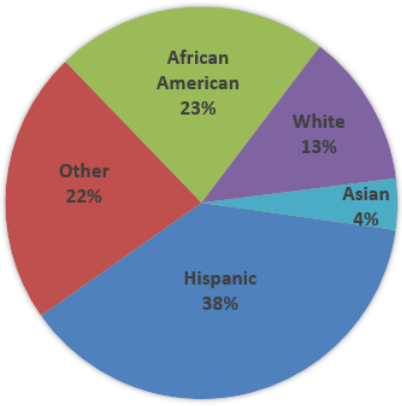
Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is 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.

OUTCOMES

* 1,086 Treatment Cycles
* 44% reported completing the EBP
* 21% Improvement in mental health functioning
* 42% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=71
Male: 35%
Female: 65%



Group Individual Psychotherapy (Group IPT)

Ages 15+

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.

Incredible Years (IY)

Young Children (ages 2-5)
Children (ages 6-12)

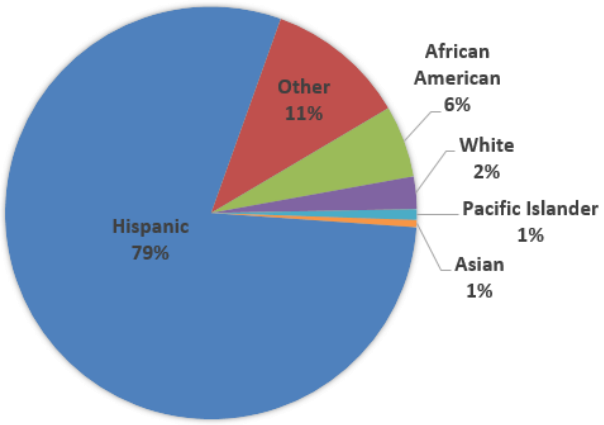
IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/ emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.

OUTCOMES

* 2,477 Treatment Cycles
* 64% reported completing the EBP
* 27% Improvement in mental health functioning
* 35% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=354
Male: 68%



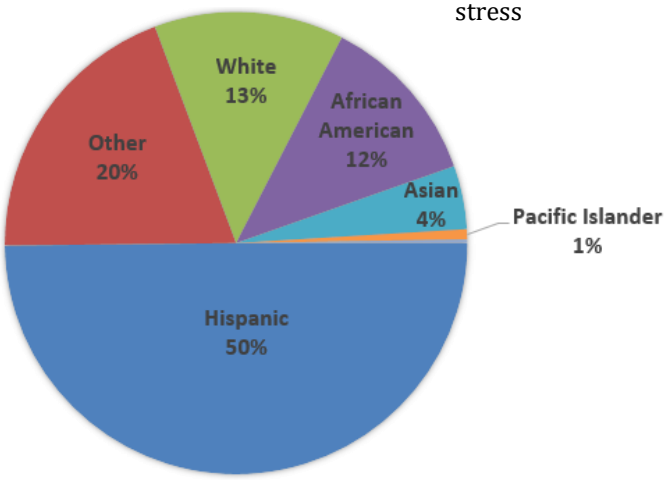
Individual Cognitive Behavioral Therapy (Ind. CBT)

TAY (ages 18-25) , Adults , Older Adults , Directly Operated Clinics only

CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.

ETHNICITY & GENDER

N=3,962
Male: 32%
Female:



OUTCOMES

Anxiety:
* 1,902 Treatment Cycles
* 43% reported completing the EBP
* 37% Improvement in mental health functioning
* 54% Reduction in symptoms related to anxiety

Depression:
* 4,687Treatment Cycles
* 42% reported completing the EBP
* 35% Improvement in mental health functioning
* 53% Reduction in symptoms related to depression

Trauma:
* 583Treatment Cycles
* 48% reported completing the EBP
* 42% Improvement in mental health functioning
* 59% Reduction in symptoms related to posttraumatic stress

Interpersonal Psychotherapy for Depression (IPT)

Children (ages 9-15) TAY , Adults , Older Adults

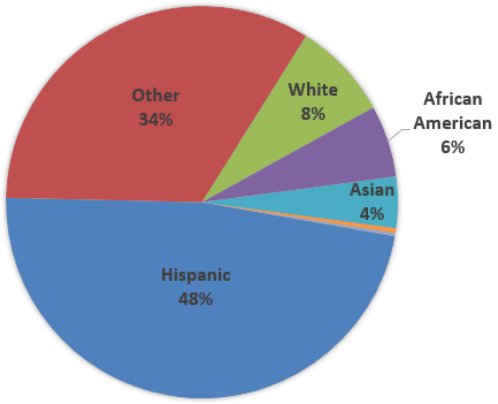
IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

OUTCOMES

* 5,443 Treatment Cycles
* 52% reported completing the EBP
* 31% Improvement in mental health functioning
* 54% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 2,110
Male: 33%
Female:



Loving Intervention Family Enrichment Program (LIFE)

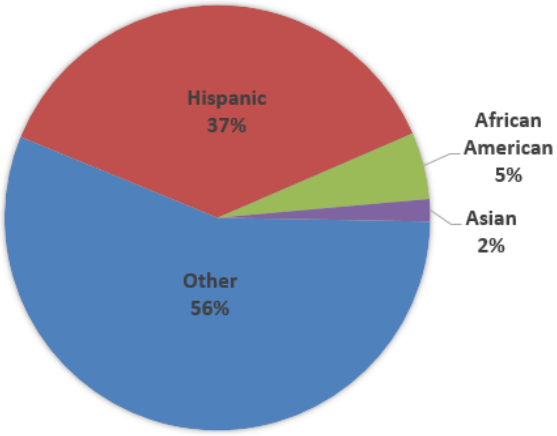
Children (ages 0-8)

An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/ or school failure.

OUTCOMES

* 402 Treatment Cycles
* 65% reported completing the EBP
* 33% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

N=59
Male: 61%
Female: 39%



Managing and Adapting Practice (MAP)

Young Children , Children , TAY (ages 16-21)

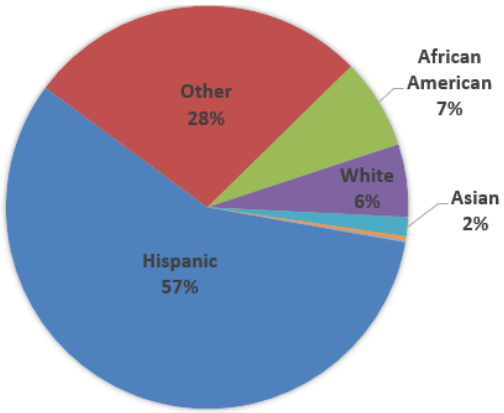
MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.

OUTCOMES

* 42,654 Treatment Cycles
* 54% reported completing the EBP
* 43% Improvement in mental health functioning
* 43% Reduction in disruptive behaviors
* 55% Reduction in symptoms related to depression
* 41% Reduction in symptoms related to anxiety
* 53% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 19,129
Male: 54%
Female: 46%



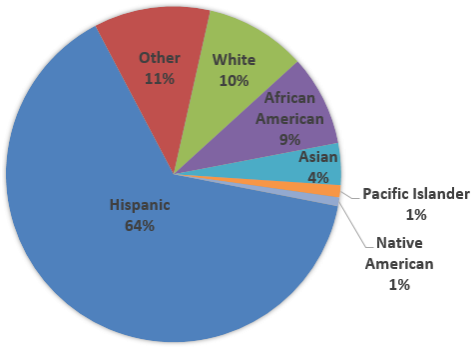
Mental Health Integration Program (MHIP) formerly known as IMPACT

Adults

MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.

ETHNICITY & GENDER

N= 595
Male: 28%
Female: 72%



OUTCOMES

MHIP-Anxiety
* 1,803 Treatment Cycles
* 39% reported completing the EBP
* 58% Reduction in symptoms related to anxiety

MHIP-Depression
* 5,275 Treatment Cycles
* 34% reported completing the EBP
* 53% Reduction in symptoms related to depression

MHIP-Trauma
* 297 Treatment Cycles
* 29% reported completing the EBP
* 24% Reduction in symptoms associated with exposure to trauma

Mindful Parenting Groups (MP)

Young Children (ages 0-3)

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.

The Mothers and Babies Course, Mamas y Bebes

Ages 13+

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.

Multidimensional Family Therapy (MDFT)

Children (ages 12-15) TAY (ages 16-18)

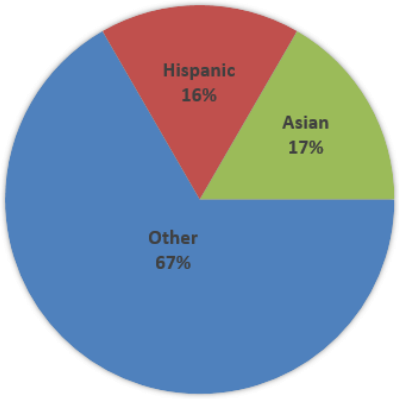
MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.

OUTCOMES

* 74 Treatment Cycles
* 89% reported completing the EBP
* 25% Improvement in mental health functioning

ETHNICITY & GENDER

N= 6
Male: 67%
Female: 33%



Multisystemic Therapy (MST)

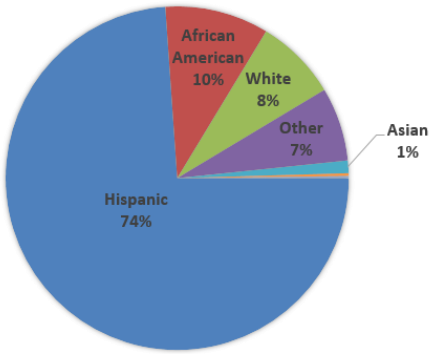
Children (ages 12-15) TAY (ages 16-17)

MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).

OUTCOMES

* 126 Treatment Cycles
* 72% reported completing the EBP
* 46% Improvement in mental health functioning

N= 1,513
Male: 67%
Female: 33%



Parent-Child Interaction Therapy (PCIT)

Young Children (2-7)

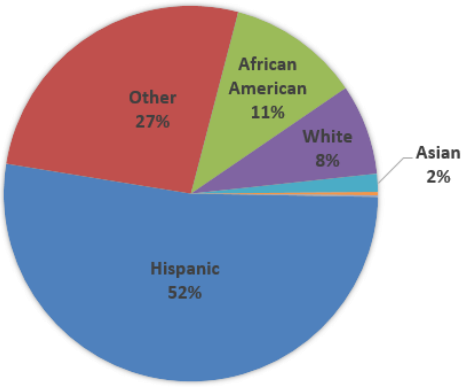
PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.

OUTCOMES

* 2,947 Treatment Cycles
* 41% reported completing the EBP
* 57% Improvement in mental health functioning
* 63% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=1,410
Male: 66%
Female: 34%



Problem Solving Therapy (PST)

Older Adults

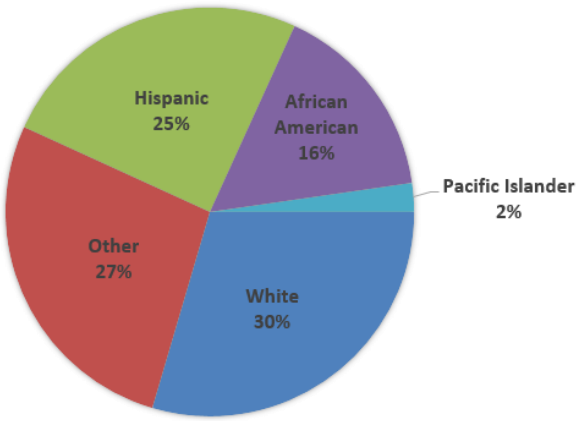
PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.

OUTCOMES

* 378 Treatment Cycles
* 61% reported completing the EBP
* 28% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 44
Male: 36%
Female: 64%



Program to Encourage Active Rewarding Lives for Seniors (PEARLS)

Older Adults

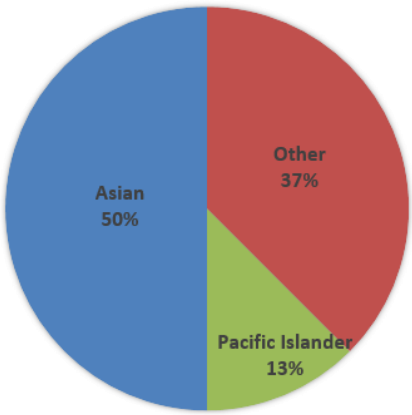
PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.

OUTCOMES

* 162 Treatment Cycles
* 50% reported completing the EBP
* 26% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 8
Male: 38%
Female: 63%



Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)

TAY (ages 18-25) Adults , Older Adults , Directly Operated Clinics Only

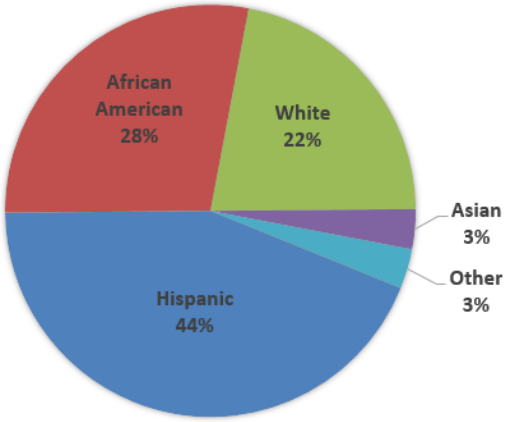
PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.

OUTCOMES

* 66 Treatment Cycles
* 52% reported completing the EBP

ETHNICITY & GENDER

N= 32
Male: 66%
Female: 34%



Promoting Alternative Thinking Strategies (PATHS)

Children (5-12)

PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.

OUTCOMES

* 745 Treatment Cycles
* 34% reported completing the EBP
* 37% Improvement in mental health functioning
* 33% Reduction in disruptive behaviors

Reflective Parenting Program (RPP)

Young Children (ages 2-5)
Children (ages 6-12)

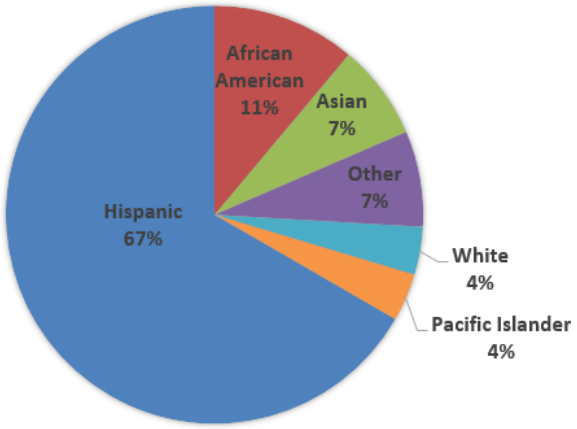
RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents / caregivers enhance their reflective functioning and build strong, healthy bonds with their children.

OUTCOMES

* 222 Treatment Cycles
* 74% reported completing the EBP
* 11% Improvement in mental health functioning
* 15% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=27
Male: 56%
Female: 44%



Seeking Safety (SS)

Children (13-15) TAY , Adults, Older Adults

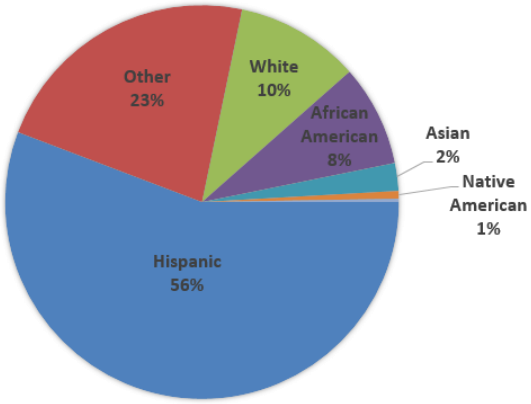
SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

OUTCOMES

* 18,075 Treatment Cycles
* 40% reported completing the EBP
* 36% Improvement in mental health functioning
* 31% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 3,290
Male: 39%
Female: 61%



Strengthening Families (SF)

Children (ages 3-15) TAY (ages 16-18)

SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle

Children (ages 3-8)

This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Young Children , Children , TAY (ages 16-18)

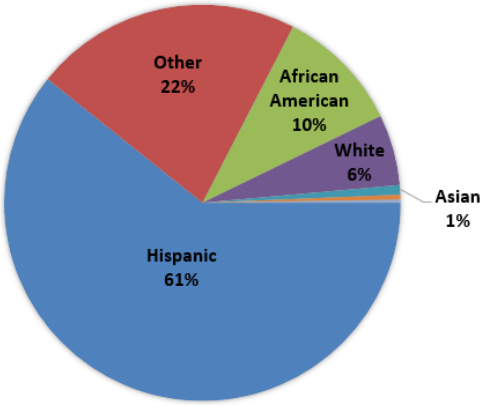
An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered 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.

OUTCOMES

* 18,440 Treatment Cycles
* 55% reported completing the EBP
* 47% Improvement in mental health functioning
* 51% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 5,781
Male: 44%
Female: 56%



Triple P Positive Parenting Program (Triple P)

Young Children (ages 0-5)
Children (ages 6-15) TAY (age 16)

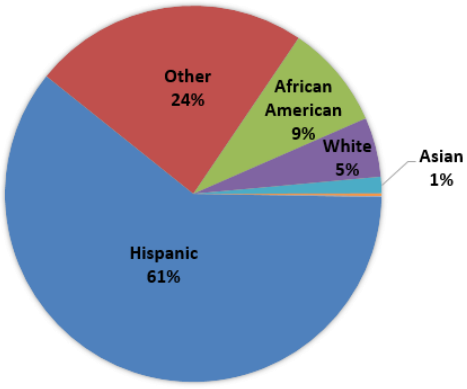
Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.

OUTCOMES

* 5,410 Treatment Cycles
* 59% reported completing the EBP
* 41% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

ETHNICITY & GENDER

N= 1,270
Male: 68%
Female: 32%



UCLA Ties Transition Model (UCLA TTM)

Young Children (ages 0-5), Children (ages 6-12)

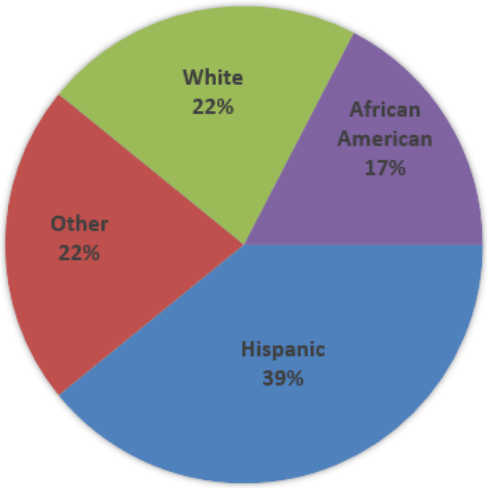
UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

OUTCOMES

* 184 Treatment Cycles
* 50% reported completing the EBP

ETHNICITY & GENDER

N=23
Male: 61%
Female: 39%



PREVENTION

The following prevention activities and services are geared toward addressing, either through education or support, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support. LA County DMH contracted with RAND corporation to develop a prevention measure for services that were in various stages of development and implementation. In addition, DMH worked with various county partners to customize measures for specific populations and settings (see Appendix VII). Due to that work, outcomes for prevention services did not begin to be widely collected until July 1, 2018 and will be reported in next year's report and 3 year plan.

ASIAN AMERICAN FAMILY ENRICHMENT NETWORK (AAFEN)

Age Group: Children (12-15), TAY (16-18)

AAFEN Program is Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their teenage children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for those emotional and behavioral problems that would qualify them for such diagnostic impressions as "Oppositional Defiant Disorder" and "Substance Abuse Disorders." Their immigrant parents and/or primary caregivers are also at high risk for such diagnostic impressions as "Dysthymic Disorder" and "Major Depression," among others. In addition, they are at serious risk for being reported to DCFS for monitoring as they resort to such measures as corporal punishment in an attempt to discipline their children.

ACTIVE PARENTING

Age Group: Children (3-17)

Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, divorce, school success, and character education. Active Parenting classes can be delivered in 1, 3, 4, or 6 group sessions. Curriculum addresses: child development, appropriate discipline, communication skills, decision-making and prevention of risk behaviors.

AMERICAN INDIAN LIFE SKILLS (AILS)

Age Group: Children (14-15), TAY (15-19)

The American Indian Life Skills Development curriculum, also known as the Zuni Life Skills Development curriculum, is a school-based, culturally sensitive, suicide-prevention program for American Indian adolescents. Tailored to American Indian norms and values, the curriculum was designed to reduce behavioral and cognitive factors associated with suicidal thinking and behavior. The curriculum typically is delivered over 30 weeks during the school year, with students participating in lessons 3 times per week. Lessons are interactive and incorporate situations and experiences relevant to American Indian adolescent life, such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons include brief, scripted scenarios that provide a chance for students to employ problem solving and apply the suicide-related knowledge they have learned.

PREVENTION

ARISE

Age Group: Children (4-15), TAY (16-25), Adult (26-59), Older Adult (60-64)

ARISE provides evidence-based life skills group based curricula and staff training programs. Programs are geared towards at-risk youth; however, the program is adaptable for adults as well. Program content focuses on: violence reduction, goal setting, anger management, drug and alcohol avoidance and other life management skills.

CHILDHELP SPEAK UP AND BE SAFE

Age Group: Children (3-15), TAY (16-19)

This is a child-focused, school-based curriculum designed to build safety skills within the child while addressing today's societal risks, such as bullying and Internet safety. The program helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse—physical, emotional, and sexual. The program focuses on enhancing the child's overall sense of confidence with regard to safety and promotes respect for self and peers that can be applied to general as well as potentially harmful situations. In addition to increasing children's ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.

COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN AND YOUTH (CSECY) TRAINING

Age Group: TAY (16-25), & Adult (26-59)

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.

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE SERVICES

Age Group: TAY (16-25), Adult (26-59)

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. The program will target victims of domestic violence. The program will educate the people who are involved in an abusive relationship on signs and symptoms of domestic violence.

PREVENTION

ERIKA'S LIGHTHOUSE: A BEACON OF HOPE FOR ADOLESCENT DEPRESSION

Age Group: Children (12-14)

The program is an introductory depression awareness and mental health empowerment program for early adolescence. The program educates school communities about teen depression, eliminates the stigma associated with mental illness and empower teens to take charge of their mental health. The Real Teenagers Talking about Adolescent Depression: A Video Based Study Guide is a depression and mental health school program designed for middle and high school classrooms and is listed in the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention "Best Practices Registry for Suicide Prevention". The program: 1.Teaches students about depression; 2.Explores the stigma surrounding the illness; and 3. Teaches students how to cope with stress and maintain good mental health.

GUIDING GOOD CHOICES

Age Group: Children (9-14)

Guiding Good Choices is a five-session; parent involvement program that teaches parents of children ages 9-14 how to reduce the risk that their children will develop drug problems. The goal of the program is to prevent substance abuse among teens by teaching parents of preteens and younger adolescents the skills they need to improve family communication and family bonding. During the course of the Guiding Good Choices program, parents will learn specific strategies to help their children avoid drug use and other adolescent problem behaviors, and develop into healthy adults. Parents will learn to set clear family guidelines on drugs, as well as learn and practice skills to strengthen family bonds, help their children develop healthy behaviors, and increase children's involvement in the family.

HEATHY IDEAS (IDENTIFYING DEPRESSION, EMPOWERING ACTIVITIES FOR SENIORS)

Age Group: Older Adults (60+)

The 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.

INCREDIBLE YEARS (ATTENTIVE PARENTING)

Age Group: Parent

The Attentive Parenting program is a 6-8 session group-based "universal" parenting program. It can be offered to ALL parents to promote their children's emotional regulation, social competence, problem solving, reading, and school readiness.

PREVENTION

LIBRARY CHILD, FAMILY, AND COMMUNITY PREVENTION PROGRAMS

Age Group: Young children and their parents, school-aged children, TAY and Older Adults **Participant Count:** 63,590

The Library Child, Family, and Community Prevention Program (Library Program) is intended to increase protective factors, mitigating the impact of risk factors assorted with serious psychiatric illness and negative outcomes. The Library Program is intended to serve four primary target populations residing in underserved communities experiencing adversity. The four target populations are: 1) young children and their parents/caregivers, 2) school aged children, 3) transitional aged youth, and 4) older adults. Program participants align with the PEI priority populations which include the following:

- Trauma Exposed Individuals
- Individuals experiencing onset of serious psychiatric illness
- Children and youth in stressed families
- Children and youth at risk for school failure
- Children and youth at risk of or experiencing Juvenile Justice involvement;
- Underserved cultural populations

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING, INTERSEX, AND 2-SPIRIT (LGBTQI2) SERVICES

Age Group: TAY (16-25)

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; 6) Development of a training curriculum to educate the community and providers about LGBTQ12 TAY issues; and 7) training of mental health providers on reaching out to and working with LGBTQ12 TAY including approaches such as LGBT Affirmative Therapy.

LIFE SKILLS TRAINING (LST)

Age Group: Children (8-15), TAY (16-18)

LST is a group-based, substance abuse prevention program developed to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive program utilizes collaborative learning strategies taught through lecture, discussion, coaching, and practice to enhance youth's self-esteem, self-confidence, decision-making ability and ability to resist peer and media pressure. LST provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.

PREVENTION

LOVE NOTES

Age Group: Children (15), TAY (16-24)

The Love Notes is created for this vulnerable, high-risk audience. In 13 lessons they discover, often for the first time, how to make wise choices about partners, sex, relationships, pregnancy, and more. Love Notes appeals to the aspirations and builds assets in disconnected youth.

MAKING PARENTING A PLEASURE (MPAP)

Age Group: Parents of children (0-8)

Make Parenting a Pleasure is a 13 week, 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 geographical background.

MINDFUL SCHOOLS

Age Group: Children (0-15), TAY (16-25), Adults (26-59)

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.

MORE THAN SAD

Age Group: Children (14-15), TAY (16-18)

This is a curriculum for teens, parents and educators to teach how to recognize the signs of depression. The program for teens teaches how to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. This program for teachers teaches educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.

NATIONAL ALLIANCE ON MENTAL ILLNESS – LOS ANGELES PEI PROGRAMS

Participant Count: 4,855

Members of NAMI are people who lives with serious mental illness, and their friends and family. We provide a vast array of programs aimed at making their lives better and encouraging conversation and understanding about serious mental illness in the public space including in places or worship, or work, on junior high, high school and college campuses, at community clubs, mental health clinics, health fairs, community health centers. Stigma Reduction and Anti-Discrimination, Public Education Awareness: reducing the time it takes for an individual or family member to find appropriate help for mental illness, connecting individuals to mental health services as early as possible, increasing the understanding of the general public on mental illness and recovery and resources. Increasing participants coping skills and empowering family members and caregivers to become advocates for mental health treatment, learning how to recognize early signs and symptoms of mental illness. Outreach and engagement. Improving family and community involvement in mental health recovery .

NURSE FAMILY PARTNERSHIP (NFP) PROGRAM

Age Group: High-risk, low-income mothers pregnant with their first child **Participant Count:** 899

The program targets high-risk, low-income mothers pregnant with their first child. NFP aims to reduce risk factors and increase protective factors. The overall program goals are to improve pregnancy outcomes, improve child health and development, and improve mother's life course. The program screens for maternal mental health, supports, and assesses for the need for additional support. NFP practice requires the ongoing monitoring of mother and child for risk factors and/or symptoms by conducting routine screenings of mother and baby. Referrals for further assessment and intervention are made when a mother or child scores high on one or more of the screeners. NFP nurses can refer them to the Clinical Social Worker paid by this program or another DMH clinic for mental health services. Further, NFP nurses can refer children to Regional Services or Medical clinics if deemed necessary.

Primary Language	Number of Clients
Arabic	1
English	635
Other Chinese	3
Other	48
Russian	1
Spanish	209
Tagalog	1
Vietnamese	1

Race	Number of Clients
American Indian	28
Asian	21
Black or African American	101
Native Hawaiian or other Pacific Islander	4
White	600 (including Hispanic)
Other	0
More than one race	0
Unknown	145

Disability	Number of Clients
No	544
Yes:	345
Difficulty seeing	2
Difficulty hearing	4
Mental domain (not including a mental illness)	Not Collected
Physical/mobility domain	Not Collected
Chronic health condition	339

Age	Number of Clients
0-15	37
16-25	629
26-59	233

PREVENTION

OLWEUS BULLYING PREVENTION PROGRAM

Age Group: Children (5-15), TAY (16-18)

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.

PARKS AND RECREATION PARKS AFTER DARK (PAD) PROGRAM DMH AND THE COUNTY OF LOS ANGELES PARKS AND RECREATION (DPR)

Age Group: Children through Older Adults **Participant Count:** 7,978

Parks After Dark (PAD) is a program featuring extended park hours and activities for youth and families to increase physical activity, reduce violence, and enhance health and social well-being among community residents. By providing Prevention and Early Intervention (PEI) through mental health education, outreach, and early identification (prior to diagnosis), the Department of Mental Health can mitigate costly negative long-term outcomes for mental health consumers and their families.

Parks are often underutilized due to high levels of crime and fear of violence, which inhibit active living efforts, cause social isolation and lead to a wide range of mental and physical health problems. Parks After Dark was designed to address a number of critical service gaps that are seen in disadvantaged communities.

Parks After Dark targets children, TAY, adults and older adults who meet the following criteria:

- Underserved ethnic and cultural populations residing in high-risk and underserved communities within the County.
- Child, TAY, adults and older adults that could benefit from PEI services and supports;

It is intended that this effort will reduce risk factors and increase protective factors which is in support of the MHSA PEI Regulations. Parks possess great potential to address these service gaps by serving as community hubs where mental health and other organizations can provide education and outreach to vulnerable populations, and participants of all ages can easily access a diverse array of important services and resources in a fun and welcoming setting that is less stigmatized than a government building or mental health clinic.

PEACEBUILDERS

Age Group: Children (0-15)

PeaceBuilders is a violence prevention curriculum and professional development program for grades pre-K to 12. Its essence is a common language - six principles, taught, modeled and practiced: Start Early; Engage Parents Prior to Adolescence; Praise Good Behavior on a Daily Basis; Discourage Insults and Other Acts of Aggression.

PEI SUPPORTIVE HOUSING SERVICES

Age Group: All Ages

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 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.

PERMANENCY PARTNERS PROGRAM (P3), UPRFRONT FAMILY FINDING (UFFF)

Age Group: Children , TAY **Participant Count:** 125

Research studies have shown that for Child Welfare system-involved children, placements with relatives help to minimize trauma; provides fewer placement changes; and increases better school stability than those placed with a foster family. Additionally, the consequences of instability and high risk factors, such as lack of positive social connections, for all children and youth, if not addressed early on in the life of a DCFS case, can result in higher risk for developing a potentially serious mental illness or systems involvement such as child welfare and juvenile justice systems. The P3 program can improve outcomes for children and youth by providing specific focus on engagement of family and NREFM in order to increase placement stability and provide opportunities for social connectedness for these children and youth since detention.

Primary Language	# of Clients
English	105
Spanish	20

Disability	# of Clients
No	23
Unknown	0
Yes:	102*
Difficulty seeing	4
Difficulty hearing	2
Mental domain (not including a mental illness)	12
Physical/mobility domain	5
Chronic health condition	23
Other	99
*some clients had more than one	

Veteran Status	# of Clients
Yes	0
No	21
Unknown	104

Race	# of Clients
Asian	4
Black or African American	48
White	70
Other	3

Age	# of Clients
0-15	119
16-25	6

Gender	Number of Clients
Assigned sex at birth:	
Male	70
Female	55
Unknown	0
Current gender identity	
Male	0
Female	1
Transgender	0
Genderqueer	0
Questioning or unsure of gender identity	0
Another gender identity	0
Unknown	0

POSITIVE PARENTING PROGRAM (TRIPLE P) LEVELS 2 AND 3

Age Group: Children (0-12), Parents/Caregivers

Triple P is intended for the prevention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Selected Triple P (Level 2 and 3) is a "light touch" parenting information presentation to a large group of parents (20 to 200) who are generally coping well but have one or two concerns. There are three seminar topics with each taking around 60 minutes to present, plus 30 minutes for question time. The Selected Triple P Seminar Series is designed to be a brief introduction to the Triple P strategies and will give the parents and caregivers you work with great ideas to take home and try out with their family.

PROJECT FATHERHOOD

Age Group: Children (0-15), TAY (16-18), Parents/Caregivers

Project Fatherhood program provides comprehensive parenting skills to men in caregiving roles using an innovative support group model. The program was developed to give urban, culturally diverse caregivers an opportunity to connect with their children and play a meaningful role in their lives. The program continues to be recognized nationally for effectively addressing the problem of absentee fathers. Through therapy, support, parenting education and other services, fathers learn to be more loving, responsible parents and active participants in their children's lives. Project Fatherhood helps fathers to be better parents through: Individual and family counseling; Group support; Significant others group; Therapeutic activities for children; Preventing child abuse and neglect; and Helping fathers to make healthier decisions in relationships. At the heart of the program is the Men in Relationships Group (MIRG), which provides comprehensive support at no cost for culturally diverse fathers.

PREVENTION

PSYCHOLOGICAL FIRST AID (PFA)

Age Group: All Ages

PFA is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism. The practice is a partnership between the National Child Traumatic Stress Network and the National Center for PTSD. The Core Actions of PFA include: Contact and Engagement; Safety and Comfort; Stabilization; Information Gathering: Current Needs and Concerns; Practical Assistance; Connection with Social Supports; Information on Coping; and Linkage with Collaborative Services. In addition to the English-language edition of Psychological First Aid (PFA), there are versions in Spanish, Japanese, and Chinese. Along with the several language translations, NCTSN members have worked to develop PFA adaptations for community religious professionals, Medical Reserve Corps members, and for staff at facilities for families and youth who are experiencing homelessness. The training for PFA and the Second Edition of Psychological First Aid Field Operations Guide and accompanying handouts are available online. PFA is also available in Spanish, Japanese, and Chinese. PFA for Schools and adaptations for community religious professionals, Medical Reserve Corps members, and for staff at facilities for families and youth who are experiencing homelessness is also available online.

SCHOOL, COMMUNITY, AND LAW ENFORCEMENT (SCALE) PROGRAM

Age Group: Children (12-15), TAY (16-18)

SCALE Program is intermediate school and high school age Asian male and female immigrant youths who are at high risk for, or are exhibiting the beginning signs of, delinquent behavioral problems. These behavioral problems include, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers). The background characteristics of these youths often include their having recently moved to the United States (e.g. within five years), and are having difficulty dealing effectively with the stress of adapting to a new environment, culture, language, etc. Many of these youths also report a lack of family support, prosocial peer network, and/or school connectedness.

SECOND STEP

Age Group: Children (4-14)

A classroom-based program, this practice teaches socio-emotional skills (Vulnerable Population) 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.

SENIOR REACH

Age Group: Older Adults

Senior Reach 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.

SUBSTANCE USE DISORDER –TRAUMA INFORMED PARENT SUPPORT (SUD-TIPS

Age Group: Parents

The SUD-TIPS program targets adult parents identified by the Department of Children and Family Services (DCFS) as substance using. This includes parents who have open DCFS cases or Emergency Response referrals. Parental substance use may be a factor contributing to a child's involvement in the child welfare system. Substance use may also contribute to difficulty managing and regulating anger, cause physical or mental impairments, prevent healthy parent-child attachment, and negatively impact overall home life stability. Substance use may be the result of past trauma and individuals with untreated mental health disorders are at greater risk for substance use.

DCFS will refer identified parents to the co-located substance use disorder (SUD) counselors who are then complete the American Society of Addiction Medicine (ASAM) triage tool to determine need for SUD treatment. If during the screening they identify that the individual would benefit from mental health intervention, the individual is then linked to mental health services.

SHIFTING BOUNDARIES

Age Group: Children (10-15)

Shifting Boundaries is a six session, group based, dating violence prevention program that focuses on peer sexual harassment. The intervention consists of a classroom-based curricula and a building-level component designed to reduce the incidence and prevalence of dating violence and sexual harassment among middle school students.

PREVENTION

TAY DROP-IN CENTER TARGETED OUTREACH & ENGAGEMENT STRATEGIES

Age Group: TAY (16-25)

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. 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.

TEACHING KIDS TO COPE

Age Group: Children (15), TAY (16-22)

This 10 session, group intervention is designed to reduce depression and stress by enhancing coping skills. Program components include: Group discussions, interactive scenes, videos, group projects, and homework assignments. Group discussions include a variety of topics, such as family life situations, typical teen stressors, self-perception issues, and interactions with others.

VETERANS COMMUNITY COLLEGES OUTREACH AND CASE MANAGEMENT SERVICES

Age Group: TAY (16-25), Adults (26-59)

Veterans attending Community Colleges in Los Angeles County and their families, an unserved or underserved population whose is at-risk for developing mental health which can cause complex issues related to the impact of military service experience and adjustment to civilian life. Veterans and their families in this target population have unique mental health needs requiring highly specialized mental health services to help them cope with complex issues related to the impact of military service. Veterans on the community college will be interviewed and assessed for mental illness or seeking information to assist with referrals and resources. For Veterans in the program, they will have access to services of housing, unemployment, linkage to mental health services that best address their mental illness.

VETERANS MENTAL HEALTH SERVICES

Age Group: TAY (16-25), Adults (26-59), Older Adults (60+)

A range of services to Veterans countywide will be expanded and initiated, including services emphasizing peer support, female veteran's 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 community-based and faith-based organizations working with veterans. Supportive housing services for Veterans and their families.

PREVENTION

VETERANS SERVICE NAVIGATORS

Age Group: TAY (16-25), Adults (26-59), Older Adults (60+)

This Veterans Mental Health Services program will utilize 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 follow with the veterans and their families to ensure that they have successfully linked and received the help they need. The Navigators engage in joint planning efforts with community partners, including veteran's groups, veteran's 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.

WHY TRY PROGRAM

Age Group: Children (7-15), TAY (16-18)

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).

YOUTH DIVERSION AND DEVELOPMENT (YDD)

The collateral consequences of arrest and incarceration for youth who have justice system involvement remains significant, including an increased risk of dropping out of high school, trauma, substance abuse, and other negative outcomes. The YDD program can improve outcomes for youth by redirecting law enforcement contact and addressing underlying needs through systems of care that prioritize equity, advance wellbeing, support accountability, and promote public safety. Law enforcement will determine whether a youth is eligible for diversion services. The screening tool is being developed.

The YDD Program is comprised of three components:

1. Annual YDD Summit: One-day conference designed to provide law enforcement, community-based agencies, other youth-serving agencies, and key stakeholders with training and capacity building.
2. Youth Intensive Case Management Services (Y-ICMS): Intensive case management provided to youth identified and referred through law enforcement through contracted community-based partners.
3. YDD Training and Technical Assistance: Education, training and technical assistance necessary to provide Y-ICMS services and ensure the success of the YDD Program.

STIGMA AND DISCRIMINATION REDUCTION

Number of people outreached:

72,753

The purpose of Stigma and Discrimination 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.

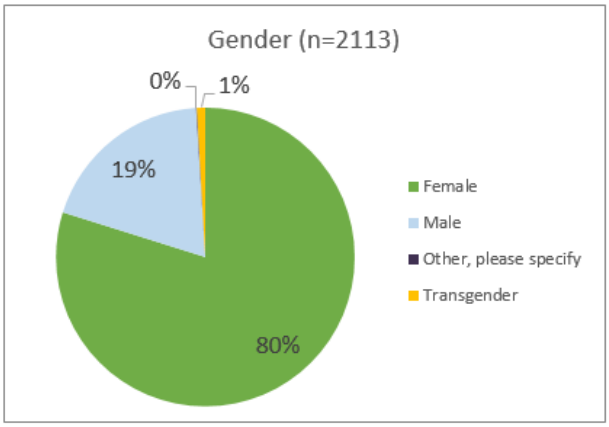
Mental Health First Aid (MHFA)

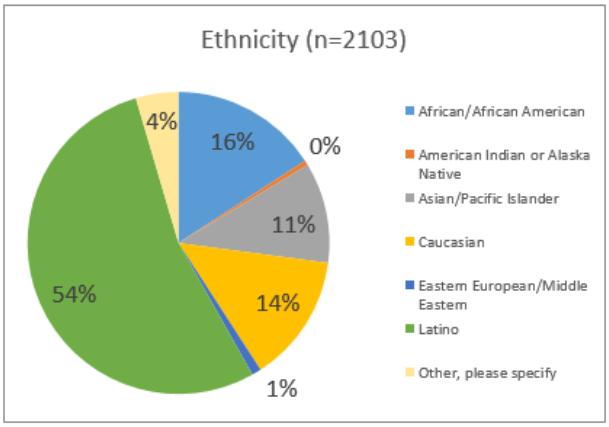
Mental Health First Aid (MHFA) is an interactive 8-hour evidence based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhance 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.

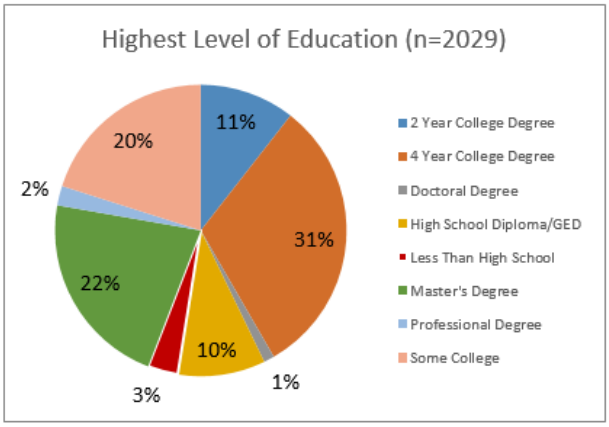
OUTCOMES for MHFA

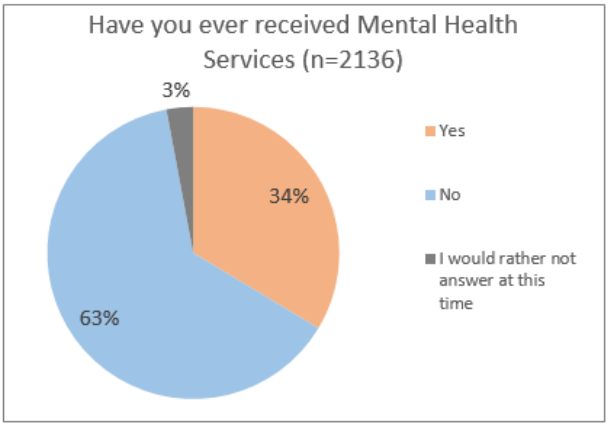
The following are results from the 2,268 surveys received for FY 2017-18:

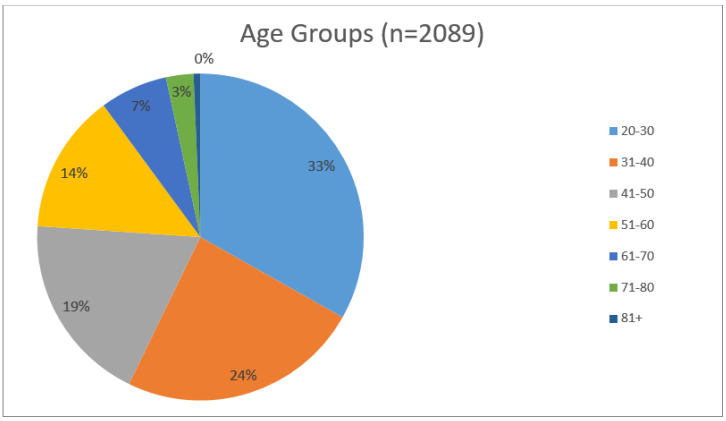
The number of surveys received in FY 2017-18 increased by 31% from the previous fiscal year (1729) and by 51% from FY 2015-16 (1502). The are two possible causes for the increase: 1) increase in survey collection rates from year-to-year and/or 2) increase in the number of people receiving SDR programs from year-to year.



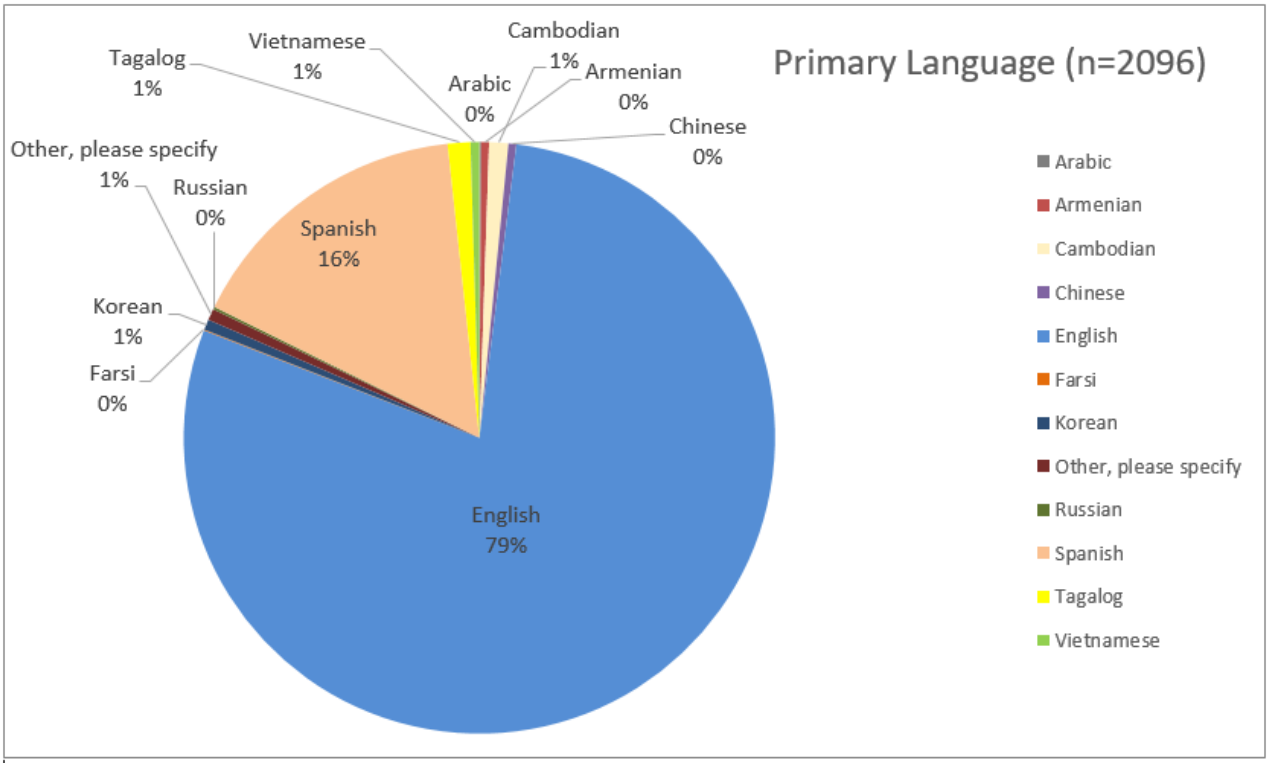


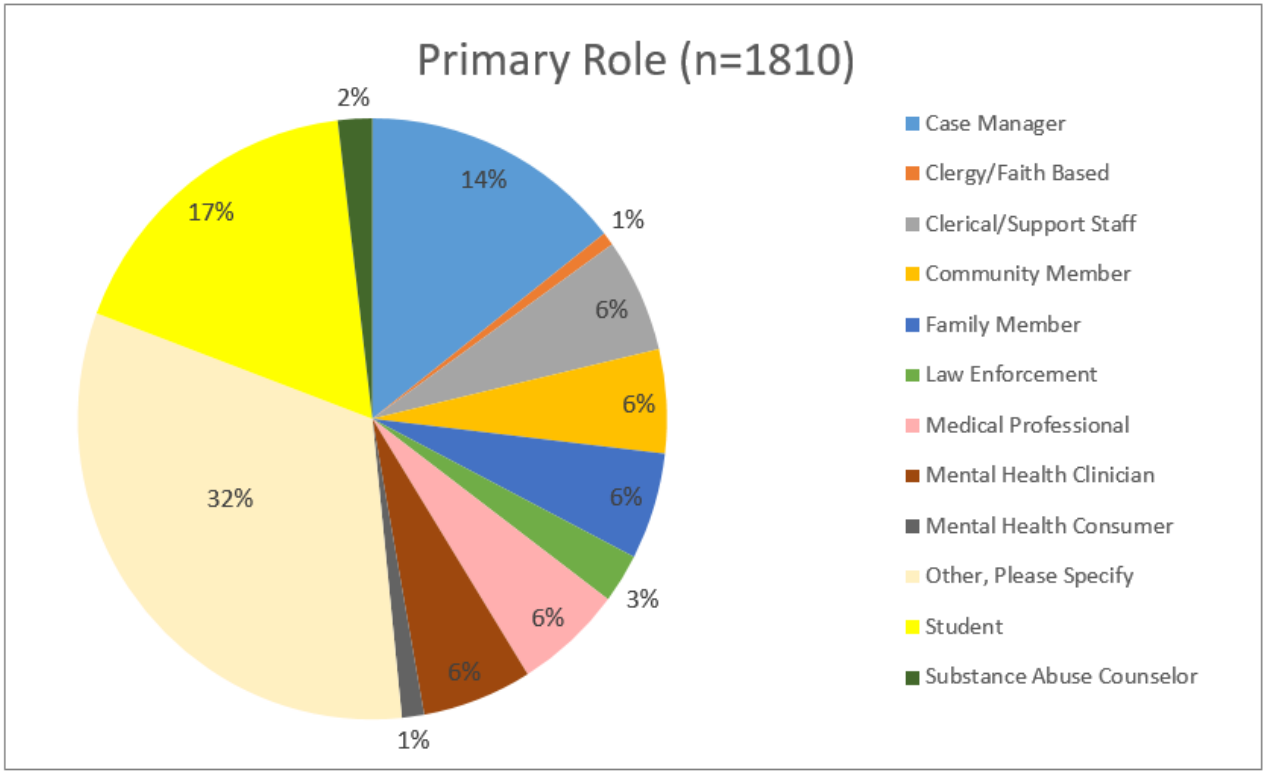






Note: The mean age of trainees who submitted a survey was 40 (age range 18-99).


Primary Language (n=2096)
Vietnamese 1%
Cambodian 1%
Tagalog 1%
Arabic 0%
Armenian 0%
Chinese 0%
Other, please specify 1%
Russian 0%
Spanish 16%
Korean 1%
Farsi 0%
English 79%
Arabic
Armenian
Cambodian
Chinese
English
Farsi
Korean
Other, please specify
Russian
Spanish
Tagalog
Vietnamese


Primary Role (n=1810)
14%
1%
6%
6%
6%
3%
6%
6%
1%
32%
17%
2%
Case Manager
Clergy/Faith Based
Clerical/Support Staff
Community Member
Family Member
Law Enforcement
Medical Professional
Mental Health Clinician
Mental Health Consumer
Other, Please Specify
Student
Substance Abuse Counselor

STIGMA AND DISCRIMINATION REDUCTION

The SDR survey has six items that assess attitudes towards persons with mental illness. Scores from the six items are added together to provide a total score, which gives some indication of whether the person completing it tends to have negative or positive perceptions of persons with mental illness. The Attitudes total score can fall into one of four ranges: Very Negative, Negative, Positive, and Very Positive. An increase in the total scores from "pre" to "post" suggests having more positive perceptions about persons with mental illness, following the training:

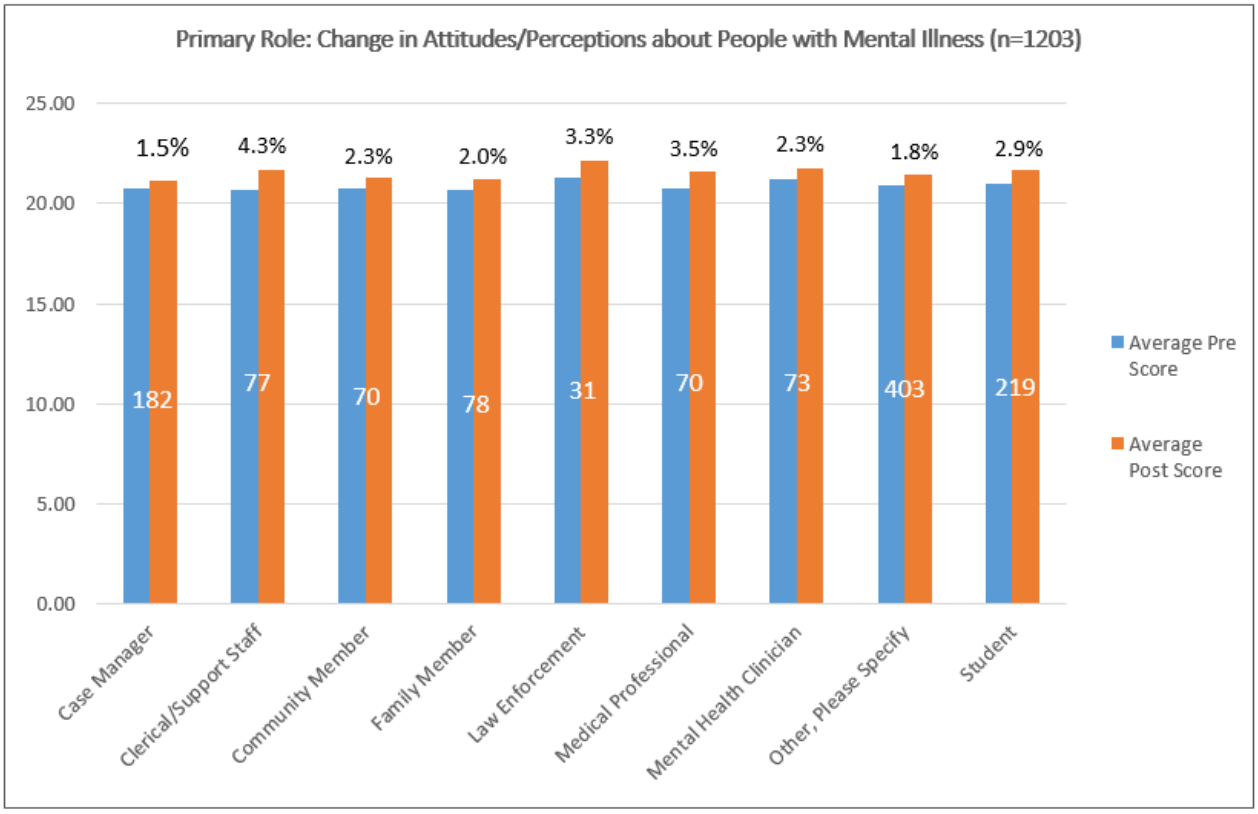
- The mean average Attitudes score improved by (3%) from "pre" to "post"
- Prior to the training, the average total score was in the Very Positive range; at "post" training, the average total score was still in the Very Positive range.
- Prior to the training, 99% of participants' total scores were in either the Positive range (609) or Very Positive range (937). At "post" training, 99% of participants were still in either the Positive range (454) or Very Positive range (1095). These results are identical to the results from FY 16-17. In that year, 99% of participants had "pre" scores in either the Positive or Very Positive range and 99% had "post" scores in either the Positive or Very Positive range.
- Prior to training, 60% of participants' (937) scored in the Very Positive range. At "post", 70% of participants' scored in the Very Positive (1095), an increase of 10%.
- Prior to the training, 12 participants scores were in either the Negative or Very Negative Attitudes Range. Seventy-five percent (75%) of those participants' scores fell in either the Positive (8) or Very Positive (1) range at "post" training.

These results suggest: 1) the great majority of participants had positive perceptions about people with mental illness prior to attending the training and their positive perceptions were either maintained or increased following training 2) training helped many participants increase their knowledge about mental health, even among participants who had a moderate level of knowledge prior to attending the training.

The SDR Survey includes a seventh item, "Please rate your current level of knowledge about mental health," which has five possible responses: Not at all Knowledgeable, Somewhat Knowledgeable, Moderately Knowledgeable, Very Knowledgeable, and Extremely Knowledgeable. An increase in the Knowledge from "pre" to "post" suggests a participant has gained knowledge about mental illness:

- The mean average knowledge score improved by (27%) from "pre" to "post"
- Ninety-eight percent (98%) of participants (1526) either increased their knowledge about mental illness or showed no change because they were already knowledgeable on the subject matter.
- Prior to the training, 67% of participants selected Moderately, Very, or Extremely Knowledgeable. "Post" training, 95% of participants selected Moderately, Very, or Extremely Knowledgeable, an increase of 28%.
- Prior to the training, 697 participants selected the response, Moderately Knowledgeable. Fifty-seven percent (57%) of these participants selected either Very Knowledgeable (349) or Extremely Knowledgeable (50), at "post" training.
- Prior to the training, 513 participants selected either the response, Not at all Knowledgeable or Somewhat Knowledgeable. Eighty-seven percent (87%) of these participants selected either Moderately Knowledgeable (277), Very Knowledgeable (141) or Extremely Knowledgeable (26), at "post" training.

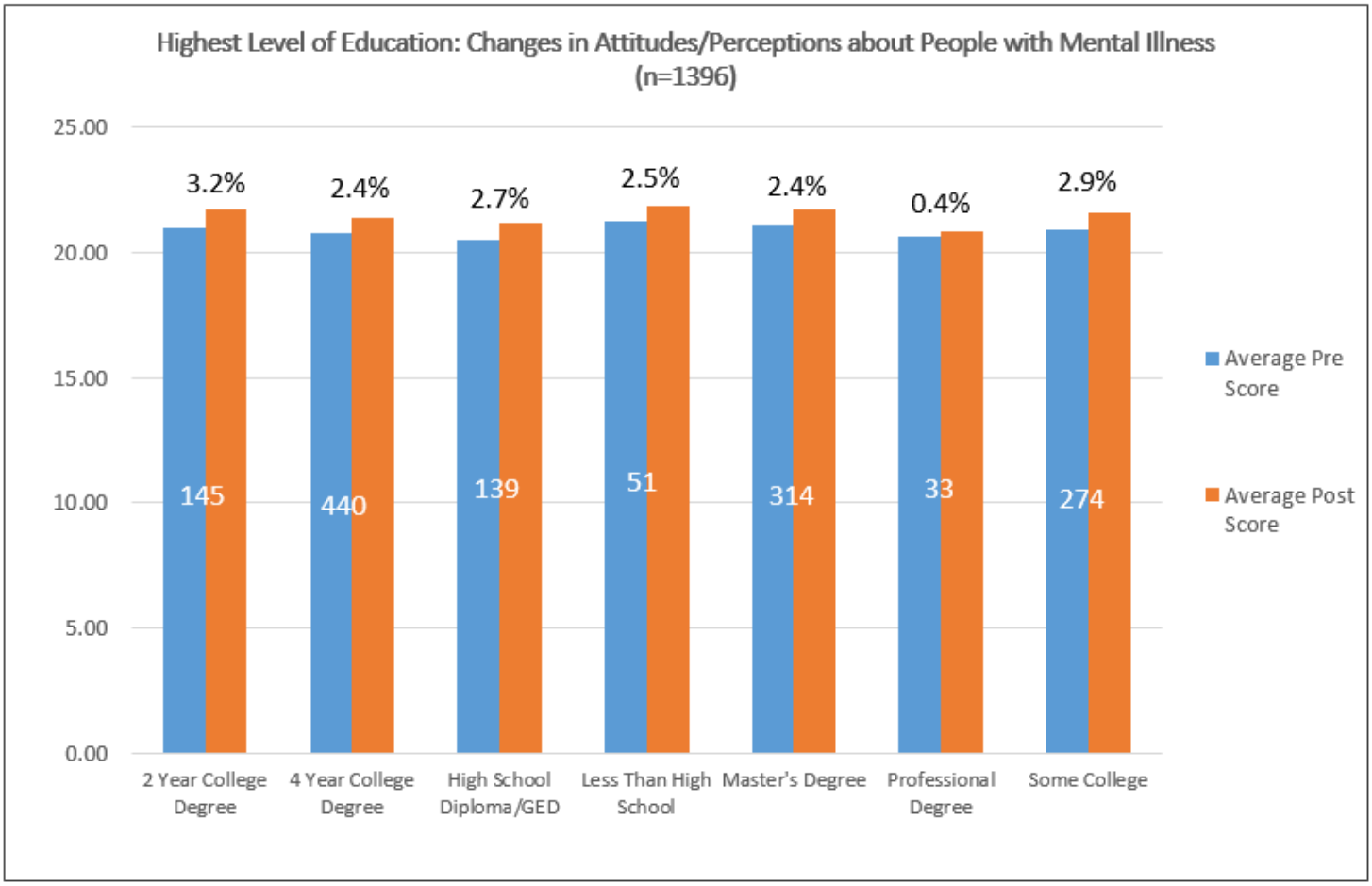
Demographic comparison charts are included when the average percent change in score from "pre" to "post", for at least one group within the category is at least double the percent change of another group. For example, in the Primary Role category, the average percent change in Perception/Attitudes score for the groups, Clerical/Support Staff (4.3%), Law Enforcement (3.3%), and Medical Professional (3.5%) are more than twice as large as the of the average percent change for the group, Case Manager (1.5%). Two sets of results met the percent change condition: 1) Primary Role: Changes in Attitudes/Perceptions about People with Mental Illness 2) Highest Level of Education: Changes in Attitudes/Perceptions about People with Mental Illness.



Note: Results for primary roles that had fewer than 30 matched "pre" and "post" SDR surveys (Clergy/Faith based, Mental Health Consumer) are not included in the chart.

Attitudes/perceptions of people who have mental illness, Primary role

- Participants who selected the primary role, Case Manager, had the lowest average percent change (1.5%), from "pre" to "post"; participants who selected Clerical/Support Staff had the highest (4.3%).
- Participants who selected the primary role, Law Enforcement, had the highest average "pre" (21.3) and "post" (22.2) scores; participants who selected Clerical/Support Staff had the lowest average "pre" (20.7) score and participants who selected Case Manager had the lowest average "post" (21.2) score



Note: Results for highest level of education that had fewer than 30 matched "pre" and "post" SDR surveys (Doctoral Degree) is not included in the chart.

Attitudes/Perceptions of people who have mental illness, Highest level of education

- Participants who selected the highest level of education, Professional Degree, had the lowest average percent change (0.4%), from "pre" to "post"; participants who selected 2-year College Degree had the highest (3.2%).
- Participants who selected the highest level of education, Less than High School, had the highest average "pre" (21.3) and "post" (21.9) scores; participants who selected High School Diploma/GED had the lowest average "pre" (20.5) score and participants who selected Professional Degree had the lowest average "post" (20.9) score.
- The low average change in score among participants in the category, Professional Degree, compared with other groups, may be an anomaly resulting from having a small n (33) and/or some characteristic of the group's participants. Deeper review of results for this group showed that 52% of the participants (17) attended the same training and 76% of those at the same training (13) reported working in the legal field, either as an attorney, supervisor, or paralegal. Among those 17 participants, the average "pre" score was (20.8), average "post" was (20.4), and average percent change was (-2.5%).

Older Adults Mental Wellness

For the majority of FY 2017-18, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of a Community Services Counselor, a Community Worker, and a Service Extender. Other Outpatient Services staff routinely provide 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 272 events during the FY 2017-18, outreaching to 3,792 Los Angeles County residents. These events include countywide educational presentations, community events such as Resource fairs, community meetings and collaboration with various agencies.

Highlights of OA ASD's accomplishments include:

- Outreached to 3,792 individuals in Los Angeles County
- Provided 264 presentations for seniors throughout the county
- Participated in 8 Resource Health Fairs throughout the county
- Increased the number of workshops in Service Areas 1, 2, 5 and 8
- Developed a new presentation "Elder Financial Exploitation: Impact on Emotional Wellbeing" for addition to the menu of topics for our Mental Wellness Series.

Strengths

OA ASD provides prevention services primarily by increasing awareness of Mental Wellness for older adults throughout Los Angeles County, particularly among underserved and under-represented communities. We continue to develop new presentation topics for seniors. OA ASD Team collaborates and coordinates with Los Angeles County Department of Mental Health contracted agencies to provide clinical back-up and coordination of translation services as needed.

GEOGRAPHICAL AREA

Table 1

Service Area	Area	Number of Presentations
1	Antelope Valley	7
2	San Fernando Valley	80
3	San Gabriel Valley	26
4	LA Metro Area	48
5	West LA Area	21
6	South LA Area	16
7	East LA Area	43
8	South Bay Area	31
Grand Total		**272**

Table 1. Demonstrates the distribution of presentations offered throughout Los Angeles County. In comparison to when ASD initially began providing presentations for older adults which required intensive outreach efforts to housing managers in senior housing and staff in senior centers, the ASD team is now contacted directly to request presentations daily.

TYPE OF FACILITY

Table 2

Facility	
Community Center	14
Senior Centers	69
Senior Housing	178
Other (Library, Church, City Hall)	11

Table 2. Illustrates the type of facilities where presentations were provided. In the past, most of our efforts focused on settings where large audiences of older adults congregate, such as senior centers. Due to an increase in awareness of our presentations, the number of senior housing complexes increased to 178 from last year's 165.

ATTENDANCE

Table 3

Number of people who attended	
Community Center	340
Senior Centers	1427
Senior Housing	1909
Other (Library, Church, City Hall)	116
Total	3792

Table 3. Displays the number in attendance at the various facilities. It is noteworthy that 25% of the team's visits were to Senior Centers where they presented to 38% of the total attendants. This compares to 72% of the team's visits being to Senior Housing sites, where they presented to 50% of the total attendants. This illustrates that for FY 17/18, the team's efforts in outreaching in senior centers was a very productive use of their time.

TOPICS

Table 4

Type of Presentation	
Bullying	14
Depression and Anxiety	19
Good Sleep	13
Grief and Loss	10
Health, Wellness, and Wholeness	22
Healthy Aging Bingo	27
Hoarding	30
Holiday Blues	43
Isolation	11
Life-Life Transitions	14
Medication Management	18
Preserving your Memory	25
Resiliency	13
Elder Financial Exploitation: (Scams)	1
Substance Use	3
Other (Resource Fairs, Community meeting)	9

Table 4. Lists the number of topics requested from our Mental Wellness Series. The "Holiday Blues" and "Hoarding" presentations are most frequently requested and scheduled by the activity coordinators at various agencies. "Hoarding" provides helpful information on the difference between hoarding, collecting and cluttering. It helps seniors understand the illness and how to get or help others. The "Holiday Blues" presentation addresses challenges faced by seniors who have experienced losses or feel alone during the holidays and provides some strategies to combat feelings of sadness.

"Grief & Loss" is a relatively new presentation that grew out of requests for assistance when a senior, or close family member of a senior, passes away. This could be in a senior housing site or within a senior center where the deceased was well-known to others. A clinician from our Outpatient Services team provides this presentation due to its sensitive nature and engages in supportive and empathic dialogue with the participants.

LANGUAGES
Table 5

Type of Presentation	
English	205
Spanish	79
Korean	15
Farsi	5
Chinese	4
Russian	3

Table 5. Details presentations provided in the following languages: English, Spanish, Korean, Farsi, Russian and Chinese. Request for Spanish has increased during the FY 17/18 due to senior housing complexes sharing information on the Wellness series.

Recommendations

OA ASD's goals for FY 18/19 include: Continue to make efforts to outreach in SA's 1 and 6, Continue to Increase presentations at Senior Centers and train and prepare Service Extenders to offer presentations.

WhyWeRise Campaign

Taken from www.rand.org. Released Wednesday, November 14, 2018
Youth-Oriented Mental Health Campaign Shows Evidence of Success

A community engagement campaign launched by Los Angeles County Department of Mental Health to address mental health barriers had an impressive reach with the younger audience it targeted and showed signs of changing attitudes, according to a new RAND Corporation evaluation. The county's WhyWeRise campaign targeted people aged 14 to 24 to encourage them to engage with mental health issues and create a movement to lower barriers to mental health access. RAND investigators found that people who were exposed to the campaign were more likely to express support toward people with mental illness. In addition, a countywide survey of youth found that people who were exposed to a campaign event in person or online were more likely to feel empowered and mobilized toward mental health activism. "The campaign was intended to elevate mental health as a civil rights issue and leverage youth enthusiasm for activism as a way to create social change," said Rebecca L. Collins, the study's lead author and a senior behavioral scientist at RAND, a nonprofit research organization. "Our findings show that they reached an impressive proportion of the target audience and seem to have influenced people's attitudes toward mental health."

In May of this year, the Los Angeles County Department of Mental Health launched a campaign intended to promote community engagement with mental health issues and create a movement to advocate for well-being and address barriers to quality treatment for mental health problems. The centerpiece of the campaign was the WeRise event that ran for three weeks in downtown Los Angeles where visitors could experience an immersive art gallery, rally, performances, panel discussions and workshops about mental health issues.

The effort was part of the county's prevention and early intervention efforts supported by the Mental Health Services Act, which was passed by voters in 2004 and created a special tax on high income residents to support mental health services and education. Funds support treatment for individuals with mental illness, but a portion is set aside for prevention and early intervention. "Most people who face mental health problems either do not seek treatment or delay seeking help," Collins said. "It's important that we address the reasons why most young people with mental health problems don't get appropriate diagnosis and treatment so that we can change that pattern."

RAND evaluated the campaign by interviewing people who took part in the event, conducting an online survey of more than 1,000 youth from throughout Los Angeles County and analyzing Twitter data from Los Angeles users on the topic of mental health before and the during the campaign. The online survey found that as many as one in five young people in the targeted age group were aware of WeRise or WhyWeRise within just a few weeks after the campaign was launched. In addition, discussion of WeRise was frequent within a Twitter community that discussed common mental health topics. The survey also found that youth who reported exposure to the campaign were more aware of the challenges faced by people with mental illness and more likely to know how to get help with mental health challenges.

While the RAND study suggests the campaign had early successes, researchers say the effort could do more to engage men, younger audiences and people who do not already have a connection to mental health. Leaders of WhyWeRise also could build stronger online connections with other social justice-oriented communities that are also on social media, and sustain the campaign for a longer period of time because public attitudes tend to change slowly. "The WhyWeRise campaign is one of many efforts that are ongoing across California to increase awareness of mental health issues and ease barriers to getting treatment," Collins said. "These efforts are most likely to make lasting changes if they are sustained over time."

The report, "Evaluation of Los Angeles County's Mental Health Community Engagement Campaign," is available at www.rand.org. Other authors of the report are Nicole K. Eberhart, William Marcellino, Lauren Davis and Elizabeth Roth.
RAND Health Care promotes healthier societies by improving health care systems in the United States and other countries.

EVALUATION –MENTAL HEALTH COMMUNITY ENGAGEMENT CAMPAIGN

To evaluate how well the campaign met its goals, RAND conducted an in -person survey of WeRise attendees; a social media analysis of Twitter conversations related to WeRise/WhyWeRise, mental health, mental illness, and well-being; and a web-based survey of a broader population of Los Angeles youth in the age range targeted by WeRise/WhyWeRise.

Overall, the evaluation found evidence that the WeRise/WhyWeRise mental health campaign had impressive reach into the Los Angeles community, with one in five young people exposed to the campaign in some way during the brief period examined. There is early evidence that the campaign might be associated with positive outcomes, such as increased supportive and understanding attitudes toward people with mental illness, awareness of the challenges people with mental illness face, knowledge of how to get help for mental health challenges, and, importantly, empowerment and mobilization toward activism around mental health issues.

Research Questions

1. **Who was reached by the campaign?**
2. **What impact did contact with the campaign have?**

RECOMMENDATIONS

- The campaign should consider using approaches aimed to reduce negative stereotypes and increase mental illness–related knowledge.
- Future events could focus on engaging men, younger audiences, and those who do not already have a connection to mental health.
- The campaign could work toward building stronger social media connections between "mainstream" and social justice–oriented online communities.
- Public attitudes tend to be slow to change, so the campaign should keep doing what it is doing.

Key Findings

The campaign attracted a large number of people

- As many as one in five young people were aware of WeRise or WhyWeRise.
- WeRise was successful in engaging racial and ethnic minorities, especially black and Latino teens.
- The WeRise/WhyWeRise campaign was associated with a moderate increase in Twitter discussion of mental health and well-being.

Those who were exposed to WeRise or WhyWeRise might have benefited from the campaign

- The in-person survey at the event found that those who were present for longer were more likely to express supportive and understanding attitudes toward people with mental illness.
- The large, countywide survey of youth found that those exposed to WeRise or WhyWeRise (either in person or online) were more likely to report feeling empowered and mobilized toward mental health activism — a key goal of the campaign.
- Those exposed to the campaign also had greater awareness of the challenges people with mental illness face, from stigma to treatment-access issues. They were also more likely to know how to get help for their own mental health challenges, consistent with one of the campaign's goals of connecting people to resources.

The WeRise event predominately attracted people who were already interested in and knowledgeable about mental health

- The campaign successfully attracted people for whom mental health was personally relevant, who can readily apply the knowledge and empowerment they get from the campaign to their own life situations.
- The campaign seems to have had better success engaging people through means other than the event.

https://www.rand.org/pubs/research_reports/RR2754.html

STIGMA AND DISCRIMINATION REDUCTION

MENTAL HEALTH PROMOTERS/PROMOTORES PROGRAM

Many underserved communities have been shown to have high rates of mental health related stigma as well as cultural/linguistic barriers that limit their access to mental health services and mental health resources available. Often these barriers limit/prevent the utilization of mental health services until symptoms are chronic and severe. Underserved communities, such as the API and Latino communities in LA County show high levels of ongoing disparities in their access and use of public mental health services. The Promotores program represents a promising approach to mental illness & disease prevention as it increases knowledge about mental illness, increases awareness about available mental health services and promotes early use of mental health services. The criteria will be to decrease mental health and stigma.

Promoters of Mental Health collectively conducted 4,287 mental health presentations throughout their service area communities and reached approximately 35,138 people. In addition, participated in 197 community events which included health fairs, resource fairs, and having resource tables twice a week at both the Mexican and Salvadorean consulates.

Training is an essential component of a Promoters of Mental Health program in the delivery of mental health education and early interventions to Latino communities.
The Department of Mental health strives to ensure that Promoters of Mental Health are exposed to information that will increase their knowledge and enhance their skills needed to implement an effective program giving them an opportunity to reflect on their professional development. Promoters also receive supervision and consultation by the administrative team providing feedback, guidance and emotional support.

Promoters receive:

- 36 hours of Mental Health Booster trainings
- 24 hours of Group Supervision
- 24 hours of Advanced Development Group (voluntary participation)
- Individual supervision as needed
- 24 hours of Linkage and Referral - stipend
- Additional presentations from guest speakers on the following topics:
    - Natural Healing-Meditation and Self Reflection
    - CHIRLA-Immigration Laws
    - Department of Occupational Rehab
    - Healing through the Arts-Facilitated by SA 7 Promoter
    - Ice Breaker Workshop-Facilitated by Sa 7 Promoter
    - Department of Mental Health-ZIKA Training

Service Area	# of Promoters	Presentations Conducted	Approximate # of People Served
2	20	17	120
3	20	7	40
4	18	1,006	9,711
6	17	698	6,788
7	29	1,368	11,791
8	20	1,191	9,105

*Promoters trained in April and June 2018

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.

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 2017-18, the program provided services to 100 individuals, who ranged in age from four (4) to thirty (30) years. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latino (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%).

OUTCOMES FOR LATINA YOUTH PROGRAM

(SEE APPENDIX FOR FULL REPORT)

A number of high risk symptoms and behaviors are tracked to measure their severity pre and post intervention. These are based on an ongoing review of literature on death caused by suicide in youth, and include: presence of substance use or abuse, suicidal ideation, past suicidal self directed violence (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. These were initially targeted for identification and treatment based on research findings which correlated them with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of issues representing high risk for suicidality. Most currently, the need to monitor program participants for suicidal behavior for one year post initiation of suicidal ideation, has been identified as an important component to be measured.

Based on research literature and LYP experience working with children and adolescents dealing with suicidal self-directed violence (suicidality), a total of 13 risk factors were evaluated by program clinicians at intake (Time 1) and at Current or Close of Case (Time 2) for their presence in program participants. These measures were studied for 35 of the program participants. Unfortunately, of the 35 randomly selected cases, only 29 had complete and usable data. The remaining six, either had not been in treatment long enough (three months or more) or the data submitted was incomplete. With regard to specific risk factors, the tables below list incidence rate and intensity at which the factors were endorsed, as well as the difference between pre and post intervention.

RISK FACTORS: INCIDENCE			
NAME	INCIDENCE TIME 1	INCIDENCE TIME 2	CHANGE
Substance Use/Abuse	6	6	0
Suicide Ideation	11	3	-8
Suicide Attempt	1	0	-1
Run Away Behavior	1	0	-1
Communication Problem	26	23	-3
Poor school Functioning	22	19	-3
Difficulty Regulating Emotions	27	25	-2
Legal/Juvenile Justice Involvement	2	3	-1
Sexual Orientation-Gender Identity Distress	4	4	0
Bullying	9	6	-3
Violence (home/community)	6	3	-3
Family High Distress	24	20	-4
Self or Family at Risk of Deportation	4	2	-2
AVERAGE	11	8.8	2.2

OUTCOMES FOR LATINA YOUTH PROGRAM CONTINUED

(SEE APPENDIX FOR FULL REPORT)

RISK FACTORS: INTENSITY			
NAME	Average INTENSITY TIME 1	Average INTENSITY TIME2	CHANGE
Substance Use/Abuse	4.7	3.8	-0.9
Suicide Ideation	6.6	3	-3.6
Suicide Attempt	1	0	-1
Run Away Behavior	5	0	-5
Communication Problem	7.7	5.5	-2.2
Poor school Functioning	7.2	4.2	-3
Difficulty Regulating Emotions	7.6	5.0	-2.6
Legal/Juvenile Justice Involvement	5.5	4.7	-0.8
Sexual Orientation-Gender Identity Distress	5.5	6	+0.5
Bullying	7.4	4.7	-2.7
Violence (home/community)	6.2	6.3	+0.1
Family High Distress	7.0	5.0	-2
Self or Family at Risk of Deportation	6.5	3.5	-3
AVERAGE	6	4	2

Briefly, the range of incidence of risk factors was found to be anywhere from 1 to 27 in the 29 program participants studied. For example, Suicide Attempt and Run Away Behavior were the risk factors less likely to be identified as problematic. They were found to be present only in one each of the program participants at Time One, and were completely absent when measured at Time Two. The risk factors with the highest incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. Their incidence at Time One was 27, 26, 24 and 22 respectively, and decreased to 25, 23, 20 and 19 at Time Two. On average, the incidence of any one risk factor was 11 at Time 1. Post intervention (Time 2) the range of incidence of any of the risk factors was 0 to 25 with an average of 9. This is a reduction in incidence of 2, suggesting that less program participants were experiencing difficulty with those factors whose incidence decreased. Most importantly the “Suicide Ideation” risk factor went from being endorse by 11 to only 3 participants from Time 1 to Time 2, this reflects 8 participants who no longer are experiencing suicidal thoughts.

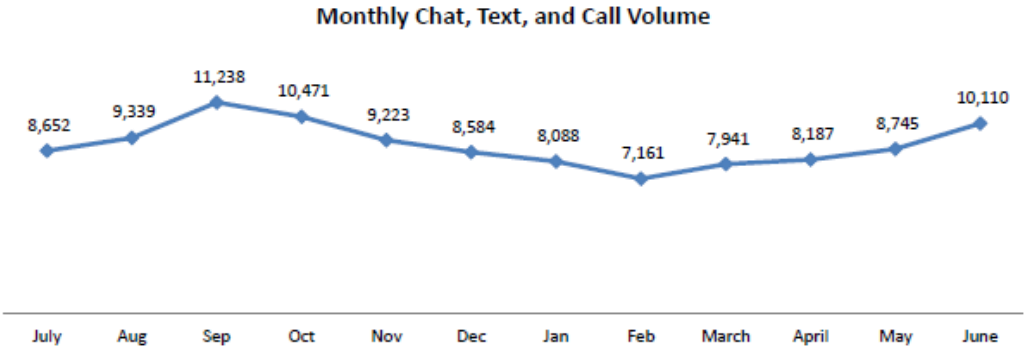
With regard to intensity of experience, clinicians rated program participants’ difficulty with the risk factors on a scale from 0-10, with 0 being “not a problem at all,” to 10 being “extremely problematic.” In this regard, the intensity was on average a 6 at Time One and a 4 at Time Two, reflecting a 2-point decrease in how problematic the risk factors were for the participants. Two risk factors were found to increase in intensity. Sexual Orientation-Gender Identity Distress increased 0.5 and problems due to Bullying increased 0.1. These negligent increases may suggest a greater willingness for clients to identify problems with these issues as time in services progresses, or an increased awareness of these as issues present in and impacting their lives, as clients develop greater insight. Conversely, the intensity at which other risk factors were experienced as problematic decreased on average by 2 points. The greatest decrease in intensity was found in the risk factor Run Away behavior, with a 5 point reduction and Suicidal Ideation, with a 3.6 point decrease. As discussed earlier, risk factors occur in clusters. Program participants were found to have difficulty with anywhere from two to eleven risk factors at Time One and this range went down to 0 to 7 at Time 2. These results suggest that the programs’ interventions are having the desired outcomes on the target population.

24/7 CRISIS HOTLINE

The 24/7 Suicide Prevention Crisis Line responded to a total of 99,574 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 10,418 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.

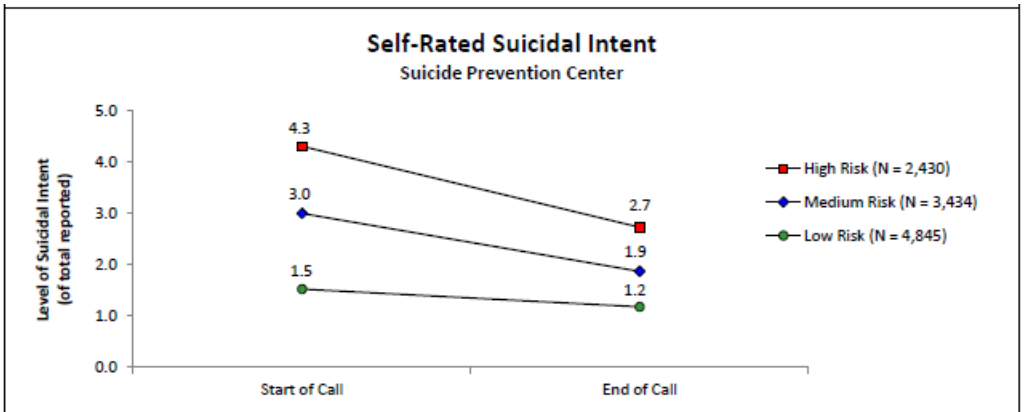
OUTCOMES FOR 24/7 CRISIS HOTLINE

(SEE APPENDIX FOR FULL REPORT)



September received the most amount of chats, texts and calls with February receiving the least.

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.

- Callers who rated their suicidal intent as high or imminent risk at the start of the call showed a 59% reduction in their intent by the end of the call.
- Callers who rated their suicidal intent as medium risk at the start of the call showed a 58% reduction in their intent by the end of the call.

SUICIDE PREVENTION

PARTNERS IN SUICIDE (PSP) TEAM FOR CHILDREN, TAY, ADULTS & OLDER ADULTS

The Partners in Suicide Prevention (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults (OA) is an innovative program offered by the Los Angeles County Department of Mental Health (DMH) is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The PSP Team offers community education and provides best-practice training models in suicide prevention, and provides linkage and referrals to age appropriate services.

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 133 suicide prevention events during Fiscal Year (FY) 2017-2018, outreaching to more than 2,051 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, the 7th Annual Suicide Prevention Summit, and collaboration with various agencies and partners. PSP's accomplishments included:

- The PSP team provided three ASIST (Applied Suicide Intervention Skills Training) trainings throughout the County to 63 participants and continued its collaboration with adjunct ASIST trainers from outside of DMH which increased its training capacity countywide, particularly in service areas further from metro Los Angeles.
- Provided 39 QPR (Question, Persuade and Refer) gatekeeper trainings throughout the County, totaling 1,116 community members trained in QPR by the PSP team during FY 2017-18.
- Provided 28 MHFA (Mental Health First Aid) trainings which is designed to teach members of the community to recognize the symptoms of mental health concerns, offer and provide initial help, and guide the individual to professional help if appropriate. Additionally 3 YMHFA (Youth Mental Health First Aid) trainings were held, with 65 community members trained to recognize symptoms of mental health concerns in youth ages 12-18.
- Four AMSR (Assessing & Managing Suicide Risk) trainings were completed this fiscal year, with a total of 114 clinicians, case managers, and nurses in both directly-operated programs and contracted providers being trained. AMSR trains on the 24 core competencies related to suicide risk assessment and reviews safety planning.
- Provided one Recognizing and Responding to Suicide Risk (RRSR) trainings to 25 participants. RRSR trains on the 24 core competencies as well as safety planning, and provides time for highly interactive discussions and role play for attendees.
- Participated in the Inter-Agency Council on Child Abuse and Neglect (ICAN)/Department of Children and Family Services (DCFS) Child Suicide Review Team at the Los Angeles County Coroner's Office.
- Coordinated and hosted the Los Angeles County Suicide Prevention Network (SPN) which has recruited over fifty members from a wide variety of organizations and conducts quarterly meetings to increase collaboration and coordination of suicide prevention activities. Quarterly Suicide Prevention Network meetings occurred on the following dates: 9/28/17, 12/7/17, 3/16/18, and 6/8/18.
- Partners in Suicide Prevention participated in Parks After Dark for the 7th year in a row. PAD was launched in 2010, at three County Parks, as the prevention component of the County's Gang Violence Reduction Initiative. PAD has successfully expanded to 33 parks Countywide and evolved into a key prevention and intervention strategy that utilizes cross-sector collaborations to promote health, safety, family cohesion, community well-being and equity in our underserved communities. This year PSP participated in 8 Parks After Dark events.

PARTNERS IN SUICIDE (PSP) TEAM FOR CHILDREN, TAY, ADULTS & OLDER ADULTS (CONTINUED)

- 7th Annual Suicide Prevention Summit "The Suicide Contagion Effect: Why Does it Happen, What We Know, & What We Can Do": held on Thursday, September 7, 2017 at the California Endowment and featured April C. Foreman, Ph.D. as keynote speaker. The theme for this year's Summit stemmed from criticism around the program "13 Reasons Why" and its depiction of suicide among high school students. Topics addressed included suicide contagion in schools, the impact (positive and negative) of social media, school response in the event of a suicide, and a discussion of a model suicide prevention program in a local school district. Additionally, there was a 'special session' geared towards clinicians that addressed professional anxieties around the use of social media. Approximately 165 attendees from mental health, education, law enforcement, and community-based organizations took part in this event which was organized and implemented by DMH and partners such as Teen Line, Didi Hirsch, and Santa Monica College.
- Throughout FY 16/17, the Older Adult System of Care outreached to community-based as well as faith-based organizations throughout the County to identify approximately 150 community members to be trained as QPR instructors in an effort to broaden the capacity of this suicide prevention gatekeeper model. The members were trained during the latter portion of FY 16/17 and began their trainings in the community during FY 17/18. Throughout this FY, 26 of these instructors remained active, training 817 of their fellow community members in this suicide prevention gatekeeper model. To strengthen the reach of this project, QPR materials were translated into Chinese, Amharic, and Korean, along with the already-existing Spanish. Instructors who spoke these languages were specifically identified to provide QPR to their respective communities.
- In an effort to increase capacity to provide RRSR, eight (8) DMH staff, most from outside of PSP, were trained in February 2018 by the American Association of Suicidology to become RRSR trainers. A RRSR Training of Trainers has not been held at DMH since approximately 2012, so a new cohort of RRSR trainers has been essential to PSP and DMH's suicide prevention efforts.

OUTCOMES FOR PARTNERS IN SUICIDE

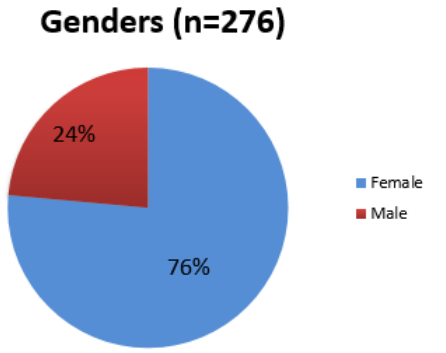
Survey Results

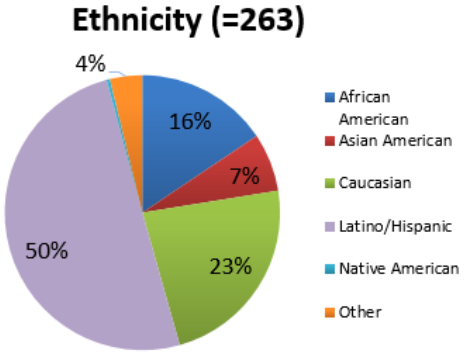
Surveys: 363

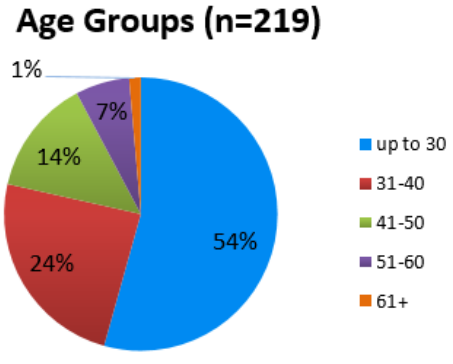
Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 2017-18, changes in knowledge about suicide were measured using the Suicide Prevention (SP) survey. Participants complete the "pre" survey, 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.

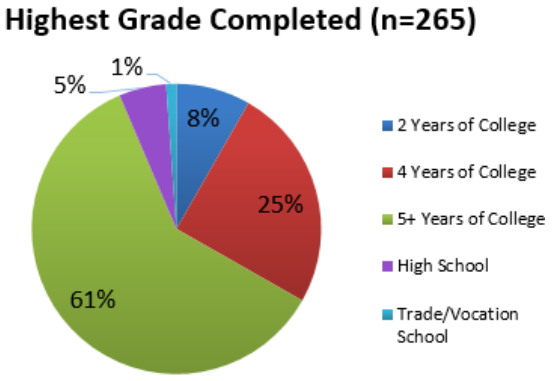
The number of surveys received in FY 2017-18 decreased by 70% from the previous fiscal year (1,197).

The are two possible causes for the decrease: 1) decrease from last year to this year in survey collection rates and/or 2) decrease from last year to this year in the number of people receiving SDR programs.









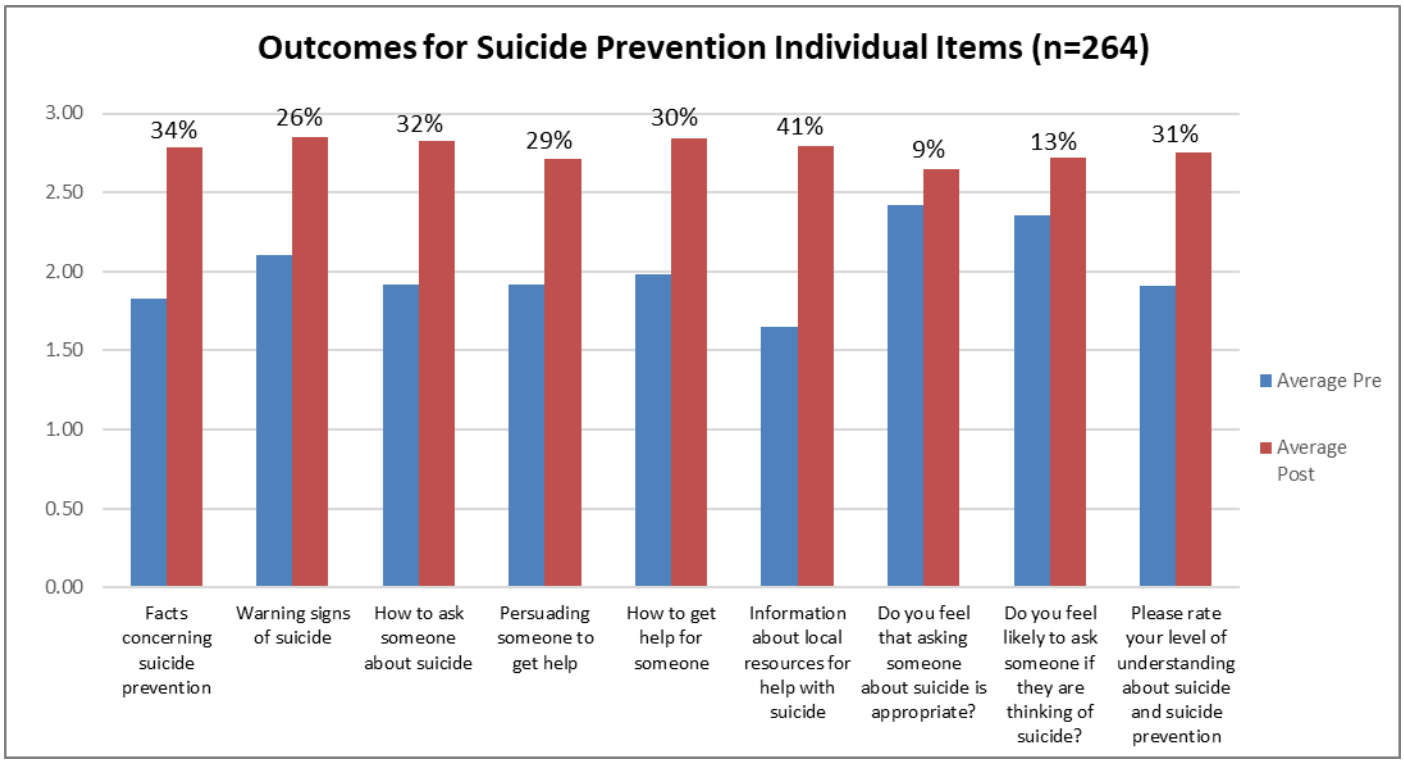
SUICIDE PREVENTION

The SP survey has 9 items. Scores from the 9 items are added together to create a total Knowledge score. The total score can fall into one of three ranges: Low Knowledge, Medium Knowledge, or High Knowledge. An increase in the total scores from "pre" to "post" suggests having more information about suicide. Survey results for FY 17-18 suggest participants' knowledge about suicide and suicide prevention increased through training and education:

- The average score increased by 27% from "pre" to "post" (243).
- The average "pre" score fell in the Medium Knowledge range and the average "post" score fell in the High Knowledge range.
- Prior to training, 21% of participants' (52) scores fell in the High Knowledge range. Post training, 91% of participants' (222) scores fell in the High Knowledge range, an increase of 80%
- Prior to training, 24% of participants' (59) scores fell in the Low Knowledge Range. "Post" training, all of these 59 participants' scores fell in the Moderate Knowledge Range (12%) or High Knowledge Range (84%).

Suicide prevention trainings have shown positive outcomes since inception in FY 2013-14. In FY 2013-14 and 2014-15 combined, participants showed an average 30% increase, in FY 2015-16 an average 25% increase, and in FY 2016-17 an average 24% increase.

Below, is chart showing the average percent change in score from "pre" to "post" training for each of the nine suicide prevention survey items in FY 2017-18, as well as few statements about the results.



- Items 1 and 6 showed the greatest improvement in score from "pre" to "post", increasing by 34% and 41%, respectively.
- Items 7 and 8 showed the least improvement in score from "pre" to "post", increasing by 9% and 13%, respectively. These items likely changed the less than the others' because: 1) their average "pre"-scores were higher than the other items', which created a "ceiling effect," i.e. scores on items 7 and 8 could not improve from "pre" to "post" as much as scores on the other items because there was less room for improvement 2) items 1-6 and 9 measure changes in knowledge while items 7 and 8 measure changes in behavior. Typically, for instructive interventions like Suicide Prevention, measures of knowledge show greater change from "pre" to "post" treatment than measures of behavior.

SCHOOL THREAT ASSESSMENT RESPONSE TEAM (START)

The START 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.

In Fiscal Year 2017-18, the School Threat Assessment Response Team (START) provided 1820 services to 305 individuals at potential or real threat to harm self and/or others on campus: 86 open cases and 219 potential cases. The law enforcement and schools continued to be the two main referral sources. After years of services delivered in the Los Angeles County, START has become one of the major violence crisis management resources in addition to the law enforcement.

START's challenge centered on a decline in the number of staff and increased in demand for services in Fiscal Year 2017-18. Nearly half the number of staff was to be filled. The number of referrals increased from 216 in Fiscal Year 2016-17 to 259 in Fiscal Year 2017-18. Note that it surged from 6 cases in July, 2017 to 53 in February, 2018 following the school shooting in Parkland, Florida. In addition to MOSAIC and Columbia-Suicide Severity Rating Scale (C-SSRS), two new violent threat assessments were being implemented: Structured Assessment of Violence Risk in Youth (SAVRY) and Workplace Assessment of Violence Risk-21 (WAVR-21). These two tools were chosen by the START clinicians. They do not quantitatively calculate the total scores (the risk levels), but present the risk factors. The presence of same risk factors may be weighted differently by various users, and which results in different risk levels. Therefore, the reported outcomes for Fiscal Year 2017-18 will be based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources.

Of the 86 open cases, male and female were 74.42% and 25.58% (Table 1). 39.54% aged between 0 and 15, while 46.51% aged between 16-25, and 13.95% older than 25 years. Note that the 0-15 age group declined from 51.18% in Fiscal Year 2016-17 to 39.54% in Fiscal Year 2017-18, while the 16-25 age group increased from 31.50% to 46.51%. English continued to be the most spoken language: 87.21% (Table 3). Hispanic clients made up of 48.84% of the 86 clients (Table 4). To meet the clients' cultural need, three fourths of the START clinicians are Spanish-speaking and proficient in the Hispanic culture. In Table 5: Service Area, SA 3 was the most served area (19.77%) replacing SA 2 in prior fiscal year, followed by SA 8 (16.28%), SA's 2, 4, and 6 (15.12%), SA 7 (11.63%), SA 5 (4.65%), and SA 1 (2.31%).

SUICIDE PREVENTION

A. Demographics

Table 1 Gender

Gender	Client Count	%
Male	64	74%
Female	22	26%
Total	86	100%

Table 2 Age

Age Group	Client Count	%
0-15	34	39.54%
16-25	40	46.51%
26-59	12	13.95%
Total	86	100%

Table 3 Spoken Language

Language	Client Count	%
English	75	87.21%
Spanish	9	10.46%
Farsi	2	2.33%
Total	86	100%

Table 4 Ethnicity

Ethnicity	Client Count	%
Hispanic	42	48.84%
White	17	19.77%
African American	9	10.47%
Chinese	3	3.5%
Other	15	17.42%
Total	86	100%

Table 5 Service Area

Ethnicity	Client Count	%
SA1-Antelope Valley	2	2.31%
SA2- San Fernando	13	15.12%
SA3- San Gabriel	17	19.77%
SA4- Metro	13	15.12%
SA5- West	4	4.65%
SA6- South	13	15.12%
SA7- East	10	11.63%
SA8- South Bay/Harbor	14	16.28%
Total	86	100%

B. Primary Diagnosis

The most common primary diagnosis was Mood Disorder (36.05%), followed by Major Depressive Disorder (27.91%), Adjustment Disorder and Schizophrenia Spectrum and Other Psychotic Disorder (8.14), Bipolar and related Disorder and Disruptive, Impulse-control and Conduct Disorder (5.81%) and Anxiety Disorder (4.65%).

Table 6: Primary Diagnosis

Primary Diagnosis	Client Count	%
Mood Disorder	31	36%
Major Depressive Disorder	24	28%
Adjustment Disorder	7	8%
Schizophrenia Spectrum & Other Psychotic Disorder	7	8%
Bipolar and related Disorder	5	6%
Disruptive, Impulse-Control, and Conduct Disorder	5	6%
Anxiety Disorder	4	5%
Encounter for observation for other suspected disease and conditions ruled out	1	1%
Obsessive-compulsive & related Disorder	1	1%
Other specified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	1	1%
Grand Total	86	100%

C. Services Rendered

Of the 86 open cases, 38 (44.19%) clients were admitted within the same day of the referrals received, 5 (5.81%) within two days, 8 (9.30%) within a week, and 35 (40.70%) exceeded one weeks partially due to difficulty in reaching the clients. In Fiscal Year 2017 -18, START admitted 45 (52.33%) cases and discharged 56 (65.12%) clients of the 56, 20 (23.26%) were admitted and discharged in the same fiscal year.

In addition to the 86 active clients, 219 refer-in cases were outreached to determine their eligibility for the START Program services. If follow-up was required to engage those potential cases, the clinicians extended their services beyond one visit.

1820 services were rendered: 757 (41.59%) to the 86 open cases, 825 (45.33%) to those 219 individuals whose cases were not activated because they were reluctant or ineligible for START Program services, and 238 (13.08%) to the community in general.

D. Changes in Violent and Suicidal Risk Level

In Fiscal Year 2017-18, 56 clients were closed with 9 dropped out early and 47 completed treatment cycles. Below table outlines the change in suicidal and violent risk levels between initial and final contacts. 30 clients posed low suicidal risk throughout the treatment cycles, 10 from moderate to low, and 7 from high to low. As for the violent risk levels, 29 cases improved from moderate to low violent risk levels, 9 remained low throughout the treatment cycles, 7 from high to low, 1 from high to moderate, and 1 remained moderate.

Table 7: Change of Suicidal and Violent Risk Levels between Initial and Final Contacts

Outcome	Change in Suicidal Risk Level	%	Change in Violence Risk Level	%
H to H	0	0.00%	0	0.00%
H to M	0	0.00%	1	1.79%
H to L	7	12.50%	7	12.50%
M to M	0	0.00%	1	1.79%
M to L	10	17.86%	29	51.79%
L to M	0	0.00%	0	0.00%
L to L	30	53.57%	9	16.07%
Early drop out	9	16.07%	9	16.07%
Total	56	100.00%	56	100.00%

E. Trainings

In FY 2017-18, START provided 42 trainings to 1518 attendees in the four subject matters: bullying, targeted school violence, orientation to START services, and suicide prevention.

Table 8: Trainings

Training	Bullying		Targeted School Violence		START		Suicide Prevention	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
12th Grade or below	0	0	0	0	1	30	0	0
College Students	0	0	0	0	11	537	2	50
Professional	1	67	7	212	15	422	3	90
Parent / Other	0	0	0	0	0	0	2	110
Total	1	67	7	212	27	989	7	250

Workforce Education and Training

The Los Angeles County MHSA - Workforce Education and Training Plan, approved April 8, 2009, seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven and 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 Los Angeles County, personnel shortages remain a constant concern; however, the needs far outweigh the positions available. In particular, the need for personnel that is bilingual and bicultural to provide services to the underserved unserved populations is critical. In addition, there is a shortage of personnel with expertise relevant to working with the following populations: 0 to 5, Children/TAY, LGBTQ, Veterans, Older Adults, Homeless, and Justice involved.

WET COORDINATION : WORKFORCE STAFFING AND SUPPORT

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

LOS ANGELES COUNTY WET OVERSIGHT COMMITTEE

The Los Angeles County WET Oversight Committee assisted in providing recommendations to the LACDMH. The Committee is composed of various subject matter experts, representing many underserved ethnicities in our County.

FINANCIAL INCENTIVE PROGRAMS

Mental Health Psychiatrist Student Loan Repayment Incentive

This financial incentive program was implemented late FY 17-18 to recruit/retain mental health psychiatrists. Given the competitive job market for mental health psychiatrists and the severe shortage of these crucial positions, MH Psychiatrists employed in the Department of Mental Health are eligible for outstanding student loan repayment awards of $50,000 annually; this award is contingent on continued employment in the Department and is not to exceed the outstanding educational loan balance. During FY 2017/2018, 9 mental health psychiatrists where awarded an aggregate total of $432,532.

Stipend Program for Psychologists, MSWs, MFTs, and Psychiatric Nurses

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 2017/2018 this program was available to 87 MFT, 92 MSW students. During this award cycle, all stipends were awarded. 74% of all recipients identified from populations recognized as un- or under- served. During the same cycle, 70% 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 2018/2019.

TRAINING AND TECHNICAL ASSISTANCE

Recovery Oriented Practices

This program offers public mental health staff (i.e., clerical, clinical staff to program administrators) a two-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 2017/2018, while the contract required 400 individuals be trained, in reality 438 members of the public mental health workforce attended this training.

Licensure Preparation Program (LPP)

This program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapy interns, and psychologists. All participants must be employed in the public mental health system and eligible 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 2017-18 is as follows:

EXAM	DMH	Contracted	Total	Bilingual Clinicians	Pass Rate
MSW Law and Ethics	35	125	160	49%	26%
MSW Clinical Exam	66	95	161	65%	11%
MFT Law and Ethics	3	110	113	51%	19%
MFT Clinical Exam	10	203	213	52%	7%
EPPP For Psychologists	7	11	18	0%	22%
CPLEE For Psychologists	5	2	7	57%	43%
TOTAL	**126**	**546**	**672**	**53%**	**15%**

Mental Health Promoters

Spanish speaking community members are trained as mental health promoters. With continued training and support, these individuals have become community champions and liaisons educating their respective communities on available mental health services and promoting anti-stigma campaigns. Presently, 133 promoters are trained. During FY 17-18, these individuals presented to approximately 37,555 community members, thru 4,287 communities based presentations.

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Navigator Skill Development Program

- **Health Navigation Certification Training**
  This program trains individuals employed as community workers, medical case works, substance abuse counselors and peer specialists and their supervisors on knowledge and skills needed to assist consumers navigate and advocate for themselves in both the public health and mental health systems. During FY 2017/2018, 26 participants completed this training.
- **Family Health Navigation Certification Training**
  This program trains family members to assist consumers navigate and advocate for themselves in both the public health and mental health systems. During FY 2017/2018, 28 participants completed this training.
- **TAY Peer Support Specialist Training**
  This program prepares young adults to work with TAY to achieve life goals for independence and self-sufficiency. TAY Peer Support Specialist training prepares participants to utilize their gifts to assist TAY in creating meaningful daily activities, engaging in their communities, building positive alliances, and empowering themselves to move towards mental wellness. During FY 2017/2018, 51 participants completed this training.

Mass Shooting Training

This workshop presented an overview to Service Area 7 community members regarding active shooting issues and concerns. For example, it provided training relevant to differentiating between a person with a mental health illness vs a person grievance issue driven. 90 community members participated in this workshop.

Translation of Mental Health Materials

MHSA WET funded translation of mental health materials, such as various forms, self-help articles and family guides into the following languages: Armenian, Arabic, Cambodian, Chinese Simplified, Chinese Traditional, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese. These efforts were intended to avail information regarding mental health to un- and under-served communities in addition to the resources provided by the Department of Mental Health.

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Online Licensure/Pre-Licensure Training

The Department purchased online registration slots that are available to clinical staff of the Los Angeles County public mental health system. The purpose of these online trainings are to provide clinical staff an opportunity to comply with State of California Board of Psychology (BOP) and Board of Behavioral Sciences (BBA) pre-licensure and continuing education mandates as required for unlicensed/licensed psychologists, social workers, marriage and family therapists, and professional clinical counselors. During FY 2017/2018, the Department purchased and disbursed the following online courses.

Pre-Licensure FY 17-18	# of Slots Purchased	Approved Participants
Aging, Long Term Care and Elder/Dependent Adult Abuse (10 Hours)	1150	287
Alcoholism/Chemical Dependency Detection and Treatment (15 Hours)	325	86
Child Abuse Assessment and Reporting (7 Hours)	1150	325
Domestic Violence Assessment, Detection and Intervention Strategies (15 Hours)	1000	125
Human Sexuality (10 Hours)	1100	256
Total	**4725**	**1079**

Continuing Education FY 17-18	# of Slots Purchased	Approved Participants
Assessment and Treatment of People Living With Human HIV and AIDS (7 Hour)	1100	253
Law and Ethics (6 Hour)	1100	261
Total	**2200**	**514**

Disbursement of available slots continue thru FY 2018/2019.

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Working with Forensic-Related Consumers

The forensic population is frequently subjected to violence and other traumatic experiences. There is ample evidence that psychological trauma interferes with the development of the brain and its maturational process, and that the manifestation of this trauma can result in adverse consequences throughout the age span. For individuals already impacted by this life experience the implications for treatment and intervention are significant. Justice involved consumers are often court-ordered and in treatment involuntarily. These trainings addressed a range of issues relevant to clinicians working with this population. Topics varied from strategies for engaging forensic consumers diagnosed with PTSD to self-care to utilizing interventions specifically targeting this treatment population. During FY 2017/2018, the following training offerings were delivered:

TRAINING	NO. TRAINED
Assessment and Best Practice Treatment of Forensic/Justice-Involved Consumers	64
Building Staff Resilience: Identifying The Emotional Hazards of Care Work	20
Criminal Justice 101 - Overview of the System and Jail Culture/Norms	48
De-Escalation Prevention, Intervention and Afterward	11
Forensic/Justice Involved Advanced LPS Training	52
Harm Reduction and the Three E's	6
Hearing Voices that are Distressing	48
Integrating Incarcerated Women into Society	36
Law and Ethics: Navigation the Criminal Justice System with Forensic/Justice Involved Consumers	47
Motivational Interviewing	20
Safety and Crisis Prevention/Interventions when Working with Forensic/Justice Involved Consumers	59
The Invisible Wound: Promoting Healing Via Trauma Informed Care Consciousness-Forensic FocuS	25
The Role of Culture in Recovery	63
TOTAL TRAINED	**499**

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Social Rehabilitation Curriculum Building

The Workforce Education and Training Division collaborated with industry subject matter experts to develop and implement trainings addressing the duties and responsibilities of a social rehabilitation specialist (SRS) (defined as public mental health staff working in positions such as, but not exclusive of community worker, employment specialist, substance abuse counselor and medical caseworker). The following trainings were delivered in FY 2017-2018:

Social Rehabilitation Specialist (SRS) Trainings	
Trainings	# of Attendees
Introduction to Social Rehabilitation Specialists	49
Law, Ethics and Boundaries for Social Rehabilitation Specialists	41
Social Rehabilitation Specialist: Co-Occurring Disorders	47
Social Rehabilitation Specialist: Safety and Crisis Prevention, Intervention and Response	57
TOTAL TRAINED	194

Interpreter Training Program

The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and 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 2017/2018 Outcomes:

TRAINING	# OF ATTENDEES
INCREASING SPANISH MENTAL HEALTH CLINICAL TERMINOLOGY	95
INCREASING MANDARIN MENTAL HEALTH CLINICAL TERMINOLOGY	13
INTRODUCTION TO INTERPRETING IN MENTAL HEALTH SETTINGS	53
TOTAL # OF ATTENDEES FOR FY 17-18 INTERPRETING PROGRAM	161

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments

During FY 2017-2018, the Department of Mental Health outreached to other Los Angeles County Departments availing funding for trainings (for their workforce/communities served) which addressed mental health issues and concerns. As a result of this outreach effort, the following trainings were delivered:

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Animal Care and Control	Working with clients experiencing mental illness	Department of Animal Care and Control staff members	60
Beaches and Harbors	Implicit Bias and Cultural Competency	Los Angeles County Employees	300
Board of Supervisors	Implicit Bias and Cultural Competency	Los Angeles County Employees	253
Children and Family Services	Implicit Bias and Cultural Competency	Los Angeles County Employees	4571
Consumer & Business Affairs	Client Engagement & Mental Health Awareness	Case managers, front line staff, outreach team	30
Fire Department	Violence Prevention Program	All employees in direct contact with patients. (All licensed EMTs and Paramedics)	3,299
Department of Health Services	Suicide Prevention - ASIST	Intensive case management staff, interim housing staff, street outreach staff , and medical staff. Basically all contracting agencies of DHS Housing for Health.	300
Department of Health Services	Opiod Overdose Prevention and Education	Intensive case management staff, interim housing staff, street outreach staff , and medical staff. Basically all contracting agencies of DHS Housing for Health.	400
Department of Health Services	Trauma Informed Care	Intensive case management staff, interim housing staff, street outreach staff , and medical staff. Basically all contracting agencies of DHS Housing for Health.	300
Department of Health Services	Vicarious Trauma	Intensive case management, interim housing staff, street outreach staff and medical staff. Basically all contracting agencies of DHS Housing for Health.	300

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments (continued)

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Department of Health Services	Critical Time Intervention	Intensive case management and management staff in Permanent Supportive Housing.	40-50
Department of Health Services	An Introduction to Motivational Interviewing	Intensive case management staff in Permanent Supportive Housing.	35-40
Department of Health Services	Working with Clients on Hoarding	Intensive case management staff, interim housing staff, street outreach staff , and medical staff. Basically all contracting agencies of DHS Housing for Health.	300
Department of Health Services	Integrating Mental Health Care into Nursing Management Leadership in Correctional Health	Nurse supervisors, managers, and directors	120
Department of Health Services	Materials for Nonviolent Crisis Intervention Training	psychiatric services staff	3000
Department of Health Services	Nonviolent Crisis Intervention Instructor Certification Program	We are several locations and departments with CHS: CRDF (Women's Jail), TTCF (Men's Jail), IRC (Intake Reception Center), FIP (Forensic Inpatient) and JMET (General Population intervention). Ideally, we would recruit one nurse and one mental health professional from each location to become a trainer for the remainder of their staff.	10
Department of Health Services - Health Services Administration	Nonviolent Crisis Intervention	Psychiatric Services Staff	18
Department of Health Services - Olive View-UCLA Medical Center	Non-Violent Crisis Intervention	Psychiatric services staff	18
Department of Human Resources	Implicit Bias and Cultural Competency	Los Angeles County Employees	487

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments (continued)

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Department of Health Services	Critical Time Intervention	Intensive case management and management staff in Permanent Supportive Housing.	40-50
Department of Health Services	An Introduction to Motivational Interviewing	Intensive case management staff in Permanent Supportive Housing.	35-40
Department of Health Services	Working with Clients on Hoarding	Intensive case management staff, interim housing staff, street outreach staff , and medical staff. Basically all contracting agencies of DHS Housing for Health.	300
Department of Health Services	Integrating Mental Health Care into Nursing Management Leadership in Correctional Health	Nurse supervisors, managers, and directors	120
Department of Health Services	Materials for Nonviolent Crisis Intervention Training	Psychiatric services staff	3,000
Department of Health Services	Nonviolent Crisis Intervention Instructor Certification Program	We are several locations and departments with CHS: CRDF (Women's Jail), TTCF (Men's Jail), IRC (Intake Reception Center), FIP (Forensic Inpatient) and JMET (General Population intervention). Ideally, we would recruit one nurse and one mental health professional from each location to become a trainer for the remainder of their staff.	10
Department of Health Services - Health Services Administration	Nonviolent Crisis Intervention	Psychiatric Services Staff	18
Department of Health Services - Olive View-UCLA Medical Center	Non-Violent Crisis Intervention	Psychiatric services staff	18
Department of Human Resources	Implicit Bias and Cultural Competency	Los Angeles County Employees	487

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments (continued)

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Department of Human Resources	Mental Health First Aid Domestic Violence Training Screen, Brief Intervention and Referral to Treatment (SBIRT)	OHP-EAP clinicians	10000
Department of Human Resources	-Gender Equity and Communication Compass Toolkit -Diversity: Employee Essentials -Diversity Made Simple Series Employee & Manager Government Combo -Understanding and Tackling Gender Bias in the Workplace	Los Angeles County Employees	100,000
Department of Military and Veterans Affairs	Introduction to Mental Health Disorders	Veterans Service Officers	50
Department of Public Health	Preventing and Addressing Older Adult Social Isolation and Loneliness: Enhancing Health and Aging Network Provider Capacity	Professional and paraprofessional staff	100
Department of Public Social Services	Moving from Understanding the Effects of Trauma on the Lives of Those we ser to Implementing Principles of Trauma Informed Care	Departmental Directors (who have the ability to develop trauma informed systems of care); and direct service staff (who interact with the Department's customers daily).	100
Department of Public Social Services	Certification 360: Two-Day Immersion in Case Management Practice	Direct service staff (GR/CalWORKs)	100
Department of Health Services	The Motivational Interviewing (MI): The Spirit of MI	Staff from the DHS-Primary Care Medical Homes who provides services to patients that had been diagnosed with substance use disorders.	100
Department of Health Services	UCLA LGBTQ Allyship Training Program	Staff from the Department of Health Services	150

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments (continued)

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Department of Health Services	Matrix Model Basic Core Training	Clinical Staff from Department of Health Services Primary Care Medical Homes	40
District Attorney's Office	Managing Vicarious Trauma	Advocates, paralegals and support staff	120
District Attorney's Office (LADA)	Impact of Trauma for the Prosecution Community	Prosecutors, Investigators and Paralegals.	300
Probation Department	Blue Courage	Staff members from each bureau within the department	30
Probation Department	Basic Peer Support	Probation Department employees from every bureau	30
Probation Department	The Link Between Animal Abuse, Child Abuse and Domestic Abuse	Juvenile and Adult Field Probation Officers	150
Probation Department	Trauma Informed Care: Post Traumatic Growth: A New Lens	Juvenile and Field Probation Officers, Supervisors and Directors	540
Probation Department	Implicit Bias and Cultural Competency	Los Angeles County Employees	140
Public Library	2018 iCount - Equity and Inclusion	Community Library Managers and Supervisors	200
Public Social Services	Academy for Coaching Excellence: Coaching Skills for Leaders and Line Staff	Management & direct service staff	145
Public Works	Implicit Bias and Cultural Competency	Los Angeles County Employees	100
Regional Planning	Implicit Bias and Cultural Competency	Los Angeles County Employees	150
Sheriff's Department	Mindfulness-Based Wellness & Resiliency Training Program	LASD, medical and mental health employees that specially work with and provide service to our mentally ill inmates within our jail facilities.	180 - 200

TRAINING AND TECHNICAL ASSISTANCE (CONTINUED)

Mental Health Training Opportunities for Other County Departments (continued)

Requesting County Department	Title of Training	Target Population	Number of Individuals to be Trained
Treasurer and Tax Collector	Mental Health Awareness Training	Staff within Tax Collection, Banking Operations, and Public Administrator branches.	115
Treasurer and Tax Collector	Implicit Bias and Cultural Competency	Los Angeles County Employees	312
Workforce Development, Aging and Community Services (WDACS)	Reentry Workforce Development	Justice-involved individuals - formerly incarcerated - reentry	Varies; initial training is targeting c.100 WDACS, AJCC and partner agency staff

CAREER PATHWAYS

Intensive Mental Health Recovery Specialist Training Program

Intensive Mental Health Recovery Specialist Training Program prepares consumers and family members, with a minimum of 2 years of college credit, to work in the mental health field as psycho-social rehabilitation specialists. This program is delivered in partnership with a mental health contractor and local community college. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system.

During FY 2017/2018, 54 individuals interested in employment in the public mental health system completed the training. Of these participants, 76% represented individuals from un- or under- served populations, and 37% spoke a second language, other than English.

No changes are planned for FY 2018/2019.

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

- **Macro Peer Advocacy Program**

This program is targeted to peers, family advocates and members to effectively promote and empower the consumer voice and advocate for continued support of MHSA recovery, resilience, and wellness tenets. Components include the legislative process, communication strategies for both written and in person presentation with county and state constituents, and development of successful political collaborative/relationship approaches. During FY 2017/2018, 11 peers participated in this training.

- **Peer Housing Specialist Training**

This program trains individuals employed as community workers, medical case workers, substance abuse counselors and peer specialists on knowledge and skills needed to assist consumers navigate and advocate for themselves in the mental health systems and with their housing circumstances. During FY 2017/2018, 48 participants completed this training.

- **Homeless Outreach Peer Enhancement Specialists (HOPES) Program**

This program trains mental health peer and family peers who volunteer in a shelter setting. These participants are to support outreach in shelter enviornments specifically to assist consumers in identifying early recovery goals related to mental health, physical health and substance use and stability. The training consists of both didactic and experiential experiences that incorporate: informative learning, role playing activities, group dynamics, shadowing, coaching, and onsite internship activities. During FY 17-18, 23 peers completed this training.

CAREER PATHWAYS

Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System (continued)

- **Individual Placement and Support (IPS)**

Individual Placement and Support (IPS) is an evidence-based approach to supported employment for people who suffer from a mental illness. IPS supports people in their efforts to achieve steady, meaningful employment in mainstream competitive jobs, either part-time or full-time. A key feature of IPS is integrating employment services with mental health services. IPS is based on eight principles. Mental health agencies that implement IPS, aim to follow these principles in delivering vocational services:

- Every person with severe mental illness who wants to work is eligible for IPS supported employment.
- Employment services are integrated with mental health treatment services.
- Competitive employment is the goal.
- Personalized benefits counseling is provided.
- The job search starts soon after a person expresses interest in working.
- Employment specialists systematically develop relationships with employers based upon their client's preferences.
- Job supports are continuous.
- Client preferences are honored.

- **Translation of Mental Health Materials**

MHSA WET funding was utilized to translate mental health materials, such as various forms, self-help articles and family guides to the following languages: Armenian, Arabic, Cambodian, Chinese Simplified, Chinese Traditional, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese. These efforts were intended to avail information regarding mental health to un- and under-served communities complimenting the resources provided by the Department of Mental Health.

- **Independent Consumer Training Program**

Peer Actions 4 Change (PA4C) group was developed through the Independent Consumer Association Development Training Program (ICADTP). The following activities were completed by PA4C with the support of SHARE (contractor lead): Monthly contract consultations between DMH Program Director, SHARE and PA4C occurred. SHARE hosted several Toastmasters meetings to support the Speakers Bureau component of the group. As a result, several members participated in speaking engagements during this time period. Other PA4C activities included organizing a Job Fair Conference Committee which met monthly and coordinated a successful conference held on September 9, 2018; $3430.10 was raised. Members also participated in the NAMI Walk and trained on Legislative Advocacy.

CAREER PATHWAYS

Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System (continued)

- **Quick Series Pocket Books**

Quick Series Pocket Books were funded and distributed throughout Los Angeles County promoting mental health awareness and emotional well-being. Approximately 15,000 out of 40,000 purchased were distributed to the community during FY 2017/2018.

Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers In The Public Mental Health System

- **Parent Partners Training Program**

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. During FY 2017/2018, 145 parents (9 cohorts) were trained.

- **Parent Partner Training Symposium**

The 3-day symposium was held twice and was attended by approximately 200 parent partners. These training opportunities covered a wide range of topics, including: integrating care/co-occurring disorders; criminal justice issues; crisis intervention and support strategies; education; employment; homelessness; housing; inpatient/hospitalizations; LGBTQI issues; older adults; residential and group homes; suicide prevention, etc.

- **PPTA Certification Exam Creation & Parent Partner/Parent Advocate Training Program Evaluation and Outcomes Report and Presentation**

During this reporting period, a vendor developed program evaluation tools and provided outcome data reports. Vendor also developed a certification examination for PPTAs whereby drafting minimum competency standards for the County of Los Angeles.

CAREER PATHWAYS

Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers In The Public Mental Health System (continued)

- ***Continuum of Care Reform (CCR)***

Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, DMH offered the following trainings and include topics subjects such as introduction to mental health, diagnosis/assessment and self-care:

TITLE OF TRAINING	INDIVIDUALS TRAINED
Child and Family Teaming: Enhancing Outcomes for Youth Involved in the Child Welfare	377
Developing Collaborative Partnerships and a Shared Vision via the Child and Family Team Process	223
Developmental and Trauma-Informed Strategies in Understanding and Assessing Young Children and Families	192
Diagnostic Manual Intellectual Disability 2 ID & MH Training	277
Fostering Resilience in Foster Youth & Families	86
Implementation of California's Cross System Integrated Core Practice Model	484
Keeping Children and Families at the Center, an Integrated Approach to Bridging, Engagement, Teaming, and Assessment	169
MH Strategies for Children and Youth with Co-Occurring Developmental Disabilities	277
Self-Care: Promoting Wellness and Resiliency	275
Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth and Families	163
Supervision of Vicarious Trauma of Clinicians Providing Trauma - Informed Care to Child Welfare Involved Children, Youth, and Families	122
TOTAL TRAINED	**2645**

CAREER PATHWAYS

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. Topics covered in these trainings included 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 outlined in the MHSA-WET Plan. During FY 2017/2018, the following were held/trained:

Training Component	Train-The-Trainer Sessions	New Speakers Trained	Presentation Participants
Adult Consumers Advocacy Speakers	2		253
Family Advocacy Speakers	1		200
Family Support and Advocacy Training	3		800
Family Support and Advocacy Training In Spanish	2		160
Family Advocacy Lobby Outreach Program			120
Family Advocate Wellness and Recovery Training Program			700
Parent/Caregiver Advocate Wellness and Recovery Training Program			550
Child/Adolescent Consumer Advocacy Speakers Bureau			48
Parent Advocacy Speakers' Bureau		20	32
Parent Support and Advocacy Training Bureau	2		250
Parent Support and Advocacy Training Bureau in Spanish	1		65
Parent and Teachers Joint Advocacy Program	1		235
TOTALs	**12**	**20**	**3,413**

INNOVATION

INNOVATION 2: COMMUNITY CAPACITY BUILDING TO PREVENT AND ADDRESS TRAUMA

This project centers on building the capacity of the community to identify and support community members at risk of trauma or experiencing trauma utilizing the assets of the community by testing out strategies that allow local communities to work together in ways that will ultimately lead to better mental health and reductions in trauma, through the building of shared community values, leadership development and community member empowerment.
The Los Angeles County Board of Supervisors approved 10 lead agencies, 2 in each Supervisorial District, to establish community partnerships in geographically-defined communities. The identified communities are those with a concentration of inequalities, including disproportionate levels of poverty, high concentrations of unserved and underserved individuals and poor health and well-being outcomes, including educational and unemployment inequities. Lead agencies were selected through a solicitation process. Each proposing organization and their community partners select specific strategies from the menu below, based on their community's interests. Beyond the implementation of selected strategies, each community partnership is responsible for building the capacity of the specific communities to work collectively toward supporting community identification and reduction of trauma, as outlined in the solicitation.

Strategies

- **Building Trauma Resilient Families** targeting children ages birth to five and their caregivers who have experienced trauma and/or are at risk for trauma. Activities include assessing and educating families and young children for exposure to Adverse Childhood Experiences (ACES).
- **Trauma-Informed Psycho-education and Support for School Communities** Training/workshops on recognizing behaviors and symptoms of stress and trauma in children provided to early care/education (EC/E) and school personnel and community mentors who work with children ages 0-15. The workshops would teach simple trauma-informed coping techniques that can be implemented within EC/E and school settings to reduce stress experienced by children.
- **Outreach and engagement to Transition Age Youth (TAY ages16-25) and TAY peer support groups** to outreach and engage TAY who are at risk of or experiencing trauma as a result of homelessness.
- **Coordinated Employment within a community**. Through a standardized employment assessment tool, a network of businesses within a specific community will be created that will provide coordinated job opportunities to individuals who are mentally ill and homeless/formally homeless. Job opportunities will be sought out in the competitive employment market and through the development of social enterprises within the neighborhood.
- **Community Integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system.** A community response involving the creation of a consortium of law enforcement, the courts and community agencies designed to reduce re-incarcerations.
- **Geriatric Empowerment Model** designed to outreach, engage and house homeless older adults.
- **Culturally competent non-traditional self-help activities for families with multiple generations experiencing trauma**, including engagement, intergenerational story- telling and intergenerational mentorship programs.

The Department held a 2-day kickoff in September, 2018 with all lead agencies and their community partners, inviting Service Area Advisory Committee representatives and DMH Service Area Chiefs. UC San Diego was awarded the evaluation of this project and has been developing the evaluation methods and instruments. The first quarterly learning session for this 4- year project is scheduled for January 15, 2019.

INNOVATION

During FY 2017-18 and, to date, in FY 2018-19, the Department received approval to implement 6 Innovation projects:

INNOVATION 3: TECHNOLOGY SUITE

After receiving approval from the Mental Health Services Oversight and Accountability Commission on October 26, 2017, The Department entered into an agreement with CalMHSA, a Point Powers Authority utilized by counties, to administer the administrative functions of this multi-county project. The participation agreement was approved by the Los Angeles County Board of Supervisors on February 20, 2018.

Components of the Technology Suite:

Accessible from a computer, cell phone and tablet utilizing customized applications for:

1. Digital detection of emotional, thought and behavioral disturbances through passively collected data and sophisticated analyses that sense changes in the user interface known to correlate with social isolation, depression, mania, the early psychotic (prodromal) syndrome, and other indicators of either the onset of new mental illness or the recurrence of a chronic condition. As concerning signals are detected, communication to the user is generated through texts, emails, peer (see below) or clinician outreach to prompt care.
2. A web-based network of trained and certified peers on call to chat 24/7 with individuals experiencing worsening symptoms of mental illness as well as family members and caregivers. A link to this network available through the reengineered DMH website and other forms of social media will be used to widely disseminate the service across Los Angeles County. It will be branded as both a support and a triage tool for anyone experiencing problems at any time, especially those unfamiliar with self-management techniques, confused or unclear about the resources available for help, or reluctant to walk into a mental health clinic.
3. Virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care. By their nature as virtual tools, this client-provider interface is available 24/7 and can be accessed in the convenience of home environments, clinical settings, and even on smart phones.

Los Angeles, Kern and Mono counties participated in vendor selection for each of these components on February 26th and 28th, 2018 and selected 7 Cups for components 2 and 3 and Mindstrong for component 1. On April 26, 2018 Orange and Modoc counties were approved to join the Technology Suite and on September 27, 2018 10 additional counties were approved, for a total of 15 counties.

During the early summer of 2018, RSE was selected as outreach, engagement and marketing firm and the University of California, Irvine as the evaluator of the project.

The Department has launched the digital phenotyping Mindstrong care application at Harbor-UCLA's outpatient Dialectical Behavioral Therapy (DBT) program as a strategy to promote early detection of emotional dysregulation. Elements of DBT, such as the Diary Card, have been incorporated into the Mindstrong application to create a more efficient way for clients to complete diary cards and for clinicians to utilize the information in the treatment process.

INNOVATION 4: TRANSCRANIAL MAGNETIC STIMULATION (TMS)

The Department received approval from the MHSOAC on April 26, 2018 to implement TMS as a strategy to effectively treat depression in clients that have tried 2 or more anti-depressants without relief and improvement. The Department will deliver TMS via an outfitted van that will travel to different outpatient mental health programs. As of December, 2018, the Department is in the process of requesting the positions and outfitting the van.

INNOVATION

INNOVATION 5: PEER SUPPORT SPECIALIST FULL SERVICE PARTNERSHIP

The Department received approval from the MHSOAC on April 26, 2018 to implement 2 teams comprised mostly of peer support specialists to provide FSP level services. The Department is in the process of identifying providers.

INNOVATION 7: THERAPEUTIC TRANSPORTATION

The Department received approval from the MHSOAC on September 27, 2018 to implement 20 teams across the county and across multiple shifts to transform the County's approach to responding to individuals placed on an involuntary hold or at significant risk of being placed on a hold through engagement, support and recovery-focused interventions delivered using specially outfitted vans, staffed with mental health clinicians, mental health counselor, RNs (MHC, RN) and peer support specialists. Staff would offer a supportive and expedited response to transportation as well as initiate supportive case management in order to begin the healing and recovery from the exacerbation of mental health symptoms from the first point of contact. Each team will respond to the Psychiatric Mobile Response Team's (PMRT) request either to transport a client who is on a hold or to intervene on the streets to avoid the need for an involuntary hold. The Department is currently in the process of requesting positions for this project

INNOVATION 8: EARLY PSYCHOSIS LEARNING HEALTHCARE NETWORK

The Department received approval from the MHSOAC for this multi-county 5-year project on December 17, 2018. The Department is currently in the scoring proposals from a 2018 solicitation to implement the Portland Identification and Early Intervention (PIER) program to identify and comprehensively treat individuals ages 12-25 who are in the prodromal or initial 18 months of a first psychotic episode. PIER is one of several coordinated specialty care models for this population. The learning healthcare network will allow counties to collect common outcome data, be able to use it to inform treatment and to engage in cross-county learning informed by outcome data.

INNOVATION 9: COSERVATEE SUPPORT

The Department received approval from the MHSOAC on September 27, 2018. This project seeks to increase conservatees' support and access to an array of services in their community in order to increase autonomy, improved quality of life and community integration. Two teams per each of the 8 service areas (SA) will be composed of a clinician and a peer mentor. Each of the sixteen teams will provide support, case management and consultative services for a caseload of 50 clients conserved through the PG, who are living in the community/B&C facility (approximately 800 individuals at this time) and not within the confines of a locked facility. These two person teams will be embedded within existing mental health clinics and will serve as PG experts or champions for clients on conservatorships. There will be regular treatment team meetings and in-service trainings for clinicians, peer mentors, families, B&C operator/staff and the PG to create shared goals and treatment plans for clients on conservatorship. The Department is currently in the process of requesting positions for this project.

TECHNOLOGICAL NEEDS

*See Appendix for more detail on the status of the MHSA IT Projects

ACCESS CALL CENTER RECORDING SYSTEM UPGRADE

Project Status: On Schedule **Project Start Date:** 3/14/2018 **Project End Date:** 6/28/2019

The Project objective is to replace aging on-premises video screen capture and audio call recording system with Cloud based call center recording system to capture calls from any location.

During FY 17-18, the project was in Planning Phase and the following activities were performed:

- Initial assessment of project scope and requirements
- Identify key risks and issue
- Identify core team members
- Identify potential solution vendors

DIGITAL WORKPLACE: ENTERPRISE MOBILITY AND SECURITY

Project Status: Ahead Schedule **Project Start Date:** 6/15/2017 **Project End Date:** 12/14/2017

Migration of County-issued mobile devices (primarily Apple iPhone models) from the current mobile device management (MDM) solution, Research in Motion's BlackBerry Enterprise Server (BES), to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform will enable DMH to ensure compliance with federal regulations, i.e., HIPAA, regarding the protection of personal health information (PHI) by establishing and applying conditional access policies that define how applications and services can be accessed both on or off the County network. Enterprise mobility management (EMM) will provide the capability to manage assigned mobile devices and allow use of only approved apps on the managed devices.

The Project is completed ahead of schedule on 12/14/2017 by migrating 1,294 devices to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform. Enterprise mobility management (EMM) provides the capability to manage assigned mobile devices in protecting Personal Health Information and allow use of only approved applications on the managed devices.

DIGITAL WORKPLACE: WI-FI ACCESS AT DMH CLINICS AND ADMIN SITES

Project Status: On Schedule **Project Start Date:** 01/01/2018 **Project End Date:** 12/31/2018

The project objective is to provide both employee and guest access wirelessly to County and Internet resources at DMH Facilities. Workers who span multiple clinical environments can be more productive in whatever space they set up to get work done and serve the clients efficiently.

The project for providing WiFi access to our directly operated locations has been divided into three phases. Phase 1 consists of 11 sites. Phase 2 consists of 21 sites. Phase 3 consists of 19 sites. At this time Phase I has been completed and Phase 2 has been initiated.

TECHNOLOGICAL NEEDS

DIGITAL WORKPLACE: VIDEO CONFERENCING/WEBCASTING EXPANSION

Project Status: On Schedule **Project Start Date:** 12/15/2017 **Project End Date:** 6/30/2019

The Project objective is to expand webcasting to the department by using Skype. Purchase and deploy new equipment for continuation of video conferencing and webcasting as a mode of communication and collaboration to save on travel time and increase productivity.

Initiated Phase 1 of the project to roll out a set of Microsoft Surface HUBS to 20 locations. The subsequent phases will include the use of telepresence and Skype capabilities throughout the department as a mode of collaboration and communication.

CONSTITUENT CALL LOG-CONSUMER AND FAMILY ADVOCACY

Project Status: On Schedule **Project Start Date:** 12/20/2017 **Project End Date:** 06/15/2018

The Office of Consumer Affairs logs complaints/issues from Constituents and resolves those concerns as a form of advocacy for LA County DMH in all Service Areas. The BOS also submits issues/complaints and requests status updates. This project will develop a solution using Microsoft Dynamics that will allow multiple staff members and interns to simultaneously enter complaint/issue information real-time, track status of complaints, track trends/call patterns, and report information. The solution will also provide a running history of transactions with constituents and accommodate the growing number of calls.

Project was implemented into production 04/30/2018 for the Office of Consumer Affairs. Approximately 17 users regularly use the application.

NETWORK ADEQUACY CERTIFICATION TOOL (NACT)

Project Status: On Schedule **Project Start Date:** 03/08/2018 **Project End Date:** 9/28/2018

The project objective is to Create a Network Adequacy Certification Tool (NACT) to comply with State Department of Health Care Services (DHCS) requirements for Mental Health Service plans Network Adequacy and Certification requirements. This is an on-line application that collects and verifies the data needed for Network Adequacy Certification. All LACDMH providers must review, update and validate their organization, service location and staff information.

Project was implemented into production on 03/20/2018. Microsoft CRM Solution was deployed for Directly Operated Providers and the Microsoft CRM Portal was deployed for Legal Entity (LE) and Fee For Service (FFS) providers.

TECHNOLOGICAL NEEDS

NOTICE OF GRIEVANCE RESOLUTION

Project Status: On Schedule **Project Start Date:** 04/20/0218 **Project End Date:** 01/31/2019

The project objective is to provide a system that will handle uniform notices that involves Los Angeles County process in dealing with Benefits. Also involves Notices of Adverse Benefits Determination, Notice of Grievance Resolution and Notice of Appeal. Delivers functionality in Microsoft Dynamics 365 to allow real-time entry of constituent grievances and grievance status tracking, trend analysis and reporting.

The application is in a sandbox environment, in execution phase, but testing has not been done. Verification of the code, security, and tables used has not been done yet.

PATIENT'S RIGHTS CHANGE OF PROVIDER

Project Status: On Schedule **Project Start Date:** 12/20/2017 **Project End Date:** 01/31/2019

The project objective is to computerize the process of Clients requesting any change of provider that is part of the services they are receiving from Directly Operated centers or Legal Entities that are contracted by LA County DMH. The Application will also track State mandated requirements that are related to any request for change of providers.

For Directly Operated (DO) users, the Microsoft CRM Dynamics Application is in the Execution Phase in the Sandbox Development environment. The primary users, patient's rights, are currently testing.

NETWORK ADEQUACY CERTIFICATION TOOL STATE SUBMISSION

Project Status: On Schedule **Project Start Date:** 02/28/2018 **Project End Date:** 03/31/2019

The objective of this project is to create an automated process to extract data from Network Adequacy Certification Tool (NACT) application and Integrated Behavioral Health Information System (IBHIS) to create submission files to be uploaded to the State of California Client & Service Information (CSI) website. This project will ensure LACDMH compliance with State Department of Health Care Services (DHCS) requirements for Mental Health Service plans network adequacy and certification requirements. The NACT application and NACT State Submission were created and developed due to the requirements of the Final Rule from Medicaid and in order to ensure that the State of California is in compliance with network adequacy standards as required by Medicaid. As a result, the State published new requirements of the various county mental health plans (MHPSs) to be in compliance with, and also required a quarterly submission of data in regards to available providers within the MHPs areas. The NACT application helped the providers submit information to Los Angeles County DMH and then the NACT submission was the resulting dataset in the format as required by the State.

For FY 2017-18, DMH was able to successfully submit as scheduled.

TECHNOLOGICAL NEEDS

CONSUMER/FAMILY ACCESS TO COMPUTING RESOURCES EXPANSION

Project Status: On Schedule **Project Start Date:** 07/01/2017 **Project End Date:** 06/30/2022

Replaces aged equipment and expands resource as an extension of the original Consumer/Family Access to Computing Resources project, having the objective of empowering consumers and their families to use IT systems at DMH and County Library locations to allow them to enhance personal skills and support wellness. The Expansion project includes additional sites including the DMH HQ-located PEER center (a clinic-support model to help consumers and fmaly members to use the computers to access their mental health records), deliver dedicated consumer/family workstations to additional sites, and continue DMH's successful collaboration with the County Library.

DIGITAL WORKPLACE: ENTERPRISE MOBILITY AND SECURITY

Project Status: Ahead of Schedule **Project Start Date:** 06/15/2017 **Project End Date:** 12/14/2017

Migration of County-issued mobile devices (primarily Apple iphone models) from the current mobile device management (MDM) solution, Research in Motion's BlackBerry Enterprise Server (BES), to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform will enable DMH to ensure compliance with federal regulations, i.e., HIPAA, regarding the protection of personal health information (PHI) by establishing and applying conditional access policies that define how applications and services can be accessed both on or off the County network. Enterprise mobility management (EMM) will provide the capability to manage assigned mobile devices and allow use of the only approved apps on the managed devices.

The project completed ahead of schedule on 12/14/2017 by migrating 1,294 devices to the cloud-based Microsoft Office365 EM+S device management module and platform.

IT ASSET MANAGEMENT MODERNIZATION

Project Status: On Schedule **Project Start Date:** 07/14/2017 **Project End Date:** 12/30/2019

This project will implement a cloud-based asset management solution, including a live database assets, bar code asset tag data capture and automated reporting, and a workflow solution integrated with existing Ivanti Service Manager and Service Management modules. Maintaining an accurate and current inventory of assets is required under the County Fiscal Manual (CFM).

PROVIDER DIRECTORY

Project Status: On Schedule **Project Start Date:** 02/28/2018 **Project End Date:** 03/31/2019

As a result of the Final Rule all Mental Health Plans (MHPs) must make available to beneficiaries the comprehensive Provider Directory in both electronic and print form (upon request). This is for both county-owned and operated, as well as contracted providers, groups, and individuals. The directory must include all licensed, waivered, or registered mental health providers.
In support of the Final Rule this project will create a DMH Provider Directory which will be public facing as well as internal. Data for the Provider will come from the Network Adequacy Certification Tool (NACT) application, a Microsoft Dynamics application built in response to the need of the data collection in order to comply with the Final Rule put forth by Medicaid and that of which the State and MHPs must be in compliance with.

DMH was able to submit to the State a version of the Provider Directory in its PDF version in compliance with the State requirements of the Final Rule on March 30, 2018.

CAPITAL FACILITIES

Olive View Medical Center:

The scope of the proposed Mental Health Wellness Center is proposed to be 10,000 square feet structure that will provide adult and family/older adult outpatient services geared toward the recovery model and includes treatment of co-occurring disorders, psychological and vocational assessment services, group and family therapy.

The completion date is April 2021.

Budget

Summary

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	382,266,105	231,667,951	141,798,256	0	3,496,669	160,725,402
2. Estimated New FY2019/20 Funding	448,933,000	112,241,000	29,543,000			
3. Transfer in FY2019/20[a/]	(30,475,786)			21,941,817	8,533,969	
4. Access Local Prudent Reserve in FY2019/20	35,117,516	9,124,344				(44,241,860)
5. Estimated Available Funding for FY2019/20	835,840,835	353,033,295	171,341,256	21,941,817	12,030,638	
B. Estimated FY2019/20 MHSA Expenditures	576,727,116	249,066,484	50,276,253	21,941,817	12,030,638	
C. Estimated FY2019/20 Unspent Fund Balance	259,113,719	103,966,811	121,065,003	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2019/20	0
3. Distributions from the Local Prudent Reserve in FY 2019/20	(44,241,860)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	116,483,542

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.

BUDGET

Community Services & Supports

	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
FSP Programs						
1. Full Service Partnerships	317,021,980	153,021,102	115,752,598		38,881,753	9,366,527
2. Recovery, Resilience & Reintegration	203,672,425	93,526,945	75,803,899		31,738,773	2,602,808
3. Alternative Crisis Services	69,060,351	43,248,699	22,043,390		1,185,324	2,582,938
4. Planning Outreach & Engagement	8,804,667	7,558,280	571,335		0	675,052
5. Linkage Services	14,059,282	13,840,260	150,172		12,767	56,083
6. Housing	40,089,862	40,089,862	0		0	0
Non-FSP Programs						
1. Recovery, Resilience & Reintegration	269,984,376	123,977,578	100,484,238		42,072,326	3,450,234
2. Alternative Crisis Services	63,748,017	39,921,876	20,347,745		1,094,146	2,384,250
3. Planning Outreach & Engagement	16,351,525	14,036,805	1,061,052		0	1,253,668
4. Linkage Services	6,025,407	5,931,540	64,360		5,471	24,036
5. Housing	818,160	818,160			0	
CSS Administration	41,834,742	40,756,009	0			1,078,733
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,051,470,794	576,727,116	336,278,789	0	114,990,560	23,474,329
FSP Programs as Percent of Total	65%					

Prevention & Early Intervention

	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						
1. Suicide Prevention	6,301,536	6,229,745	59,816	11,487		488
2. Stigma Discrimination Reduction Program	22,878,000	22,878,000				
3. Prevention	96,404,080	95,948,754	384,044	58,592		12,690
4. Early Intervention	292,788,488	109,214,804	110,833,426	72,034,394		705,864
5. Outreach	698,306	628,663	58,026	11,143	-	474
PEI Administration	14,166,518	14,166,518				
Total PEI Program Estimated Expenditures	433,236,928	249,066,484	111,335,312	72,115,616	0	719,516

BUDGET

Innovation

	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. Community Capacity Building	21,000,000	21,000,000				
2. Technology Suite	6,400,000	6,400,000				
3. Technology Suite 2.0	6,603,971	6,603,971				
4. Mobile Transcranial Magnetic Stimulation	724,028	724,028				
5. Peer Support Specialist Full Service Partnership	2,454,601	2,454,601				
6. Therapeutic Transportation	10,381,409	6,807,536	3,358,030			215,843
7. Early Psychosis Learning Health Care Network	963,740	963,740				
8. Ongoing Focused Support for Conservatees Living in the Community	4,269,447	3,176,500	1,053,446			39,501
9.	0					
INN Administration	2,145,877	2,145,877				
Total INN Program Estimated Expenditures	54,943,073	50,276,253	4,411,476	0	0	255,344

Workforce, Education and Training

	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	8,713,000	8,713,000				
2. Mental Health Career Pathway	2,507,534	2,507,534				
3. Financial Incentive	2,153,094	2,153,094				
4. Residency and Internship	7,155,542	7,155,542				
WET Administration	1,412,647	1,412,647				
Total WET Program Estimated Expenditures	21,941,817	21,941,817	0	0	0	0

Capital Facilities/Technological Needs

	Fiscal Year 2019-20					
	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. Olive View Medical Center proving Recovery, Resilience & Reintergration	6,000,000	6,000,000				
2.	0					
3.	0					
CFTN Programs - Technological Needs Projects						
4. Integrated Behavioral Health Information System (IBHIS)	1,377,288	1,377,288				
5. Consumer/Family Access to Computer Resources	363,000	363,000				
6. Data Warehouse Re-Design (Healthcare Enterprise Analytice)	800,000	800,000				
7. Telepsychiatry Implementation (Visual Care)	200,000	200,000				
8. DMH Resource Search/Performance Dashboards	1,000,000	1,000,000				
9. Hybrid Integration Platform	500,000	500,000				
10. Digital Workplace: Wifi at Clinics	1,279,258	1,279,258				
11. Asset Management Modernization (ITAM Implementation)	90,350	90,350				
CFTN Administration	420,742	420,742				
Total CFTN Program Estimated Expenditures	12,030,638	12,030,638	0	0	0	0

Prudent Reserve Calculation based on SB 192

Fiscal Year	Check Issue Date		State Allocation	CSS Allocation		% of Prudent Reserve	Reduction of Prudent Reserve IN 19-017	Balance of Prudent Reserve
FY 2012-13	7/15/2013		$ 41,743,946	$ 31,725,399				
FY 2013-14	08/15/13 thru 07/15/2014		353,022,452	268,297,064				
FY 2014-15	08/15/14 thru 07/15/2015		494,150,406	375,554,309				
FY 2015-16	08/15/15 thru 07/15/2016		405,033,272	307,825,287				
FY 2016-17	08/15/16 thru 07/15/2017		520,880,544	395,869,213				
FY 2017-18	08/15/17 thru 06/15/2018		507,409,047	385,630,876				
			2,322,239,667	1,764,902,147				
	Divide by 5			352,980,429				
	Prudent Reserve Amount - 33%			116,483,542	a			
	DMH Prudent Reserve	CSS		127,577,750		79.4%	(35,117,517)	92,460,233
		PEI		33,147,652		20.6%	(9,124,344)	24,023,308
	Total DMH Prudent Reserve			160,725,402	b	100.0%	(44,241,860)	116,483,542
	Overstated Prudent Reserve Amount			44,241,860	c=b-a		(44,241,860)	116,483,542

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Los Angeles

Fiscal Year: 2019-20

Local Mental Health Director

Name: Jonathan E. Sherin, M.D., Ph.D.

Telephone: (213) 738-4601

Email: jsherin@dmh.lacounty.gov

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Jonathan E. Sherin, M.D., Ph.D. — Local Mental Health Director (PRINT NAME)

Signature — 4/24/19 — Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

Appendix

SCHOOL BASED SERVICES

FOR

LATINA YOUTH PROGRAM (LYP)

Evaluation Report

CONTRACT YEAR 2017-2018

Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

INTRODUCTION

The purpose of this report is to summarize progress with regard to ongoing operations and outcome trends of Pacific Clinics' School Based Services for the Latina Youth Program (LYP), for the contract year 2017-2018 (FY 17 - 18). This report contains the results of ongoing literature review updates, which inform program objectives, goals and outcome measures; client demographic information; and documentation on program services and outcomes. Data for this evaluation was gathered through various sources. Current literature was reviewed. Information was also gathered from the U.S. Center for Disease Control (CDC) on youth suicidal self-directed violence and death by suicide in general and in Latina youth in particular. Client data has been gathered from computer generated reports used to monitor program activities. Program staff completed assessment questionnaires regarding risk factor incidence and intensity in program participants. The report is designed to give an overview of program participants, the mental health issues they deal with, suicide behavior, program performance, and outcomes.

SUMMARY

Suicidal Self-directed Violence (suicide) is the second-leading cause of death for children, teens and young people ages 5 to 24 years, according to the U.S. Center for Disease Control and Prevention (June, 2018). In California suicide rates in general have risen 14.8 percent from where they were in 1999. Mental illness is the leading risk factor for suicide. More than 90 percent of people who die by self-directed violence (suicide), suffer from depression and other mental disorders, often exacerbated by substance-abuse disorders. Females with a mental health condition are about twice as likely to commit suicide than their female counter parts without a known mental health condition. This same risk factor is not true for males (CDC, June 2018).

Implemented in 2001 as a demonstration project focusing on Latina adolescent suicide prevention, the Pacific Clinics Latina Youth Program (LYP) is now in its 18th year of services. During the 2017 - 2018 contract year (FY 17-18), the program provided services to 100 individuals, who ranged in age from four to thirty years. The greatest majority of clients were within the 13 to 19 years of age range. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latinix (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%). The program is designed to decrease physical barriers to services by going out into the community. Pacific Clinics has collaborative agreements to provide services in 35 schools and services are provided in 10 different cities. Program participants originate from 35 different cities throughout Los Angeles County.

In terms of length of services, client participation in the program ranged from 1 to 12 months, with an average of 4.7 months. The program provided a total of about 1,913 hours of services during this contract year. The average cost per client during contract

year was $3,713.78. The majority of program participants were diagnosed with some type of depressive disorder (56%). An additional 23% were assessed to be suffering from an anxiety related disorder and another 21% were diagnosed with other disorders such as those related to attention deficit and other behavioral problems.

A total of 13 risk factors were evaluated by program clinicians at intake and at either current or close of case for their incidence and level of intensity in program participants. These risk factors include: Substance Use/Abuse; Suicide Ideation; Suicide Attempt; Run Away Behavior; Communication Problems; Poor School Functioning; Difficulty Regulating Emotions; Legal/Juvenile Justice Involvement; Sexual Orientation-Gender Identity Distress; Bullying; Violence (home/community); Family High Distress; and, added most currently due to the political climate and its impact on children and families, Self or Family at Risk of Deportation. The risk factors with the highest incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. The Suicide Ideation risk factor had the most significant decrease in incidence.

With regard to intensity of experience of the risk factors, clinicians rated program participants' difficulty with the risk factors on a scale from 0-10, with 0 being "not a problem at all," to 10 being "extremely problematic." A 2-point decrease in how problematic the risk factors were for the participants was found on average. The greatest decrease in intensity was found in the risk factors Run Away Behavior and Suicidal Ideation. These results suggest that the programs' interventions are having the desired outcomes on the target population.

BACKGROUND

Suicidal Self-directed Violence (suicide) is the second-leading cause of death for children, teens and young people ages 5 to 24 years. It is surpassed only by accidents, primarily motor vehicle fatalities, according to the U.S. Center for Disease Control and Prevention (June, 2018). Suicidal ideation, suicide attempts and death by suicide are on the rise for those aged 10 to 19 years. One in five teenagers in the U.S. seriously considers suicide annually; 8 percent of adolescents attempt suicide, representing approximately 1 million individuals. Of these, nearly 300,000 receive medical attention for the attempt; and approximately 1,700 teenagers die by suicide each year. Additionally, suicide rates have continued to rise in every state of the U.S., and suicide is one of just three of the leading causes of death that are on the rise while the rate of other causes of death decreases in this age group. In California suicide rates in general have risen 14.8 percent from where they were in 1999. Over the past 15 years, suicide rates in the general population have risen by 30 percent. It is estimated that 69 billion dollars are spent annually due to deaths as a result of suicidal self-directed violence, in direct, medical and lost productivity costs.

Mental illness is the leading risk factor for suicide. More than 90 percent of people who die by self-directed violence (suicide), suffer from depression and other mental disorders, often exacerbated by substance-abuse disorders. Among younger children, suicide

attempts are often impulsive. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity. A number of external circumstances seem to overwhelm at-risk teens who are unable to cope with the challenges of adolescence. Examples of stressors are disciplinary and legal problems, interpersonal losses, family and community violence, sexual orientation confusion, physical and sexual abuse, run away behavior, and being the victim of bullying. Risk behaviors associated with suicide in children and young people are likely to occur in clusters e.g., various risk factors present in one individual at the same time, rather than any one risk factor on its own. Trends indicate that adolescent risk behavior may become increasingly problematic in the future, as the initiation of risky behaviors is occurring at progressively younger ages. Finally, other factors associated with increased risk for suicidality include poverty, lack of insurance coverage which affects access to preventative and early health and mental health care, and the experience of systemic oppression i.e., racism, sexism, homophobia, threat of deportation, etc.

LYP (Latina Youth Program)

A lengthy description of the program was provided in the 2016-2017 evaluation report. Here, a brief recount is given: Implemented in 2001 as a demonstration project focusing on Latina adolescent suicide prevention, the Pacific Clinics Latina Youth Program (LYP) is now in its 18th year of services. The 1999 COSSMHO report found that Latina youth were subject to the most serious risk and threat of pregnancy, substance abuse, depression, delinquency and high rates of dropping out of school. These are risk factors often associated with increased risk for suicidality. Not surprisingly the Los Angeles County suicide data at that time, reflected that 80% of suicides in the group of individuals between 10 and 17 years old, were committed by Hispanics. This represented a 33% increase from 1997. As stated above, the picture for death by self-directed violence (suicide) continues to be alarming. Rates of death by suicide, and by implication attempts are on a steady upward tick. Forty-five thousand people die as a result of suicide each year, that is equivalent to one life lost every 12 minutes. Further, approximately one million people attempted suicide in the past year, according to the CDC. Mental disorders continue to play a major role. The CDC reports that of those individuals who die by suicides: in individuals with known mental health conditions, 31% are female and 69% are male; of those individuals who do not have a known mental health condition, 16% are female and 84% are male. Thus, females with a mental health condition are about twice as likely to commit suicide as their female counter parts without a known mental health condition. This same risk factor is not true for males (CDC, June 2018).

Based on the long standing experience of Pacific Clinics and the research literature a school-based program was determined to have the greatest chance of reaching and connecting with those children and adolescents most in need of the program's services. Additionally, locating the program within the schools has allowed Pacific Clinics to impact families, the school staff and the greater community in a more effective way, with regard to enlisting their collaboration in addressing the needs of "at-risk" youth, with regard to suicide prevention. LYP is designed as a collaborative, school based, education, early

intervention, and intensive services program. Pacific Clinics has coordinated the collaboration of many diverse agencies in support of this program. These agencies include community-based organizations, service providers, schools, churches, and local, county, state and federal government representatives.

The primary goals of the Program continue to be: To promote 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; 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 early intervention and health promotion; and to enhance awareness and education among school staff and community members regarding substance abuse and depression.

A number of high risk symptoms and behaviors are tracked to measure their severity pre and post intervention. These are based on an ongoing review of literature on death caused by suicide in youth, and include: presence of substance use or abuse, suicidal ideation, past suicidal self directed violence (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. These were initially targeted for identification and treatment based on research findings which correlated them with high risk for suicidality. In subsequent years "issues related to sexual identity" was included as a factor in the list of issues representing high risk for suicidality. Most currently, the need to monitor program participants for suicidal behavior for one year post initiation of suicidal ideation, has been identified as an important component to be measured.

2017 – 2018 CONTRACT YEAR LYP PERFORMANCE

CLIENT DEMOGRAPHICS

During the 2017 - 2018 contract year, the program provided services to 100 individuals, who ranged in age from four to thirty years. The greatest majority of clients were within the 13 to 19 years of age range. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latinix (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%). The tables below summarize this information.

GENDER	
	Number
Male	50
Female	50
ETHNICITY- RACE	
	Number
American Indian	1
Black/African	
Latino/Hispanic/Latinx	77
Asian	2
White/Caucasian	5
Other Not Specified	15

AGE	
Age	Total
4	1
6	1
7	3
8	2
9	2
11	2
12	4
13	8
14	8
15	8
16	12
17	15
18	15
19	10
20	4
21	1
22	1
23	1
24	1
30	1
Total	100

SERVICES

Client participation in the program ranged from 1 to 12 months. On average, clients received services for 4.7 months, for an average of about 20 contacts. This represents an average of 1,248 minutes of contact time. The program provided a total of about 1,913 hours of services during this contract year. The average cost per client during this contract year was $3,713.78, compared to the average County cost for the same period of $3,171.79. This $541.99 difference may reflect the higher needs clients seen by a program that focusses on suicide-related prevention and treatment have, versus those clients seen by other types of prevention programs.

The majority of program participants were diagnosed with some type of depressive disorder (56%). An additional 23% were assessed to be suffering from an anxiety related disorder and another 21% were diagnosed with other disorders such as those related to attention deficit and other behavioral problems. The tables below list the diagnoses, the number of unduplicated clients within each diagnosis and the number of contacts received by those clients. On average clients with a depression related diagnosis received approximately 16 contacts, while those diagnosed with an anxiety related disorder received about 24 contacts, and clients under other categories of diagnoses received about 21 contacts. As stated above, overall participants in the LYP received on average 20 contacts. The client with Panic Disorder without Agoraphobia required the most services, followed by those with a diagnosis of Post Traumatic Stress Disorder and Attention-deficit Hyperactivity disorder, predominantly hyperactive type.

DEPRESSIVE DISORDERS		
DIAGNOSIS	N	CONTACTS
Dysthymic disorder	21	264
Major depressive disorder, single episode, moderate	9	95
Major depressive disorder, recurrent, moderate	8	142
Major depressive disorder, single episode, unspecified	5	95
Major depressive disorder, recurrent severe w/o psych features	5	77
Major depressive disorder, single episode, severe w/o psych features	4	81
Major depressive disorder, recurrent, mild	2	32
Major depressive disorder, recurrent, in partial remission	1	19
Major depressive disorder, single episode, mild	1	97
	56	X = 16

ANXIETY RELATED DISORDERS		
DIAGNOSIS	**N**	**CONTACTS**
Generalized anxiety disorder	12	284
Post-traumatic stress disorder, unspecified	3	100
Adjustment disorder with anxiety	2	45
Anxiety disorder, unspecified	2	10
Post-traumatic stress disorder, chronic	2	23
Panic disorder without agoraphobia	1	56
Post-traumatic stress disorder, acute	1	40
	23	X = 24

OTHERS		
DIAGNOSIS	**N**	**CONTACTS**
Oppositional defiant disorder	6	120
Attention-deficit hyperactivity disorder, combined type	4	99
Adjustment disorder w mixed disturbance of emotions and conduct	2	32
Adjustment disorder with mixed anxiety and depressed mood	2	32
Attention-deficit hyperactivity disorder, predominantly hyperactive type	2	82
Attention-deficit hyperactivity disorder, predominantly inattentive type	2	30
Unspecified mood [affective] disorder	2	35
Adjustment disorder, unspecified	1	10
	21	X = 21

LOCATIONS

The program is designed, among other things, to decrease physical barriers to services by going out into the community. Pacific Clinics has collaborative agreements to provide services in 35 schools. Of these, 14 are elementary, 12 are middle and 9 are senior high schools. The program provides services in 10 different cities. The tables below reflect the types of schools with which Pacific Clinics collaborates and the cities in which programs are located. Program participants originate from 35 different cities, throughout Los Angeles County.

SCHOOL TYPE	
Elementary Schools	14
Middle Schools	12
High Schools	9
TOTAL	35

LOCATINOS	
CITY	NUMBER OF PROGRAMS
El Monte	2
La Mirada	2
La Puente	2
Montebello	3
Monrovia	2
Norwalk	3
Pasadena	2
Pico Rivera	2
Santa Fe Springs	3
Whittier	14
TOTAL	35

RISK FACTORS

As stated previously, based on research literature and LYP experience working with children and adolescents dealing with suicidal self-directed violence (suicidality), a total of 13 risk factors were evaluated by program clinicians at intake (Time 1) and at Current or Close of Case (Time 2) for their presence in program participants. These measures were studied for 35 of the program participants. Unfortunately, of the 35 randomly selected cases, only 29 had complete and usable data. The remaining six, either had not been in treatment long enough (three months or more) or the data submitted was incomplete. With regard to specific risk factors, the tables below list incidence rate and intensity at which the factors were endorsed, as well as the difference between pre and post intervention.

RISK FACTORS: INCIDENCE			
NAME	INCIDENCE TIME 1	INCIDENCE TIME 2	CHANGE
Substance Use/Abuse	6	6	0
Suicide Ideation	11	3	-8
Suicide Attempt	1	0	-1
Run Away Behavior	1	0	-1
Communication Problem	26	23	-3
Poor school Functioning	22	19	-3
Difficulty Regulating Emotions	27	25	-2
Legal/Juvenile Justice Involvement	2	3	-1
Sexual Orientation-Gender Identity Distress	4	4	0
Bullying	9	6	-3
Violence (home/community)	6	3	-3
Family High Distress	24	20	-4
Self or Family at Risk of Deportation	4	2	-2
AVERAGE	11	8.8	2.2

RISK FACTORS: INTENSITY			
NAME	Average INTENSITY TIME 1	Average INTENSITY TIME2	CHANGE
Substance Use/Abuse	4.7	3.8	-0.9
Suicide Ideation	6.6	3	-3.6
Suicide Attempt	1	0	-1
Run Away Behavior	5	0	-5
Communication Problem	7.7	5.5	-2.2
Poor school Functioning	7.2	4.2	-3
Difficulty Regulating Emotions	7.6	5.0	-2.6
Legal/Juvenile Justice Involvement	5.5	4.7	-0.8
Sexual Orientation-Gender Identity Distress	5.5	6	+0.5
Bullying	7.4	4.7	-2.7
Violence (home/community)	6.2	6.3	+0.1
Family High Distress	7.0	5.0	-2
Self or Family at Risk of Deportation	6.5	3.5	-3
AVERAGE	6	4	2

Briefly, the range of incidence of risk factors was found to be anywhere from 1 to 27 in the 29 program participants studied. For example, Suicide Attempt and Run Away Behavior were the risk factors less likely to be identified as problematic. They were found to be present only in one each of the program participants at Time One, and were completely absent when measured at Time Two. The risk factors with the highest

incidence rates were Difficulty Regulating Emotions, Communication Problems, Family High Distress and Poor School Functioning. Their incidence at Time One was 27, 26, 24 and 22 respectively, and decreased to 25, 23, 20 and 19 at Time Two. On average, the incidence of any one risk factor was 11 at Time 1. Post intervention (Time 2) the range of incidence of any of the risk factors was 0 to 25 with an average of 9. This is a reduction in incidence of 2, suggesting that less program participants were experiencing difficulty with those factors whose incidence decreased. Most importantly the "Suicide Ideation" risk factor went from being endorse by 11 to only 3 participants from Time 1 to Time 2, this reflects 8 participants who no longer are experiencing suicidal thoughts.

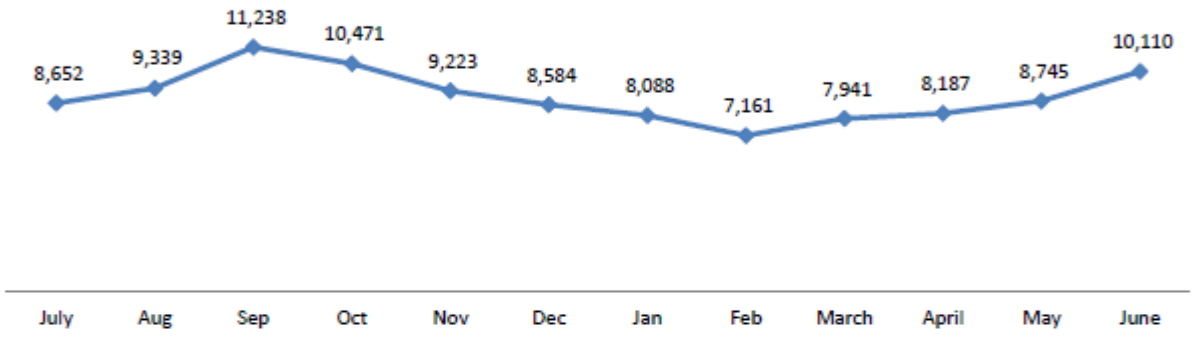
With regard to intensity of experience, clinicians rated program participants' difficulty with the risk factors on a scale from 0-10, with 0 being "not a problem at all," to 10 being "extremely problematic." In this regard, the intensity was on average a 6 at Time One and a 4 at Time Two, reflecting a 2-point decrease in how problematic the risk factors were for the participants. Two risk factors were found to increase in intensity. Sexual Orientation-Gender Identity Distress increased 0.5 and problems due to Bullying increased 0.1. These negligent increases may suggest a greater willingness for clients to identify problems with these issues as time in services progresses, or an increased awareness of these as issues present in and impacting their lives, as clients develop greater insight. Conversely, the intensity at which other risk factors were experienced as problematic decreased on average by 2 points. The greatest decrease in intensity was found in the risk factor Run Away behavior, with a 5 point reduction and Suicidal Ideation, with a 3.6 point decrease. As discussed earlier, risk factors occur in clusters. Program participants were found to have difficulty with anywhere from two to eleven risk factors at Time One and this range went down to 0 to 7 at Time 2. These results suggest that the programs' interventions are having the desired outcomes on the target population.

Pacific Clinics

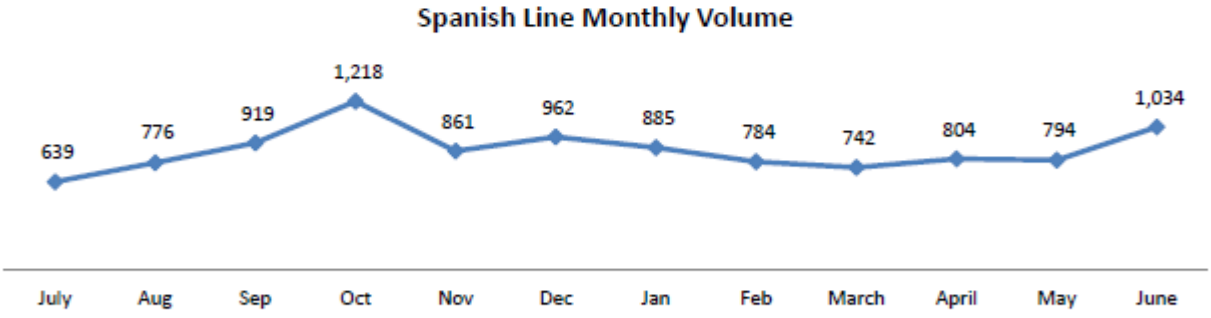
ADVANCING BEHAVIORAL HEALTHCARE

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

CALL ANALYSIS FOR FISCAL YEAR 2017-2018	
	Fiscal Year 17-18
TOTAL CALLS	99,574
TOTAL CHATS	8,079
TOTAL TEXTS	86
GRAND TOTALS	107,739



Total Calls by Language	
	Fiscal Year 17-18
Korean	24
Spanish	10,418
Vietnamese	6



Total Calls, Chats, and Texts for the Top Counties in California		
County	Fiscal Year 17-18	Percentage of State
Los Angeles	37,361	43%
Orange	11,608	13%
San Bernardino	5,675	7%
Riverside	5,029	6%
Santa Clara	2,829	3%
Ventura	2,190	3%

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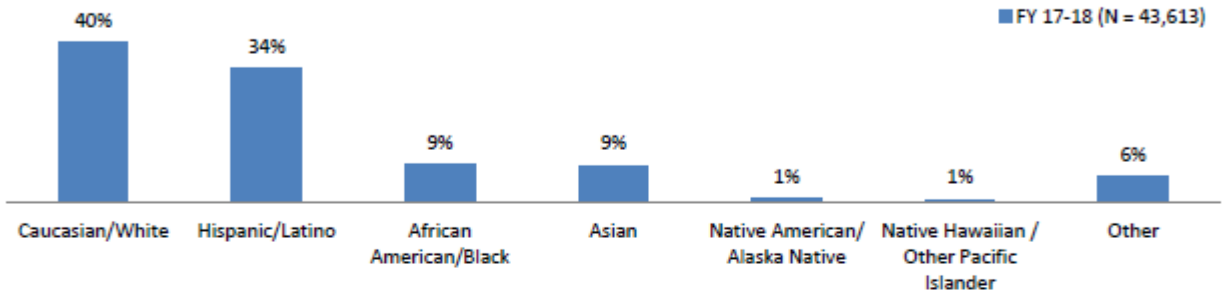
SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

Didi Hirsch MENTAL HEALTH SERVICES

2017-2018 DEMOGRAPHICS
Gender

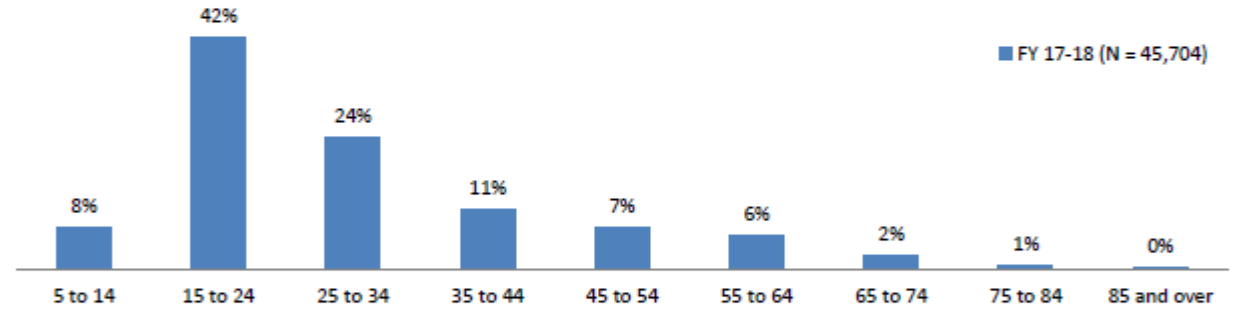
	Fiscal Year 17-18
Female	35,925
Male	30,150

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 17-18	Percentage
Suicidal Desire	27,828	48%
Relationship/ Family Issues	20,480	35%
Depression	18,531	32%
Past Suicidal Ideation/Attempt	16,357	28%
Anxiety/Stress	16,314	28%

*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.

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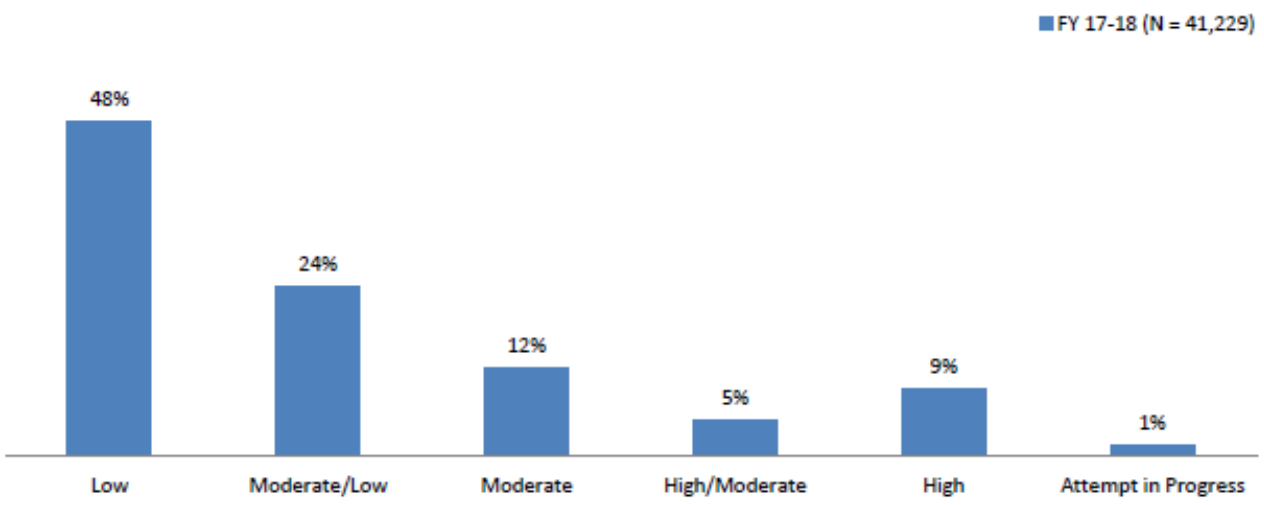
SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

SUICIDE RISK ASSESSMENT		
Rates of Suicide Risk Factors among Callers (callers may identify more than one)		
	Fiscal Year 17-18	**Percentage**
History of Psychiatric Diagnosis	14,836	30%
Prior Suicide Attempt	13,876	28%
Substance Abuse - Current or Prior	8,543	17%
Suicide Survivor	4,988	10%
Access to Gun	1,751	3%

**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.

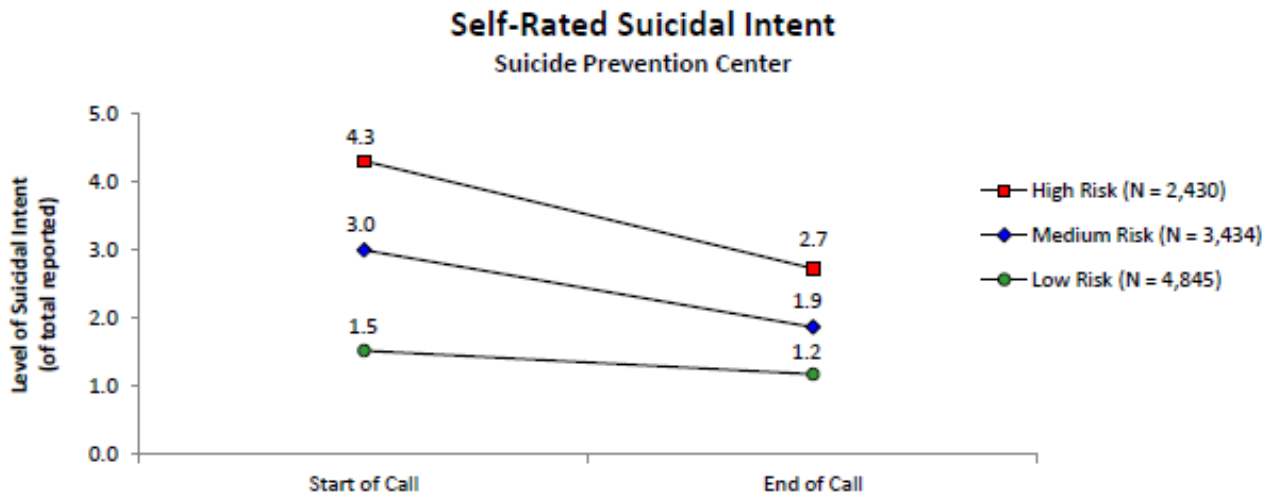
Risk assessment is based on the four core principles of suicide risk: Suicidal Desire, Suicidal Capability, Suicidal Intent, and Buffers/Connectedness (Joiner et al., 2007). A caller's risk level is determined by the combination of core principles present. Fore example, a caller who reports having only 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.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

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 17-18	Percentage
Third Party Rescue	2,057	49%
Self-Rescue	980	23%
SPC Initiated Rescue - Voluntary	214	5%
SPC Initiated Rescue - Involuntary	169	4%
Mandated Report	770	18%

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.

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

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	90	60	25	30
Standard	656	459	224	197
Extended	185	117	77	68
Grand Total	**931**	**636**	**326**	**295**

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. Figures do not include attendance at Info Tables

Individuals reached through these efforts:	
County	**Fiscal Year 17-18**
LA	5,606
Orange	2,607
Total	**8,213**

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
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**	2 - 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
	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) 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 Parent:** English, Spanish
	Seeking Safety (SS)	13+	Outcome Questionnaire - 45.2	19+	PTSD Checklist-5 (PCL-5)***	19+	**PCL-5:** Available in all threshold languages
	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*** PTSD Checklist-5 (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+	PTSD Checklist-5 (PCL-5)****	18+	Available in all threshold languages
	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
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 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 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
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**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **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**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **SESBI-R**: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7					
	Family Connections (FC)	0 - 18					
	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
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) Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)	2 - 16	**ECBI**: Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese **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			
	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

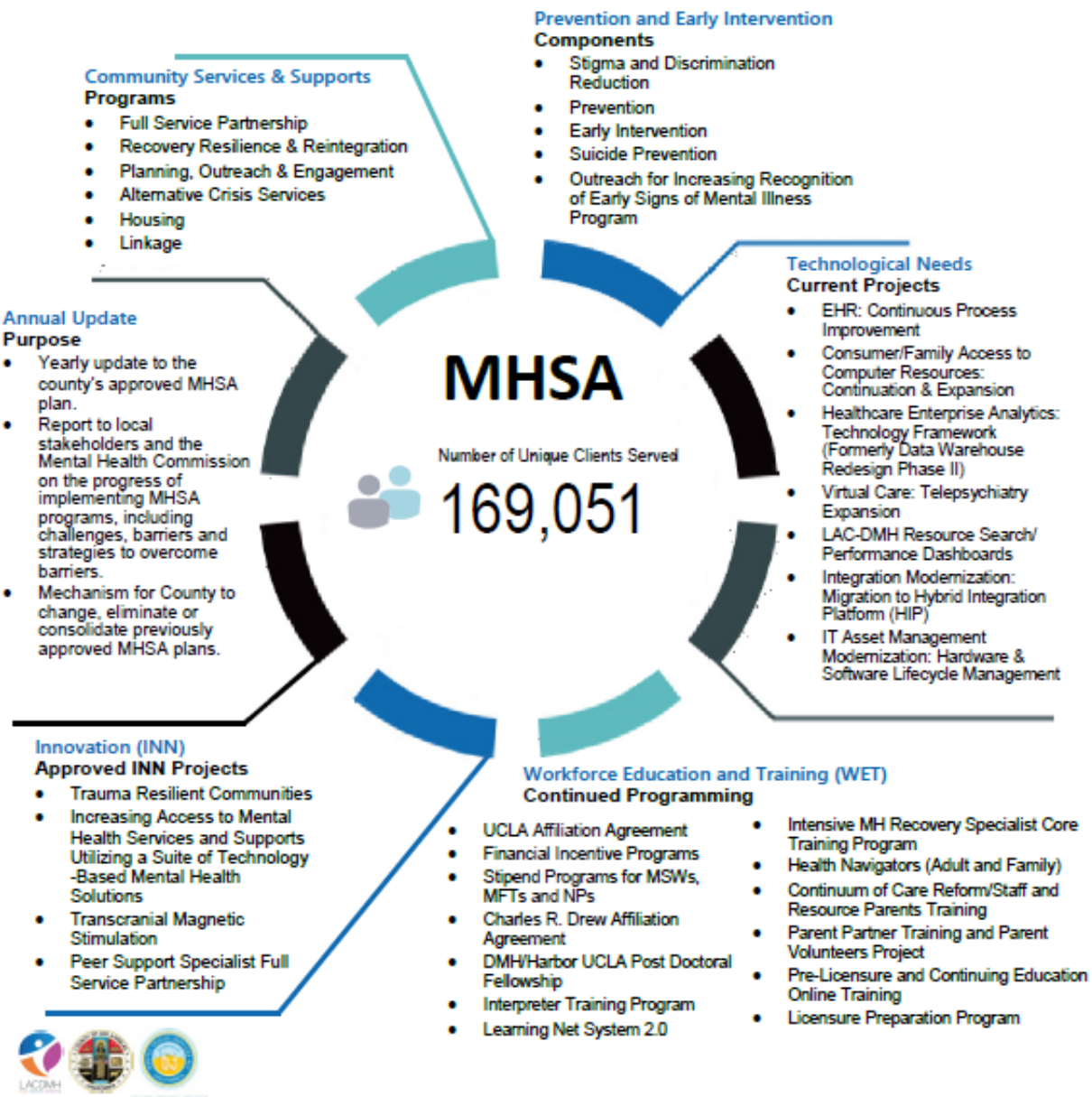
* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** For treatment cycles beginning before November 1, 2015 the DSM-IV UCLA PTSD-RI Child/Adolescent, Parent, and Adult Short Form will be required.
**** For treatment cycles beginning before October 1, 2017 the Posttraumatic Stress Diagnostic Scale (PDS) 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 are available in all threshold languages/scripts: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese, as well as Japanese.
2. Patient Health Questionnaire-9 (PHQ-9) and Posttraumatic Stress Disorder Checklist-5 (PCL-5) are available in all threshold languages/scripts: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH SERVICES ACT INFORMATION FISCAL YEAR 2019-2020

The County of Los Angeles is organized into eight (8) Service Areas (SAs), each with its own characteristics and diverse ethnic make-up. Services within the Los Angeles County - Department of Mental Health (LAC-DMH) are organized on a geographic basis to facilitate greater ease of access. However, clients are free to request services in any geographic area within the system, and may secure referrals to any mental health program, whether directly-operated or contracted with the Local Mental Health Plan (LMHP). The population of LA County is 10,192,376, 48.4% Latino, 28.3% White, 8.5% African American, 14.4% Asian, 0.2% Pacific Islander and 0.2% American Indian.

Mental Health Services Act (MHSA) refers to Proposition 63 which was passed in November 2004 and became state law on January 1, 2005. The Act is funded by a 1 percent tax on personal income above $1 million dollars to expand mental health services and programs serving all ages.



Service Area 1 - Antelope Valley

SA 1 is the largest service area geographically, yet it has the smallest population with approximately **396,357** inhabitants. Spanish is a prominent language. SA1 has a younger population than the other service areas, with a reported 31% of the population between the ages of 1-15.

0-18	19-20	21-25	26-59	60-64	65+
113,478	14,524	36,641	172,652	19,754	39,308
29%	4%	9%	44%	5%	10%

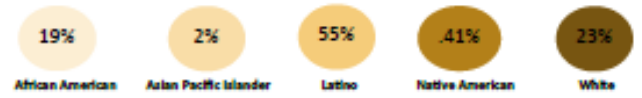
The highest % of Native Americans was in SA 1.

Female 50.3% (199,307)

Male 49.7% (197,050)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=112,355



Age Group N=115,014

0-18	19-20	21-25	26-59	60-64	65+
45,539	4,271	10,549	43,085	4,042	7,528
40%	4%	9%	38%	4%	7%

Female 51.6% (59,393)

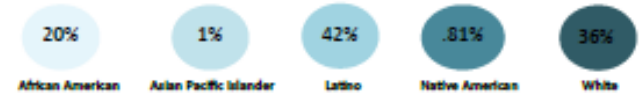
Male 48.4% (55,621)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
589	472	16	351	61,506	111	121	61	36,666	485	295
0.6%	0.5%	0.0%	0.3%	61.1%	0.1%	0.1%	0.1%	36.4%	0.5%	0.3%

Service Area 1 reported 2 threshold languages as their primary languages: English, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=28,609



Age Group N=23,594

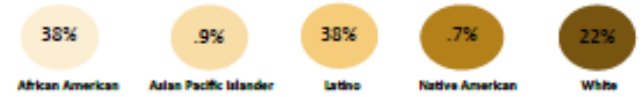
0-18	19-20	21-25	26-59	60-64	65+
10,712	600	1,852	8,767	790	873
45%	3%	8%	37%	3%	4%

Female 68.7% (18,143)

Male 31.3% (8,266)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=13,695



Age Group N=15,546

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
5,716	3,551	5,648	631
37%	23%	36%	4%

Female 48.5% (7,528)

Male 51.5% (7,998)

Primary Language of Consumers Served, N=10,977

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
3	0	1	9,936	5	1	9	0	0	1,015	5	2
0.02%	0.0%	0.01%	74.6%	0.04%	0.01%	0.07%	0.00%	0.0%	7.6%	0.04%	0.02%

Spanish is the non-English threshold language reported for consumers in outpatient programs by Service Area I.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

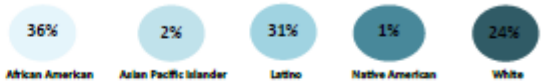
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

8,136

CHILD	TAY	ADULT	OLDER ADULT
1,570	1,341	4,678	729



English	Spanish	Other	Unknown/not reported
7,367 91%	638 8%	129 2%	2 .02%

Full Service Partnership

Number of Unique Clients Served

830

CHILD	TAY	ADULT	OLDER ADULT
324	121	272	129

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

7,461

CHILD	TAY	ADULT	OLDER ADULT
1,310	1,239	4,440	635

Service Area I FSP Capacity as of 10/1/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	160	116	73%
Transitional Age Youth	64	66	103%
Adult	486	232	48%
Older Adult	86	98	114%

Countywide FSP Capacity as of 10/1/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	462	60.4%
AOT	300	262	81.9%
IMHT	300	297	99%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

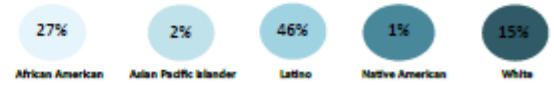
PEI

Number of Unique Clients Served

3,388

CHILD	TAY	ADULT	OLDER ADULT
2,629	437	341	18

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other
3,119 92%	220 6%	49 1%

Service Area 2 - San Fernando Valley

SA 2 is the most populous service area in Los Angeles County with a population of approximately 2,173,732. English and Spanish are the predominant languages. Although the number of children is within the county average, due to the overall population, there are more children in SA 2 than in any other service area.

African American	Asian Pacific Islander	Latino	Native American	White
4%	12%	40%	.18%	45%

0-18	19-20	21-25	26-59	60-64	65+
518,831 23%	62,652 3%	161,505 7%	1,071,750 48%	125,891 6%	288,192 13%

Female 50.5% (1,125,035)

Male 49.5% (1,103,786)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=488,022

African American	Asian Pacific Islander	Latino	Native American	White
4%	8%	59%	.16%	30%

Age Group N=497,831

0-18	19-20	21-25	26-59	60-64	65+
161,324 32%	14,448 3%	39,791 8%	218,836 44%	19,963 4%	43,469 9%

Female 50.7% (252,413)

Male 49.3% (245,418)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
5,158 1.2%	42,129 9.4%	252 0.1%	4,236 0.9%	136,133 30.5%	7,094 1.6%	5,740 1.3%	6,034 1.3%	230,798 51.6%	6,699 1.5%	2,748 0.6%

Service Area II reported 8 threshold languages as their primary languages: Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=128,540

African American	Asian Pacific Islander	Latino	Native American	White
3%	3%	40%	.41%	54%

Age Group N=96,207

0-18	19-20	21-25	26-59	60-64	65+
35,779 37%	2,074 2%	6,695 7%	39,754 41%	4,589 5%	7,315 8%

Female 68.7% (76,731)

Male 31.3% (34,980)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=30,078

African American	Asian Pacific Islander	Latino	Native American	White
12%	3%	54%	.4%	30%

Age Group N=35,601

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
11,455 32%	7,061 20%	14,382 40%	2,703 8%

Female 49.4% (17,595)

Male 50.6% (17,992)

Primary Language of Consumers Served, N=27,437

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
1,001 3.1%	19 0.1%	10 0.03%	20,370 63.9%	326 1.0%	60 0.19%	13 0.04%	16 0.05%	81 0.3%	5,408 17.0%	92 0.29%	41 0.1%

Armenian, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area II.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

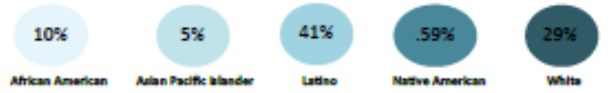
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

21,090

CHILD	TAY	ADULT	OLDER ADULT
3,664	3,675	11,522	2,765



English	Spanish	Farsi	Russian	Arabic	Other	Unknown/not reported
15,855 75%	3,153 15%	374 2%	90 .43%	67 .32%	1,544 7%	7 .03%

Full Service Partnership

Number of Unique Clients Served

1,882

CHILD	TAY	ADULT	OLDER ADULT
670	424	713	146

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

16,823

CHILD	TAY	ADULT	OLDER ADULT
3,066	2,663	9,042	2,500

Service Area II FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	430	370	86%
Transitional Age Youth	168	165	98%
Adult	1,115	515	46%
Older Adult	128	111	87%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

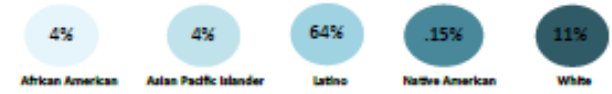
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

7,193

CHILD	TAY	ADULT	OLDER ADULT
5,317	1,418	461	130

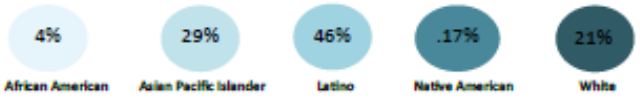


English	Spanish	Other	Farsi	Unknown/not reported
5,504 77%	1,386 19%	250 4%	51 .71%	2 .03%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

Service Area 3 - San Gabriel Valley

The total population in the San Gabriel Valley is approximately 1,777,760 with Latinos being the largest ethnic group in the area, followed by Asians.



0-18	19-20	21-25	26-59	60-64	65+
417,958 23%	56,940 3%	137,653 8%	823,464 46%	105,994 6%	257,195 14%

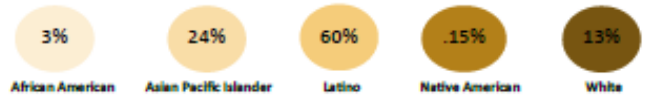
The highest % of 60-64 year olds was in SA 3.

Female 51.1% (920,188)

Male 48.9% (879,016)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=378,717



Age Group N=383,357

0-18	19-20	21-25	26-59	60-64	65+
125,484 33%	11,900 3%	31,049 8%	158,882 41%	16,470 4%	39,572 10%

Female 51.2% (196,266)

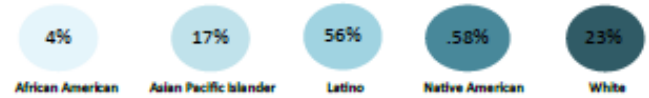
Male 48.8% (187,091)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
2,264 0.7%	1,935 0.6%	1,156 0.3%	26,632 7.8%	110,456 32.4%	634 0.2%	4,254 1.2%	274 0.1%	175,412 51.4%	4,015 1.2%	14,059 4.1%

Service Area III reported 4 threshold languages as their primary languages: English, Korean, Spanish, and Vietnamese.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=78,654



Age Group N=81,052

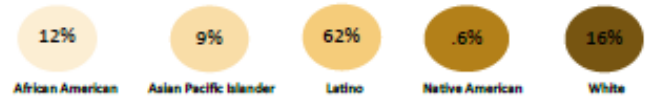
0-18	19-20	21-25	26-59	60-64	65+
31,256 39%	1,913 2%	5,872 7%	31,915 39%	3,786 5%	6,310 8%

Female 68.8% (64,834)

Male 31.2% (29,432)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=26,157



Age Group N=31,021

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
13,693 44%	5,663 18%	9,912 32%	1,753 6%

Female 48.4% (15,025)

Male 51.6% (15,992)

Primary Language of Consumers Served, N=22,158

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
65 0.2%	19 0.1%	413 0.20%	16,937 61.2%	5 0.02%	26 0.09%	290 1.10%	82 0.30%	2 0.01%	4,076 14.7%	30 0.11%	213 0.4%

Cantonese, Korean, Mandarin, Spanish, Other Chinese, Spanish, and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area III.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

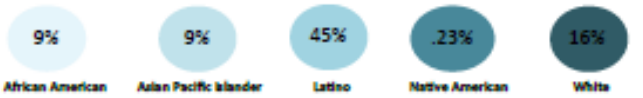
Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports
Number of Unique Clients Served

17,220

CHILD	TAY	ADULT	OLDER ADULT
5,522	3,212	7,380	1,506



English	Spanish	Other	Cantonese	Mandarin	Arabic	Unknown/not reported
13,024 76%	2,583 15%	926 5%	308 2%	300 2%	17 0.10%	62 .36%

Full Service Partnership
Number of Unique Clients Served

1,905

CHILD	TAY	ADULT	OLDER ADULT
565	383	727	307

Recovery, Resilience, and Reintegration
Number of Unique Clients Served

13,745

CHILD	TAY	ADULT	OLDER ADULT
4,852	2,450	5,675	1,085

Service Area III FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	378	343	91%
Transitional Age Youth	188	164	87%
Adult	875	483	55%
Older Adult	203	186	92%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

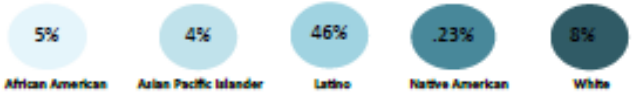
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI
Number of Unique Clients Served

7,447

CHILD	TAY	ADULT	OLDER ADULT
5,265	1,576	611	180

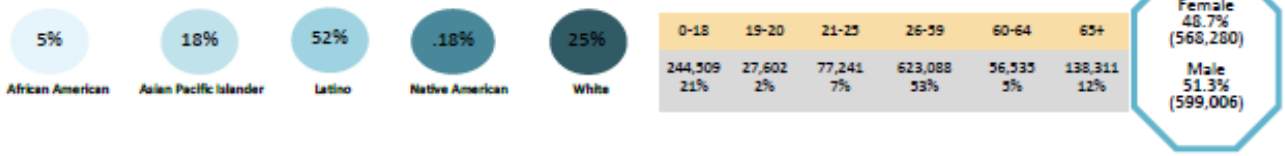
Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



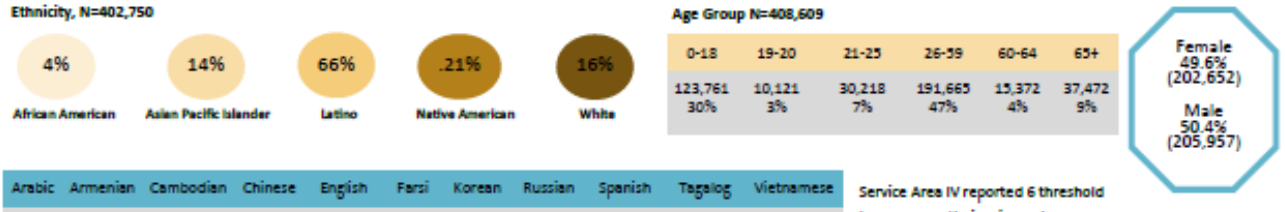
English	Spanish	Other	Cantonese	Mandarin
5,263 71%	1,872 25%	191 3%	65 .87%	56 .75%

Service Area 4 - Metro

Service Area 4 has a population of 1,140,742. It has the highest number of homeless persons within its boundaries. The Metro area has the second highest poverty rate in the county.



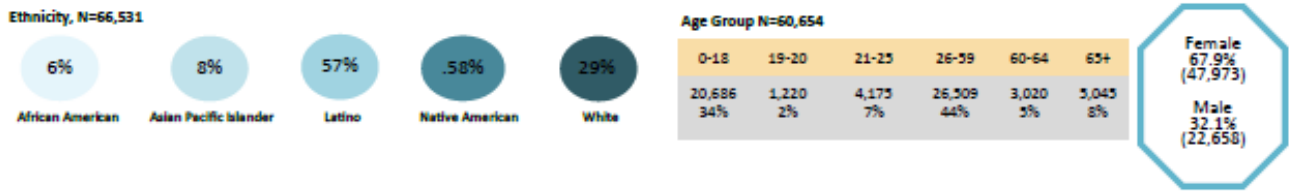
Estimated Population Living at or below 138% Federal Poverty Level



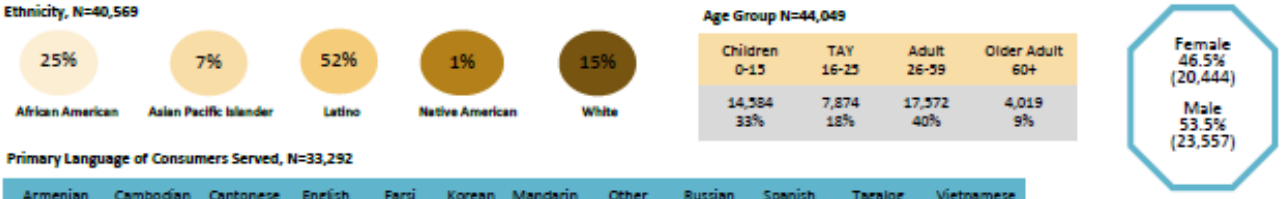
Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,256	6,278	854	7,947	87,546	1,248	23,751	4,836	230,863	5,612	2,208
0.3%	1.7%	0.2%	2.1%	23.3%	0.3%	6.4%	1.3%	62.0%	1.5%	0.6%

Service Area IV reported 6 threshold languages as their primary languages: Armenian, English, Korean, Russian, Spanish, and Tagalog.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group



Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs



Primary Language of Consumers Served, N=33,292

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
205	123	137	24,033	93	686	120	35	85	7,544	99	132
0.5%	0.3%	0.34%	60.1%	0.2%	1.71%	0.30%	0.09%	0.2%	18.9%	0.25%	0.3%

Armenian, Cantonese, Korean, Russian , Spanish, and Tagalog are the non-English threshold languages reported for consumers in outpatient programs by Service Area IV.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

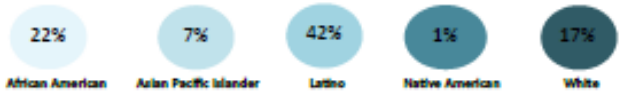
Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

29,965

CHILD	TAY	ADULT	OLDER ADULT
4,422	5,014	17,249	3,811



English	Spanish	Other	Cantonese	Mandarin	Russian	Unknown/not reported
23,222	4,303	2,117	97	75	88	63
78%	15%	7%	.32%	.25%	.29%	.21%

Full Service Partnership

Number of Unique Clients Served

2,407

CHILD	TAY	ADULT	OLDER ADULT
497	434	1,154	391

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

16,949

CHILD	TAY	ADULT	OLDER ADULT
3,522	2,040	9,002	2,807

Service Area IV FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	408	341	84%
Transitional Age Youth	229	192	84%
Adult	1,794	680	38%
Older Adult	148	167	112%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

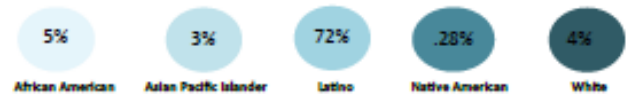
PEI

Number of Unique Clients Served

6,372

CHILD	TAY	ADULT	OLDER ADULT
4,285	1,431	630	133

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other	Farsi	Unknown/not reported
4,105	2,089	163	14	1
64%	33%	3%	.22%	.02%

Service Area 5 - West

SA 5 has a population of 646,531. It has the largest number of individuals reporting to speak English as their primary language. Approximately 18% of its population is older adults, compared to 13% countywide. Its median household income is $61,000 compared to $48,000 countywide.

African American	Asian Pacific Islander	Latino	Native American	White
6%	14%	16%	.15%	64%

0-18	19-20	21-25	26-59	60-64	65+
117,073 18%	22,635 3%	42,942 7%	337,341 51%	38,044 6%	102,046 16%

Female 51.5% (340,001)

Male 48.5% (320,080)

The highest percentage of Whites and 65+ year olds was is in SA 5.

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=103,437

African American	Asian Pacific Islander	Latino	Native American	White
7%	16%	23%	.13%	54%

Age Group N=107,126

0-18	19-20	21-25	26-59	60-64	65+
17,946 17%	3,879 4%	13,819 13%	55,936 52%	4,495 4%	11,051 10%

Female 51.7% (55,422)

Male 48.3% (51,704)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,423 1.6%	440 0.5%	107 0.1%	3,409 3.8%	56,116 62.0%	5,521 6.1%	1,743 1.9%	1,210 1.3%	19,382 21.4%	523 0.6%	706 0.8%

Service Area V reported 3 threshold languages as their primary languages: English, Farsi, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=19,348

African American	Asian Pacific Islander	Latino	Native American	White
8%	3%	21%	.78%	67%

Age Group N=13,423

0-18	19-20	21-25	26-59	60-64	65+
3,692 28%	226 2%	870 7%	6,683 50%	737 6%	1,216 9%

The highest prevalence of SED and SMI among Males and the Medi-Cal enrolled population was in SA 5.

Female 67.4% (10,624)

Male 32.6% (5,129)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=8,715

African American	Asian Pacific Islander	Latino	Native American	White
27%	3%	30%	.6%	39%

Age Group N=10,152

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
2,316 23%	1,423 14%	5,200 51%	1,213 12%

Female 49.4% (5,014)

Male 50.6% (5,134)

Primary Language of Consumers Served, N=7,706

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
5 0.1%	0 0.0%	2 0.02%	6,921 76.3%	64 0.7%	7 0.08%	4 0.78%	2 0.02%	14 0.2%	682 7.5%	5 0.06%	0 0.00%

Farsi, and Spanish are the non-English threshold languages reported for consumers in outpatient programs by Service Area V.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

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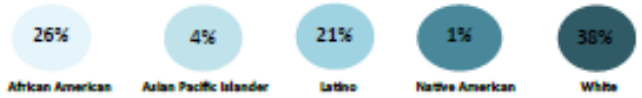
Community Services & Supports

Number of Unique Clients Served

8,919

CHILD	TAY	ADULT	OLDER ADULT
641	1,259	5,877	1,292



English	Spanish	Other	Farsi	Russian	Arabic	Unknown/not reported
7,897 89%	554 6%	309 3%	102 1%	32 .36%	9 .10%	16 .18%

Full Service Partnership

Number of Unique Clients Served

797

CHILD	TAY	ADULT	OLDER ADULT
80	133	515	93

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

5,413

CHILD	TAY	ADULT	OLDER ADULT
539	586	3,341	1,067

Service Area V FSP Capacity as of 11/14/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	62	46	74%
Transitional Age Youth	73	66	90%
Adult	723	396	55%
Older Adult	29	32	110%

Countywide FSP Capacity as of 11/14/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	468	61%
AOT	300	258	86%
IMHT	300	286	95%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

Prevention and Early Intervention

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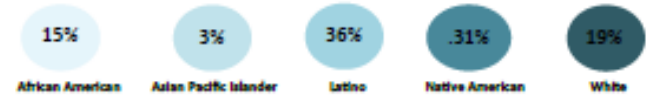
PEI

Number of Unique Clients Served

1,628

CHILD	TAY	ADULT	OLDER ADULT
891	287	351	119

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.



English	Spanish	Other	Farsi	Russian
1,332 82%	196 12%	71 4%	21 1%	8 .49%

Service Area 6 - South

The population is approximately 1,030,078; however, 48% of its population is 25 years of age or less. It has the highest poverty rate in the county – 61% of its population lives below the 200% federal poverty level (FPL). Two ethnic groups account for 94% of the population--African American and Hispanic.

0-18	19-20	21-25	26-59	60-64	65+
321,073 31%	40,721 4%	96,899 9%	460,516 44%	41,781 4%	87,744 8%

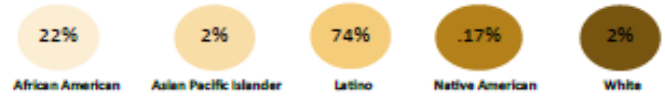
The highest percentage of African Americans, Females, 0-18, and 19-20 year olds were in SA 6.

Female 51.2% (537,259)

Male 48.8% (511,475)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=510,298



Age Group N=515,778

0-18	19-20	21-25	26-59	60-64	65+
216,622 42%	18,032 4%	46,794 9%	192,637 37%	15,344 3%	26,349 5%

Female 51.3% (264,375)

Male 48.7% (251,403)

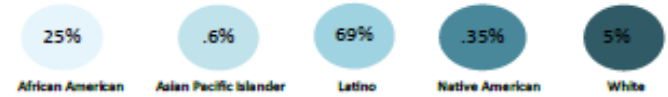
Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
509 0.1%	99 0.02%	207 0.04%	2,487 0.5%	126,532 26.3%	318 0.1%	1,960 0.4%	78 0.02%	348,008 72.4%	303 0.1%	307 0.1%

Service Area 6 reported 2 threshold languages as their primary languages: English, and Spanish.

The highest % of 0-18 year olds estimated to be living at or below the 138% FPL was in SA 6.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=79,833



Age Group N=81,445

0-18	19-20	21-25	26-59	60-64	65+
36,548 45%	1,949 2%	6,188 8%	30,437 37%	2,920 4%	3,403 4%

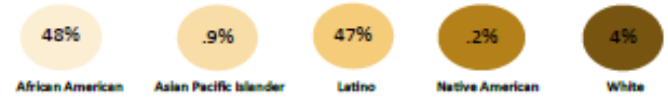
The highest prevalence of SED and SMI among the African American ethnic group was in SA 6.

Female 69.1% (63,443)

Male 30.9% (28,309)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=32,754



Age Group N=35,815

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
13,434 38%	5,184 15%	14,970 42%	2,227 6%

Female 50.5% (18,084)

Male 49.5% (17,719)

Primary Language of Consumers Served, N=28,600

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
1 0.00%	2 0.01%	11 0.03%	22,224 69.4%	6 0.02%	37 0.12%	16 0.05%	3 0.01%	3 0.01%	6,280 19.6%	7 0.02%	10 0.03%

Spanish is the non-English threshold languages reported for consumers in outpatient programs by Service Area VI.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

22,617

CHILD	TAY	ADULT	OLDER ADULT
5,416	3,563	11,940	2,212

English	Spanish	Other	Russian	Arabic	Mandarin	Unknown/not reported
17,931	3,903	688	5	5	9	76
79%	17%	3%	.02%	.02%	.04%	.34%

Full Service Partnership

Number of Unique Clients Served

2,312

CHILD	TAY	ADULT	OLDER ADULT
985	423	891	90

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

18,282

CHILD	TAY	ADULT	OLDER ADULT
4,283	2,660	9,720	2,042

Service Area VI FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	594	534	90%
Transitional Age Youth	268	205	77%
Adult	1,298	773	60%
Older Adult	43	39	90%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

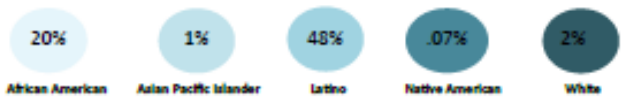
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

5,496

CHILD	TAY	ADULT	OLDER ADULT
3,940	956	579	108

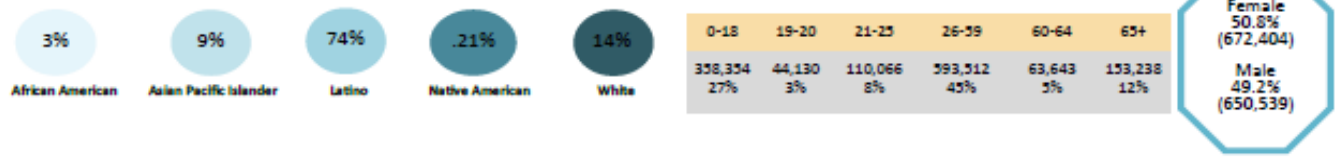


English	Spanish	Other	Unknown/not reported
3,910	1,339	246	1

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

Service Area 7 - East

The population within the boundaries of SA 7 is approximately 1,309,383. It also has a young population with 43% under the age of 26. It is reported that 70% of the population is Latino with Spanish being spoken in 54% of the households.



0-18	19-20	21-25	26-59	60-64	65+
358,354 27%	44,130 3%	110,066 8%	593,512 45%	63,643 5%	153,238 12%

Female 50.8% (672,404)

Male 49.2% (650,539)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=354,931

Age Group N=357,167

0-18	19-20	21-25	26-59	60-64	65+
141,912 40%	11,302 3%	28,478 8%	136,683 38%	12,242 3%	26,550 7%

Female 51.0% (182,148)

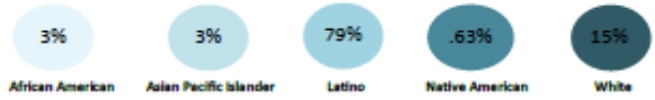
Male 49.0% (175,019)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,521 0.4%	767 0.2%	536 0.2%	2,429 0.7%	68,517 20.2%	141 0.04%	3,470 1.0%	147 0.04%	258,174 76.3%	1,991 0.6%	872 0.3%

Service Area VII reported 3 threshold languages as their primary languages: English, Korean, and Spanish.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=68,802



Age Group N=68,150

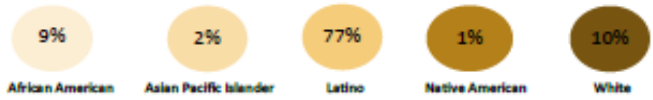
0-18	19-20	21-25	26-59	60-64	65+
29,899 44%	1,666 2%	5,148 8%	24,822 36%	2,640 4%	3,976 6%

Female 69.5% (54,248)

Male 30.5% (23,805)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=23,574



Age Group N=26,848

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
11,537 43%	5,811 22%	8,093 30%	1,407 5%

Female 48.8% (13,091)

Male 51.2% (13,750)

Primary Language of Consumers Served, N=19,557

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
9 0.04%	41 0.2%	8 0.03%	14,219 59.3%	2 0.01%	50 0.21%	38 0.16%	3 0.01%	1 0.0%	5,151 21.5%	29 0.12%	6 1.0%

Korean and Spanish are the non-English threshold language reported for consumers in outpatient programs by Service Area VII.

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

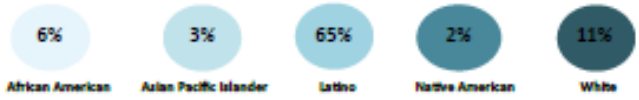
Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports
Number of Unique Clients Served

11,421

CHILD	TAY	ADULT	OLDER ADULT
3,344	2,009	5,340	1,065



English	Spanish	Other	Arabic	Mandarin	Unknown/not reported
8,410 74%	2,809 25%	176 2%	10 .09%	12 .11%	4 .04%

Full Service Partnership
Number of Unique Clients Served

1,646

CHILD	TAY	ADULT	OLDER ADULT
567	310	613	212

Recovery, Resilience, and Reintegration
Number of Unique Clients Served

9,823

CHILD	TAY	ADULT	OLDER ADULT
2,846	1,705	4,694	857

Service Area VII FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	363	308	85%
Transitional Age Youth	173	143	83%
Adult	920	520	57%
Older Adult	99	120	121%

Countywide FSP Capacity as of 10/01/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	452	59%
AOT	300	261	87%
IMHT	300	295	98%

Clients can be seen in more than one age group in a year. Child slots include Wraparound Child and Wraparound TAY. Adult slots include Forensics and Homeless.

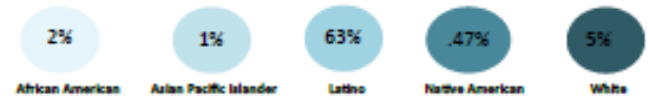
Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI
Number of Unique Clients Served

6,178

CHILD	TAY	ADULT	OLDER ADULT
4,039	1,289	799	178

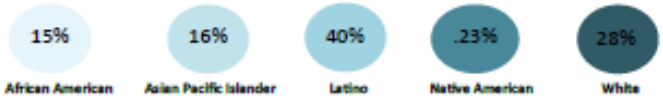


English	Spanish	Other
4,383 71%	1,709 28%	86 1%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

Service Area 8 - South Bay

The population of SA 8 is 1,550,198. It has a household income slightly higher than the county average, and the number of individuals who graduate from college is slightly higher than the county average.



0-18	19-20	21-25	26-59	60-64	65+
386,870 25%	45,372 3%	114,285 7%	737,620 47%	84,153 5%	200,650 13%

Female 51.1% (800,958)

Male 48.9% (767,992)

Estimated Population Living at or below 138% Federal Poverty Level

Ethnicity, N=396,580

Age Group N=404,580

0-18	19-20	21-25	26-59	60-64	65+
147,403 36%	12,783 3%	33,240 8%	167,525 41%	14,667 4%	28,962 7%

Female 48.6% (196,430)

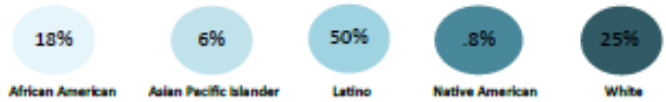
Male 51.4% (208,150)

Arabic	Armenian	Cambodian	Chinese	English	Farsi	Korean	Russian	Spanish	Tagalog	Vietnamese
1,952 0.5%	278 0.1%	6,009 2%	3,294 0.9%	145,789 40%	689 0.2%	4005 1%	404 0.1%	193,921 53%	4,160 1%	2,903 0.8%

Service Area VIII reported 5 threshold languages as their primary languages: Cambodian, English, Korean, Spanish and Vietnamese.

Estimated Prevalence of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) Among Medi-Cal Enrolled Population by Ethnicity & Age Group

Ethnicity, N=69,559



Age Group N=67,708

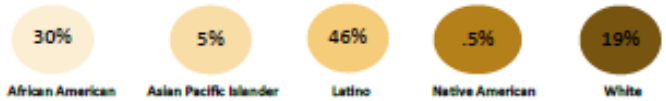
0-18	19-20	21-25	26-59	60-64	65+
27,555 41%	1,551 2%	5,079 8%	26,851 40%	2,882 4%	3,790 6%

Female 69.1% (53,481)

Male 30.9% (23,934)

Consumers Served in Los Angeles County Department of Mental Health Outpatient Programs

Ethnicity, N=32,288



Age Group N=37,767

Children 0-15	TAY 16-25	Adult 26-59	Older Adult 60+
12,734 34%	5,555 15%	16,588 44%	2,890 8%

Female 49.2% (18,561)

Male 50.8% (19,187)

Primary Language of Consumers Served, N=27,764

Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese
7 0.02%	691 0.02%	7 .01%	21,267 75%	6 .04%	94 .01%	26 .08%	15 .05%	1 .00%	5,385 16.2%	89 .27%	176 .5%

Spanish, Cambodian, Korean and Vietnamese are the non-English threshold language reported for consumers in outpatient programs by Service Area VIII

Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2016 as reported in the Quality Improvement Work Plan Evaluation Report Calendar Year 2016 and Quality Improvement Work Plan Calendar year 2017

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. CSS serves clients and their families who have the most severe and persistent mental illnesses or serious emotional disturbances, including those who are at risk of homelessness, jail, or being put or kept in other institutions because of their mental illness, focused on serving the unserved and underserved. The plan provides help to ethnic and racial communities who have difficulty getting the help they need for themselves or their families when they have serious mental health issues.

Community Services & Supports

Number of Unique Clients Served

22,478

CHILD	TAY	ADULT	OLDER ADULT
4,245	3,218	12,670	2,866

English	Spanish	Other	Tagalog	Arabic	Mandarin	Unknown/not reported
18,014 80%	2,748 12%	1,606 7%	65 .29%	18 .08%	14 0.07%	13 0.06%

Full Service Partnership

Number of Unique Clients Served

2,567

CHILD	TAY	ADULT	OLDER ADULT
611	507	1,249	285

Recovery, Resilience, and Reintegration

Number of Unique Clients Served

18,049

CHILD	TAY	ADULT	OLDER ADULT
3,659	2,361	10,018	2,442

Service Area VIII FSP Capacity as of 9/17/2018

FSP Program	# of Slots	Auth Slots	% Target Met
Child	160	116	72.5%
Transitional Age Youth	64	66	103.1%
Adult	486	230	47%
Older Adult	86	98	114.0%

Countywide FSP Capacity as of 9/17/2018

FSP Program	# of Slots	Auth Slots	% Target Met
IFCCS	765	462	60.4%
AOT	300	262	81.9%
IMHT	300	297	99%

Clients can be seen in more than one age group in a year.

Prevention and Early Intervention

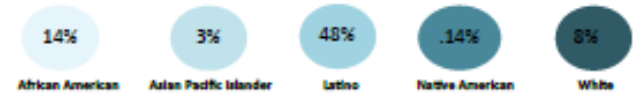
The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

PEI

Number of Unique Clients Served

7,283

CHILD	TAY	ADULT	OLDER ADULT
5,052	1,195	965	201



English	Spanish	Other	Arabic	Unknown/not reported
5,096 70%	2,013 28%	166 2%	5 .07%	3 .04%

Data Source: Direct service claiming as of 10/1/2018 for Fiscal Year 2017-18.

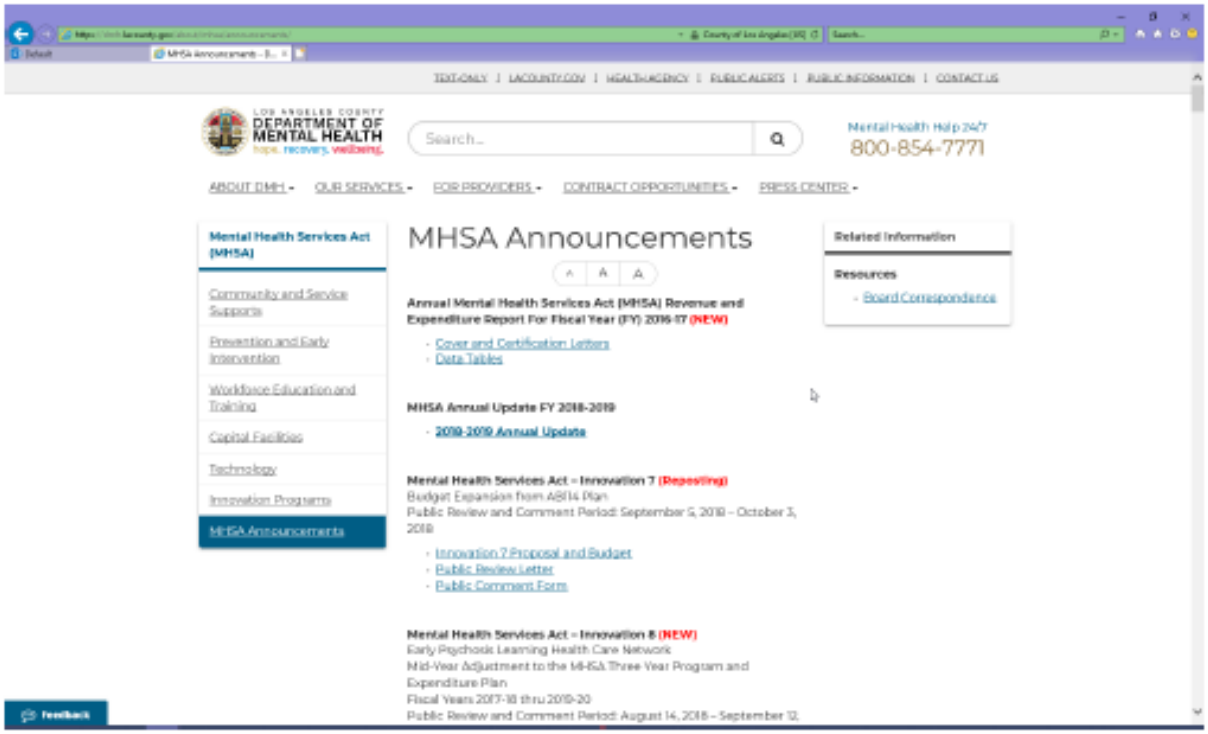
COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
PROGRAM DEVELOPMENT & OUTCOMES DIVISION

QUESTIONS TO GUIDE DISCUSSION

- What are your unmet needs of the Service Area?
- How do you propose we address the unmet needs?
- How do we improve transitions between levels of care to ensure successful flow?

MHSA ANNUAL UPDATES

Electronic copies of the MHSA Annual Updates and the MHSA Three Year Program and Expenditure Plans are located at the following web address: https://dmh.lacounty.gov/about/mhsa/announcements/



CONTACT INFORMATION

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name:	Network Adequacy Certification Tool (NACT) State Submission	**DMH Project ID #:**	1803976484
Project Status:	☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Project Start Date:**	02/28/18
		Project End Date:	03/31/19
Project Contact:	Martin Corral		
E-mail Address:	mcorral@dmh.lacounty.gov	**Phone Number:**	(213) 251-6502

Project Objectives

The objective of this project is to create an automated process to extract data from the Network Adequacy Certification Tool (NACT) application and Integrated Behavioral Health Information System (IBHIS) to create submission files to be uploaded to the State of California Client & Service Information (CSI) website. This project will ensure LACDMH compliance with State Department of Health Care Services (DHCS) requirements for Mental Health Service plans network adequacy and certification requirements. The NACT application and NACT State Submission were created and developed due to the requirements of the Final Rule from Medicaid and in order to ensure that the State of California is in compliance with network adequacy standards as required by Medicaid. As a result, the State published new requirements of the various county mental health plans (MHPs) to be in compliance with, and also required a quarterly submission of data in regards to available providers within the MHPs areas. The NACT application helped the providers submit information to Los Angeles County DMH and then the NACT submission was the resulting dataset in the format as required by the State.

Project Name:	Network Adequacy Certification Tool (NACT) State Submission	**DMH Project ID #:**	1803976484

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

Project is currently on schedule. For FY 17-18, DMH was able to successfully submit on time. The State submission included the spreadsheet with all the data pulled from the NACT application, as well as; time-distance analysis, Heat maps of our providers and client density for psychiatry and outpatient services for youth and adult, and an accessibility chart. Data was also pulled from DMH Financial records to help with the analysis in conjunction with the provider data from the NACT.

Submissions are required every quarter, except for June 2018, whereas the State stated that there was no need as they were still reviewing data from the initial submission by all of the counties.

This project working in conjunction with the NACT application development, Version 2.0. That will require changes to the front-end design and as well as the back-end tables structure.

Major Accomplishments

Data was exported from the NACT application, a Microsoft Dynamics application, and then uploaded into Microsoft SQL tables so that queries could be written to create final data tables in the same structure as the required Excel spreadsheets for the State. Submission to State was accomplished on March 30, 2018.

In conjunction with data pulled from the NACT application and the financial records, DMH was also able to submit Heat density maps of providers and clients, perform time-distance analysis with a very short lead time from the State. Required to work with multiple divisions to have the NACT application created and then to extract and analyze the data submitted by the State.

Future developments to have more automated processes through SQL Server Integration Services (SSIS) packages. Version 2.0 of the NACT application will require updates to SSIS packages. Also, future submissions to State will not be in Excel format, instead an Electronic Date Interchange (EDI) process will be used, this will also require some changes to automated processes.

Prepared By:

Signature _____ **Date:** 1/9/19 **Phone:** 213-251-6502

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name:	Access Call Center Recording System Upgrade	**DMH Project ID #:**	
Project Status:	☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Project Start Date:**	03/14/18
		Project End Date:	06/28/19
Project Contact:	Kiran Gidwani		
E-mail Address:	kgidwani@dmh.lacounty.gov	**Phone Number:**	(213) 251-6617

Project Objectives

The Project objective is to replace aging on-premises video screen capture and audio call recording system with Cloud based call center recording system to capture calls from any location.

Project Name:	Access Call Center Recording System Upgrade	**DMH Project ID #:**	

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

During FY 17-18, the project was in Planning Phase and the following activities were performed:
- Initial assessment of project scope and requirements
- Identify key risks and issue
- Identify core team members
- Identify potential solution vendors

Major Accomplishments

Identification of critical issue - Update Business Associate Agreement in order to comply with new HIPPA regulations and to protect LA County from liability in the event of a data breach.

Prepared By:

Signature _____ **Date:** _____ **Phone:** _____

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Constituent Call Log-Consumer and Family Advocacy **DMH Project ID #:**

Project Status: ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 12/20/17

Project End Date: 06/15/18

Project Contact: David Anderson

E-mail Address: danderson@dmh.lacounty.gov **Phone Number:** (213) 251-6524

Project Objectives

The Office of Consumer Affairs logs complaints/issues from Constituents and resolves those concerns as a form of advocacy for LA County DMH in all Service Areas. The BOS also submits issues/complaints and requests status updates. This project will develop a solution using Microsoft Dynamics that will allow multiple staff members and interns to simultaneously enter complaint/issue information real-time, track status of complaints, track trends/call patterns, and report information. The solution will also provide a running history of transactions with constituents and accommodate the growing number of calls.

Project Name: Constituent Call Log-Consumer and Family Advocacy **DMH Project ID #:**

Project Phase

*Implementation Status. If project is behind schedule, please describe the delay(s) and corrective actions taken

Project was implemented into production 04/30/2018 for the Office of Consumer Affairs. Approximately 17 users regularly use the application.

Major Accomplishments

The Microsoft CRM application was coded, tested and moved to production on 04/30/2018. Proper security roles were established to support the application. The proper licenses were provided. A very intuitive user manual was created for user reference.

Prepared By:

Signature _____ **Date:** _____ **Phone:** _____

Approval Signature _____ **Date:** _____ **Phone:** _____

Mirian Avalos, Chief Information Officer

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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Chief Information Office

MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Consumer / Family Access to Computing Resources Expansion **DMH Project ID #:** 1489099727

Project Status: ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 07/01/17

Project End Date: 06/30/22

Project Contact: Dean Whitehead

E-mail Address: dwhitehead@dmh.lacounty.gov **Phone Number:** (213) 480-3662

Project Objectives

Replaces aged equipment and expands resource as an extension of the original Consumer / Family Access to Computing Resources project, having the objective of empowering consumers and their families to use IT systems at DMH and County Library locations to allow them to enhance personal skills and support wellness. The Expansion project includes additional sites including the DMH HQ-located PEER center (a clinic-support model to help consumers and family members to use the computers to access their mental health records), deliver dedicated consumer/family workstations to additional sites, and continue DMH's successful collaboration with the County Library.

Project Name: Consumer / Family Access to Computing Resources Expansion **DMH Project ID #:** 1489099727

Project Phase

*Implementation Status. If project is behind schedule, please describe the delay(s) and corrective actions taken

Implementation Phase include Current activities: Refresh by LAC Library IT Staff
Next steps include: Continued reporting.

Major Accomplishments

Require new IT assets procured, tagged, delivered to and received by LAC Library staff. PRC location provisioned and active. Physical refresh at existing sites/facilities has been underway since August 2018.

Prepared By:

Signature _____ **Date:** 01/08/19 **Phone:** (213) 480-3662

Approval Signature _____ **Date:** _____ **Phone:** _____

Mirian Avalos, Chief Information Officer

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Digital Workplace: Enterprise Mobility and Security **DMH Project ID #:** 1384427693

Project Status: ☐ Not Started ☐ On Schedule ☒ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 06/15/17
Project End Date: 12/14/17

Project Contact: Dean Whitehead
E-mail Address: dwhitehead@dmh.lacounty.gov **Phone Number:** (213) 480-3662

Project Objectives

Migration of County-issued mobile devices (primarily Apple iPhone models) from the current mobile device management (MDM) solution, Research in Motion's BlackBerry Enterprise Server (BES), to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform will enable DMH to ensure compliance with federal regulations, i.e., HIPAA, regarding the protection of personal health information (PHI) by establishing and applying conditional access policies that define how applications and services can be accessed both on or off the County network. Enterprise mobility management (EMM) will provide the capability to manage assigned mobile devices and allow use of only approved apps on the managed devices.

Project Name: Digital Workplace: Enterprise Mobility and Security **DMH Project ID #:** 1384427693

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

The Project is completed ahead of schedule on 12/14/2017 by migrating 1,294 devices to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform. Enterprise mobility management (EMM) provides the capability to manage assigned mobile devices in protecting Personal Health Information and allow use of only approved applications on the managed devices.

Major Accomplishments

Worked with County Internal Services Department (ISD) to establish a DMH-specific instance/domain on the County MDM. Migrated 1,294 devices from BES to EM+S to complete project ahead of schedule.

Prepared By:

Signature _____ **Date:** 01/09/19 **Phone:** (213) 480-3662

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: IT Asset Management Modernization **DMH Project ID #:** 1384179774

Project Status: ☐ Not Started ☒ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 07/14/17
Project End Date: 12/30/19

Project Contact: Whitehead, Dean
E-mail Address: dwhitehead@dmh.lacounty.gov **Phone Number:** (213) 480-3662

Project Objectives

This project will implement a cloud-based asset management solution, including a live database of assets, bar code asset tag data capture and automated reporting, and a workflow solution integrated with the existing Ivanti Service Manager and Service Management modules. Maintaining an accurate and current inventory of assets is required under the County Fiscal Manual (CFM).

Project Name: IT Asset Management Modernization **DMH Project ID #:** 1384179774

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

Implementation Phase:
Current activities include: Updating Project Charter and Plan; Validating IT assets data for Proof of Concept (POC); drafted reply for Auditor A-C audit reporting.
Next Steps include: Meeting and working with Administrative Services Bureau (ASB) Meeting: NEW PDF inventory forms, instructions, schedule POC, procure and test tag bar code scanners for POC non-sequential asset re-tagging.

Major Accomplishments

Data compilation completed for over 90 percent of IT assets based on physical inventories. However, extensive normalizing is required prior to upload. Alternative data collection methods are in development.

Prepared By:

Signature _____ **Date:** 01/08/19 **Phone:** (213) 480-3662

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Network Adequacy Certification Tool (NACT) **DMH Project ID #:**

Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 03/08/18
Project End Date: 09/28/18

Project Contact: David Anderson
E-mail Address: danderson@dmh.lacounty.gov **Phone Number:** (213) 251-6524

Project Objectives

The project objective is to Create a Network Adequacy Certification Tool (NACT) to comply with State Department of Health Care Services (DHCS) requirements for Mental Health Service plans Network Adequacy and Certification requirements. This is an on-line application that collects and verifies the data needed for Network Adequacy Certification. All LACDMH providers must review, update and validate their organization, service location and staff information.

Project Name: Network Adequacy Certification Tool (NACT) **DMH Project ID #:**

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

Project was implemented into production on 03/20/2018. Microsoft CRM Solution was deployed for Directly Operated Providers and the Microsoft CRM Portal was deployed for Legal Entity (LE) and Fee For Service (FFS) providers.

Major Accomplishments

DMH has developed an on-line application (CRM) to collect and verify the data needed for network adequacy certification. All LACDMH providers (DO & LE & FFS) must review, update and validate their organization, service location and staff information.

Security was setup for DOs in the Microsoft CRM application and security was setup for LE and FFS Providers in the Microsoft CRM portal. This was all completed before the project went live.

Prepared By:

Signature _____ **Date:** _____ **Phone:** _____

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Notice of Grievance Resolution **DMH Project ID #:**

Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 04/20/18
Project End Date: 01/31/19

Project Contact: David Anderson
E-mail Address: danderson@dmh.lacounty.gov **Phone Number:** (213) 251-6524

Project Objectives

The project objective is to provide a system that will handle uniform notices that involves Los Angeles County process in dealing with Benefits. Also involves Notices of Adverse Benefits Determination, Notice of Grievance Resolution and Notice of Appeal. Delivers functionality in Microsoft Dynamics 365 to allow real-time entry of constituent grievances and grievance status tracking, trend analysis and reporting.

Project Name: Notice of Grievance Resolution **DMH Project ID #:**

Project Phase
*Implementation Status: *If project is behind schedule, please describe the delay(s) and corrective actions taken*

The application is in a sandbox environment, in execution phase, but testing has not been done. Verification of the code, security, and tables used has not been done yet.

Major Accomplishments

RSM, a Microsoft partner, developed the CRM Dynamics application with Microsoft's guidance. The Application was developed off site. The file was sent to DMH and subsequently imported into a CRM instance.

Prepared By:

Signature _____ **Date:** _____ **Phone:** _____

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Patient's Rights Change of Provider	**DMH Project ID #:**
Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Project Start Date:** 12/20/17 **Project End Date:** 01/31/19
Project Contact: David Anderson	
E-mail Address: danderson@dmh.lacounty.gov	**Phone Number:** (213) 251-6524

Project Objectives

The project objective is to computerize the process of Clients requesting any change of provider that is part of the services they are receiving from Directly Operated centers or Legal Entities that are contracted by LA County DMH. The Application will also track State mandated requirements that are related to any request for change of providers.

Project Name: Patient's Rights Change of Provider **DMH Project ID #:**

Project Phase
*Implementation Status *If project is behind schedule, please describe the delay(s) and corrective actions taken*

For Directly Operated (DO) users, the Microsoft CRM Dynamics Application is in the Execution Phase in the Sandbox Development environment. The primary users, patient's rights, are currently testing.

Major Accomplishments

Completed coding the application in Microsoft CRM Dynamics. Security profiles have been established. Provided approximately 120 licenses to DO users to allow them to access the application via CRM.

Prepared By:

Signature _____ **Date:** _____ **Phone:** _____

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Provider Directory	**DMH Project ID #:** 1803901534
Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule	**Project Start Date:** 02/28/18 **Project End Date:** 03/31/19
Project Contact: Martin Corral / Anna D. Vuong	
E-mail Address: mcorral@dmh.lacounty.gov	**Phone Number:** (213) 251-6502

Project Objectives

As a result of the Final Rule all Mental Health Plans (MHPs) must make available to beneficiaries the comprehensive Provider Directory in both electronic and print form (upon request). This is for both county-owned and operated, as well as contracted providers, groups, and individuals. The directory must include all licensed, waivered, or registered mental health providers.
In support of the Final Rule this project will create a DMH Provider Directory which will be public facing as well as internal. Data for the Provider Directory will come from the Network Adequacy Certification Tool (NACT) application, a Microsoft Dynamics application, built in response to the need of the data collection in order to comply with the Final Rule put forth by Medicaid and that of which the State and MHPs must be in compliance with.

Project Name: Provider Directory **DMH Project ID #:** 1803901534

Project Phase
*Implementation Status *If project is behind schedule, please describe the delay(s) and corrective actions taken*

Provider Directory is currently on schedule. A concern with providing the directory in the threshold languages, is that the contract for the translation services is still under development. The contract may utilize Microsoft artificial intelligence, Cortana, to provide trans-literation and translation services. Initial work would require a re-design of the current database so that it could accommodate the needed format for the translation process and be able to move to Azure SQL databases for access.

Major Accomplishments

DMH was able to submit to the State a version of the Provider Directory in its PDF version in compliance with the State requirements of the Final Rule on March 30, 2018.

DMH was able to migrate the data source for this project from the paper-based manual process to an automated process which automatically pulls data from the current golden source of provider information, the NACT application, which is a Microsoft Dynamics application. Initial data was pulled from Integrated Behavioral Health Information System (IBHIS) and then confirmed or modified by the providers to ensure that the most current information was supplied. They are now able to update as they require whenever changes within their organization occur, which is recommended at least to be on a monthly or twice a month occurrence.

Provider Directory is currently created through a Cognos report that is then able to present the directory on screen and is able to be saved and/or printed as a PDF version for the clients and staff.

Prepared By:

Signature _____ **Date:** 1/9/19 **Phone:** 213-251-6502

Approval Signature _____ **Date:** _____ **Phone:** _____
Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Digital Workplace: Video Conferencing/Webcasting Expansion **DMH Project ID #:**

Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 12/15/17

Project End Date: 06/30/19

Project Contact: Chuck Chiu

E-mail Address: cchiu@dmh.lacounty.gov **Phone Number:** (213) 251-6704

Project Objectives

The Project objective is to expand webcasting to the department by using Skype. Purchase and deploy new equipment for continuation of video conferencing and webcasting as a mode of communication and collaboration to save on travel time and increase productivity.

Project Name: Digital Workplace: Video Conferencing/Webcasting Expansion **DMH Project ID #:**

Project Phase

*Implementation Status. *If project is behind schedule, please describe the delay(s) and corrective actions taken*

Initiated Phase 1 of the project to roll out a set of Microsoft Surface HUBS to 20 locations. The subsequent phases will include the use of telepresence and Skype capabilities throughout the department as a mode of collaboration and communication to save on travel time and increase productivity.

Major Accomplishments

Planning and funding for the Microsoft HUBS were found while working with ISD, DMH was able to place an order for 20 Microsoft HUBS.

Prepared By:

Signature _____ **Date:** 01/09/09 **Phone:** (213) 251-6704

Approval Signature _____ **Date:** _____ **Phone:** _____

Mirian Avalos, Chief Information Officer

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MHSA IT Annual Project Status Report

Fiscal Year 2017-2018

Project Name: Digital Workplace: Wi-Fi Access at DMH Clinics and Admin sites **DMH Project ID #:**

Project Status: ☐ Not Started ■ On Schedule ☐ Ahead of Schedule ☐ Behind Schedule

Project Start Date: 01/01/18

Project End Date: 12/31/18

Project Contact: Chuck Chiu

E-mail Address: cchiu@dmh.lacounty.gov **Phone Number:** (213) 251-6704

Project Objectives

The project objective is to provide both employee and guest access wirelessly to County and Internet resources at DMH Facilities. Workers who span multiple clinical environments can be more productive in whatever space they set up to get work done and serve the clients efficiently.

Project Name: Digital Workplace: Wi-Fi Access at DMH Clinics and Admin sites **DMH Project ID #:**

Project Phase

*Implementation Status. *If project is behind schedule, please describe the delay(s) and corrective actions taken*

The project for providing WiFi access to our directly operated locations has been divided into three phases. Phase 1 consists of 11 sites. Phase 2 consists of 21 sites. Phase 3 consists of 19 sites. At this time Phase I has been completed and Phase 2 has been initiated.

Major Accomplishments

During this time period, Phase 1 was completed providing WiFi access to 11 Directly operated clinics.
A quote for Phase 2 with the Internal Services Department (ISD) was created.

Prepared By:

Signature _____ **Date:** 01/09/19 **Phone:** (213) 251-6704

Approval Signature _____ **Date:** _____ **Phone:** _____

Mirian Avalos, Chief Information Officer

County of Los Angeles-Department of Mental Health
Fiscal Year 2017-2018
Promoters Summary Report

SUMMARY OF PRESENTATIONS
TABLE

Service Area	Presentations Conducted	Approximate # of People Served
*Service Area 2	17	120
*Service Area 3	7	40
Service Area 4	1006	9711
Service Area 6	698	6788
Service Area 7	1368	11,791
Service Area 8	1191	9105

*Promoters - Trained in April and June 2018

Promoters of Mental Health Expansion

Mental Health Promoters have advanced personally and professionally since 2011, when the program was initially implemented in Los Angeles County, serving Service Area 7. The program is expanding to all service areas. There are currently 20 trained Spanish-speaking Community Mental Health Promoters in Service Areas 2, 3, 4, and 6. There are a few more in SA's 7 with 29 Promoters, and SA 8 with 24 Promoters, due to our expansion into Public Health and specialized training for Public Health Promotes.
This expansion is designed to promote mental health and well-being, support and help to strengthen families by providing educational mental health workshops, resources and linkage to mental health and other needed services.

Promoters of Mental Health collectively conducted 4,287 mental health presentations throughout their service area communities and reached approximately 35,138 people. In addition, participated in 197 community events which included health fairs, resource fairs, and having resource tables twice a week at both the Mexican and Salvadorian consulates.

Total Number of Promoters per Service Area

- **SA 2 – 20**
- **SA 3 - 20**
- **SA 4 - 18**
- **SA 6 - 17**
- **SA 7 - 29**
- **SA 8 - 20**

Training

Training is an essential component of a Promoters of Mental Health program in the delivery of mental health education and early interventions to Latino communities.
The Department of Mental health strives to ensure that Promoters of Mental Health are exposed to information that will increase their knowledge and enhance their skills needed to implement an effective program giving them an opportunity to reflect on their

professional development. Promoters also receive supervision and consultation by the administrative team providing feedback, guidance and emotional support.

Our Promoters receive:

- 36 hours of Mental Health Booster trainings
- 24 hours of Group Supervision
- 24 hours of Advanced Development Group (voluntary participation)
- Individual supervision as needed
- 24 hours of Linkage and Referral - stipend
- Additional presentations from guest speakers on the following topics:
  - Natural Healing-Meditation and Self Reflection
  - CHIRLA-Immigration Laws
  - Department of Occupational Rehab
  - Healing through the Arts-Facilitated by SA 7 Promoter
  - Ice Breaker Workshop-Facilitated by Sa 7 Promoter
  - Department of Mental Health-ZIKA Training

Collaboration with the Department of Public Health - EXIDE

The Department of Public Health (DPH) requested the continued assistance of the Promoters of Mental Health to outreach the Latino communities affected by the Exide Battery Plant located in the City of Vernon. A total of 13 Promoters collaborated with DPH providing 469 hours of community outreach in affected communities. These activities included community meeting participation, participating in community resource fairs assisting DPH register residents for lead level blood testing and registering homes for soil clean-up and door-to-door outreach. In addition, 88 Exide-Lead Contamination presentations were conducted at various community schools, churches and other community organizations.

EXIDE Community Project

FY 2017-2018

Activity	Quantity	Hours Completed
EXIDE Community Outreach	Average number of Promoters: 3 per event	469 hours
Exide Community Presentations	88 Exide presentations	Approximately 1.5. hours per presentations

ZIKA AND OTHER MOSQUITO BORNE DISEASES

Lastly, Promoters were also asked to assist the Department of Public Health with a community education program to prepare county residents for the potential of the spread of the Zika Virus and other mosquito borne diseases. To accomplish this task, a total of 14 Promoters were selected based on their previous community outreach participation and received a train-the-trainer 4 hour training on mosquito borne diseases and provided with all power points, scripted materials and visual aids such as small potted plants, pictures of the various types of mosquitos, mosquito repellants, bottle caps and other small potential water catchment objects to demonstrate to workshop participants the various unsuspecting locations that mosquitos lay their eggs.

ZIKA Virus Community Project
FY 2017-2018

ZIKA	EVENT DATE	# of hours
All SA – Resource Tables and Street Outreach	9/2017-11/2017 Avg. # of Promoters per event: 22	689
All SA's – ZIKA Refresher Training -	12/29/17 28 Promoters X 3 hours each	84 hours
All SA's – Power Point training on Mosquito Borne Diseases	4/11/18 14 Promoters X 3 hours each	42 hours
Community Mosquito Borne Disease Presentations	Various Dates throughout May and June 2018	78 presentations
Community Mosquito Borne Disease Information Tabling	Various Dates	23 hours

Promoter Highlights

- Thanksgiving Celebration- Promoters from all Service Areas collaborated and put together a celebratory event with food, music and entertainment. Promoters created a thankful tree that took center stage throughout the Thanksgiving holiday.
- SB82 Homeless Staff training- Promoters facilitate Mental Health 101 training
- 21st Annual Parent Academy – A conference put together by several school districts and provide workshops and helpful resources that raises awareness of Parent Involvement opportunities and provides opportunities for increased parent involvement. Promoters facilitated workshops on the following:
  - Symptoms and Treatment of Anxiety
  - Grief and Loss
  - Domestic Violence
- LA County DMH Promoters entered into an MOU with the Gloria Molina Greater Los Angeles YWCA Center in the incorporated area of Walnut Park and TELACU Housing Corporation to conduct Mental Health presentations to those served.
- First annual resource fair took place on May 18, 2018 which yielded 24 vendors and approximately 70 attendees. The fair was coordinated and executed solely by the Promoters. The group was able to obtain all items used for the fair via donations, including several items to raffle off to attendees. Providence clinic was also onsite and provided free glucose and blood pressure screenings.
- Promoters shared a resource table with the Department of Public Health providing mental health and mosquito borne disease information. at the yearly **Vision y Compromiso** Conference, an organization committed to community well-being by supporting Promotoras and Community Health Workers through self-empowerment, educational programs, health advocacy outreach, specifically aimed at Latinos and their families.

Outreach

The Promoters program demonstrates the effectiveness of collaboration between non-profit and community-based partnerships in developing awareness about mental health. The Promoters are effective in reaching residents of their community because they are part of that community, raised in the culture and fluent in the local language and share some life experience with the community members they serve. The project team and

Promoters have established connections with schools and other community organizations and are invited to return year after year. The program establishes new routes to preventative mental health care for underserved communities and helps community members to take collective action to promote mental health in their homes and families and help the Department address the issues of disparate access to mental health services for Latino communities. A breakdown of presentation locations and modules conducted are listed below:

Community Event Participation:

SA 2 –3
SA 3 –0
SA 4 –130
SA 6 – 18
***SA 7 – 13**
SA 8 – 36

SAMPLE LOCATION PRESENTATION SITES

- *Cabrillo High School*
- *Trinity Church*
- *Volunteers of America*
- *Inglewood School District*
- *St. Gertrude's Health Fair*
- *Core - Resource Table*
- *Centro Estrella Children's Resource Fair*
- *Maywood City Hall Health Fair*
- *Lanterman Regional Center*
- *Carecen*
- *Iglesia Universal del Reino de Dios*
- Dolores Huerta School
- Club Nutricion
- All People's Comm Ctr
- Telacu Housing Corp
- Cerritos Park
- Pico Housing Corporation
- Cesar Chavez Community Center
- *Weekly Resource and Information tables at the following consulates*
  - *Mexican*
  - *Guatemala*
- Providence Little Company of Mary Fair – Wilmington
- Torrance School Fair
- Charles R. Drew University Of Medicine and Science Conference
- Parks after Dark- Parks throughout all Service Areas
- Providence Little Company of Mary Fair – Wilmington
- Torrance School Fair
- Charles R. Drew University Of Medicine and Science Conference
- Parks after Dark- Parks throughout all Service Areas

SERVICE AREA REPORTS

SERVICE AREA 2

Presentations Conducted: 17 ***Number of Referrals: 0*** ***Approximate # of People Served: 120***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
2	4	0	3	0	0	0	5	3	0

Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
0	0	0	0	0	0	0	0	0	0	0	17

Breakdown of Completed Modules

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide	Childhood Disorders
4	5	0	2	0	2	0	0	4

SERVICE AREA 3

Presentations Conducted: 7 ***Number of Referrals: 6*** ***Approximate # of People Served: 40***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
0	0	0	0	0	0	0	0	0	7

Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
0	0	0	0	0	0	0	0	0	0	0	7

Breakdown of Completed Modules

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide	Childhood Disorders
2	1	1	1	1	1	0	0	0

SERVICE AREA 4

Presentations Conducted: 1006 ***Number of Referrals: 150*** ***Approximate # of People Served: 9711***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
215	1	21	1	10	43	99	20	25	0

Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
41	71	84	89	68	46	58	97	108	145	141	58

Breakdown of Completed Modules

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide	Childhood Disorders
119	114	119	85	95	85	79	80	230

SERVICE AREA 6

Presentations Conducted: 698 ***Number of Referrals: 101*** ***Approximate # of People Served: 6788***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
52	5	6	13	0	2	8	5	5	5

Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
3	17	43	65	58	28	64	89	96	104	113	18

Breakdown of Completed Modules

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide Prevention	Childhood Disorders
82	72	71	67	65	69	51	56	165

SERVICE AREA 7

Presentations Conducted: 1368 ***Number of Referrals: 154*** ***Approximate # of People Served: 11,791***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
77	9	15	26	8	8	5	28	6	10

Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
31	87	149	198	145	80	95	130	147	138	113	84

Breakdown of Completed Modules

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide	Childhood Disorders
174	149	129	128	120	129	109	97	333

SERVICE AREA 8

Presentations Conducted: 1191 ***Number of Referrals: 105*** ***Approximate # of People Served: 9105***

Location Sites

Schools	Churches	MH Clinics/Wellness Ctrs.	Private Homes	Social Service Organizations/Child Care Ctrs.	Senior Centers	Housing Complex	Community Ctrs./City Org.	County Facilities/ Library & Parks	Other
148	32	29	92	33	1	2	38	10	10

*Presentations per Month

July 2017	Aug. 2017	Sept. 2017	Oct. 2017	Nov. 2017	Dec. 2017	Jan. 2018	Feb. 2018	Mar. 2018	Apr. 2018	May 2018	June 2018
62	99	130	143	111	72	122	150	141	64	44	53

*Breakdown of Completed Modules

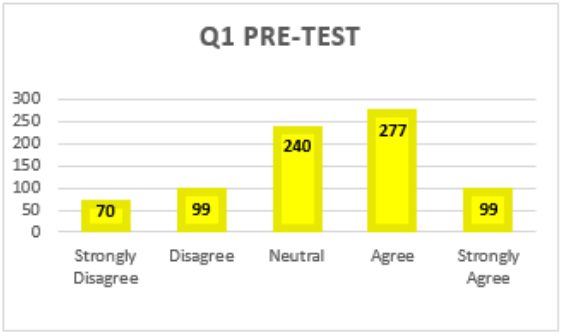
Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide Prevention	Childhood Disorders	Psycho-educational Workshops
116	123	109	94	98	104	91	107	281	*68

*NOTE: 68 Psycho-educational classes conducted in collaboration with Abriendo Puertas, a-profit that teaches recent Latino immigrants in America the skills needed to raise their young children ages 0-5 years and uses the "popular education" approach to engage parents.

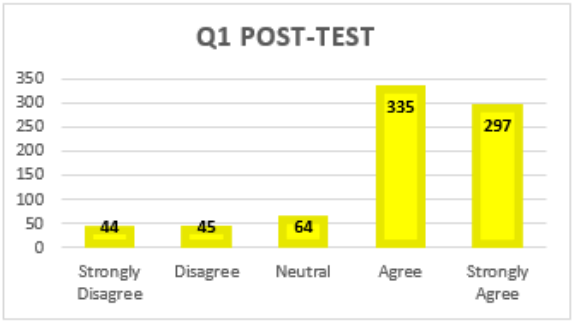
Mental Health Stigma Reduction – SA 7

(N=785)

1. There are things I can do as a person without formal training to help someone with a mental illness.

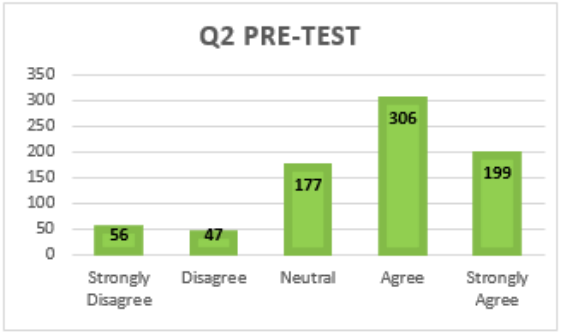


43% Agree or Strongly Agree

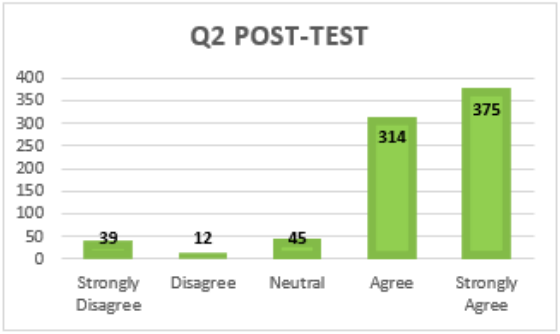


81% Agree or Strongly Agree

2. I would be likely to seek mental health services for myself, or a family member, if I suspected a mental health problem.



64% Agree or Strongly Agree

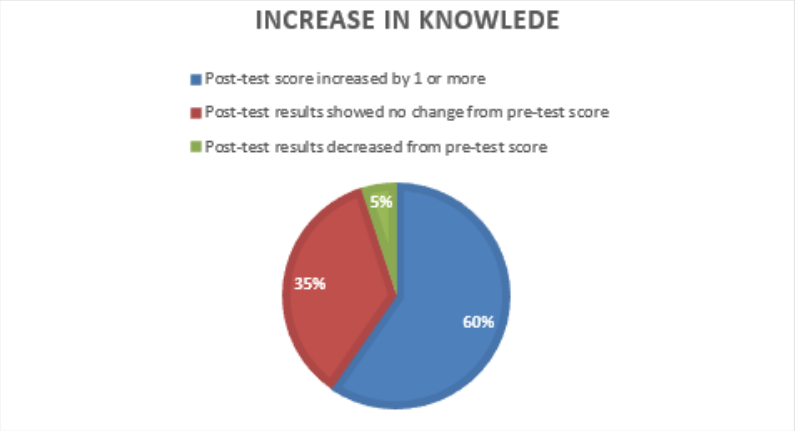


88% Agree or Strongly Agree

Mental Health Stigma Reduction – SA 7

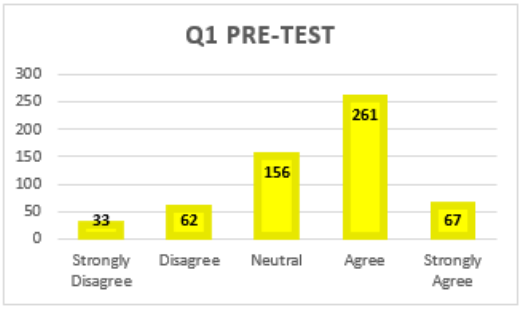
(N=785)

1. If a person is suffering from a mental illness, it is because they have done something wrong.
2. If a person just doesn't think too much about his mental disorder, it will get better.
3. If someone is depressed, you should **NOT** ask whether or not he /she has had thoughts of suicide, because it might put the idea into his/her head.
4. Once a person has been told he has a mental illness, it is a life-long condition and he will never recover.
5. Mentally ill people are off in their own world and therefore are not affected by others who fear, reject or label them.
6. A mentally ill person cannot work; they can't handle the stress of a job.

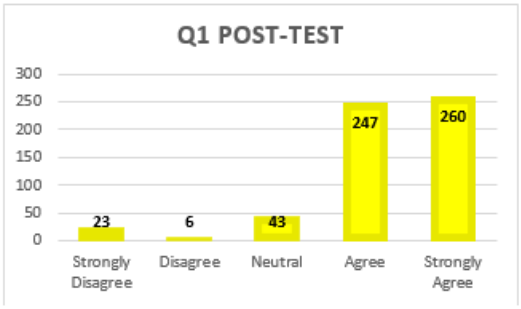


Child Abuse Reporting Process – SA 7
(N=579)

1. I know some of the signs and behavior changes that suggest a child is being abused.

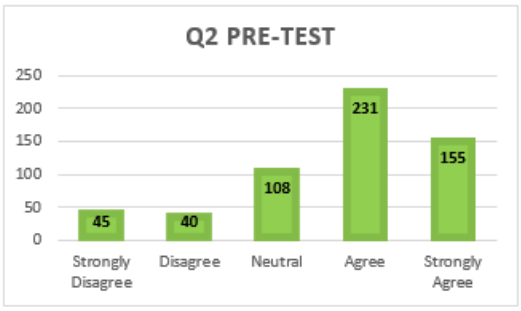


56% Agree or Strongly Agree

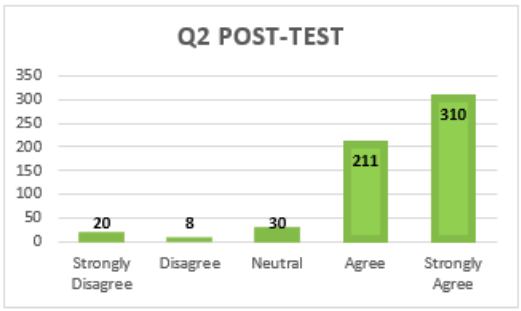


88% Agree or Strongly Agree

2. If a child I knew was a victim of abuse I would encourage that he or she receive mental health services.



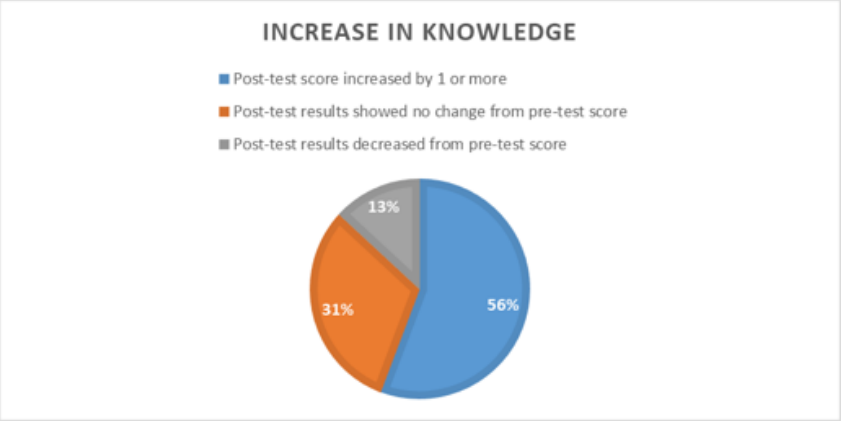
67% Agree or Strongly Agree



90% Agree or Strongly Agree

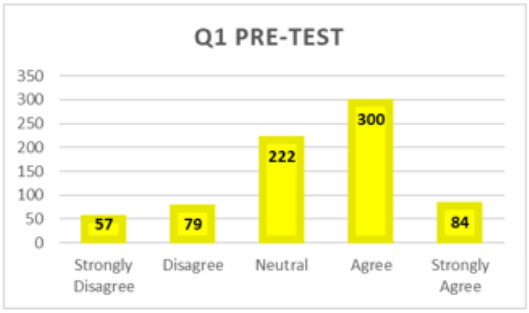
Child Abuse Reporting Process – SA 7
(N=579)

1. Child abuse always involves physical injury to a child.
2. People who are mandated reporters do not have to report child abuse when they only suspect it.
3. A child who has nightmares or is bedwetting may be being sexually abused.
4. A child who is overly compliant, passive and or withdrawn may be a victim of abuse.
5. A young child who shows sophisticated knowledge or unusual sexual behavior has probably matured more quickly than others.
6. A child who frequently shows up with injuries such as bruises, burns, or broken bones is probably just an accident-prone or clumsy child.

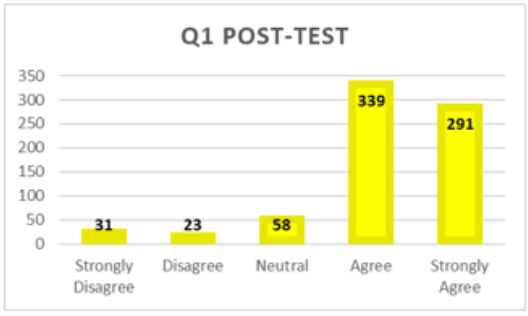


Impact of Grief and Loss – SA 7
(N=742)

1. I am able to identify some of the warning signs that a child or teen is having trouble handling the death of a loved one.

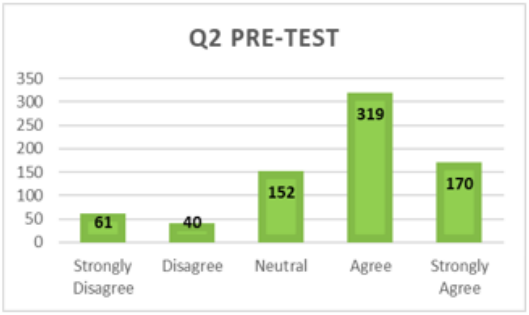


51% Agree or Strongly Agree

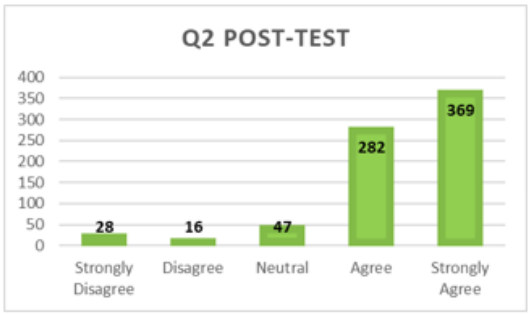


85% Agree or Strongly Agree

2. If I felt that I, or a friend or relative was having a prolonged grief reaction to a loss, I would seek treatment or encourage that person to seek help.



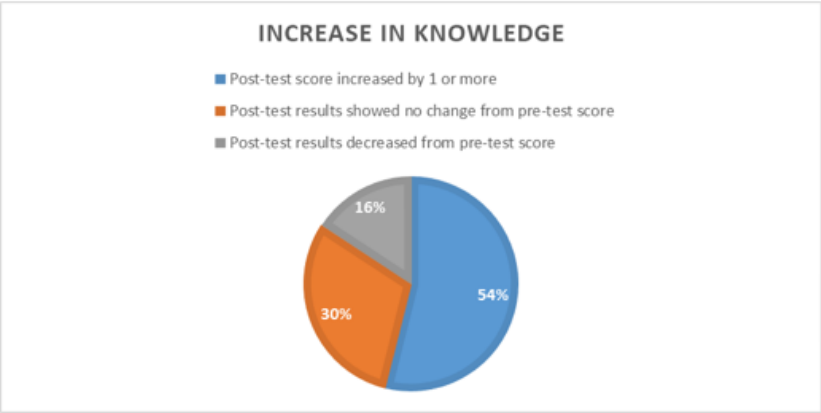
66% Agree or Strongly Agree



88% Agree or Strongly Agree

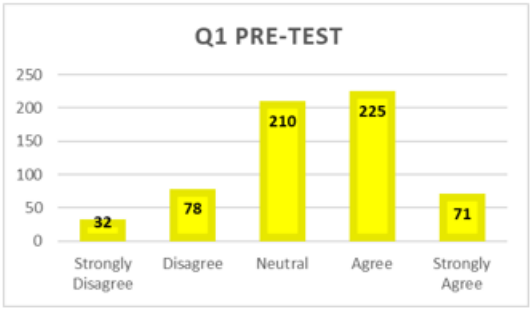
Impact of Grief and Loss – SA 7
(N=742)

1. The most common reaction in the first stage of grief is Depression.
2. Guilt can be a normal reaction to loss.
3. Anger is not a healthy reaction to loss and should be discouraged by family and friends who want to be supportive.
4. Deep sadness is a normal reaction to loss.
5. Defiance, promiscuity, and/or dropping out of school are behaviors that suggest that a teenager has not resolved the death of a loved one properly.
6. Since children under the age of ten are fearful of death but have difficulty understanding it, you should keep silent about it and not allow them to participate in any funeral rites.

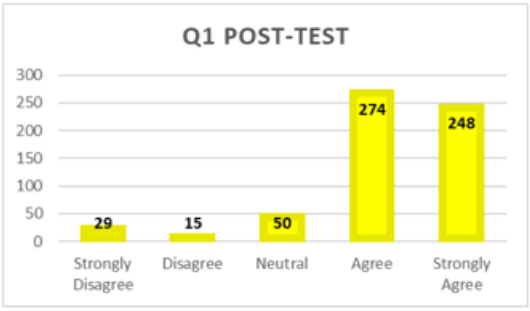


Suicide Among Youth and Older Adults – SA 7
(N=616)

1. I can recognize the signs and behavior changes that indicate that a person is at risk of suicide.

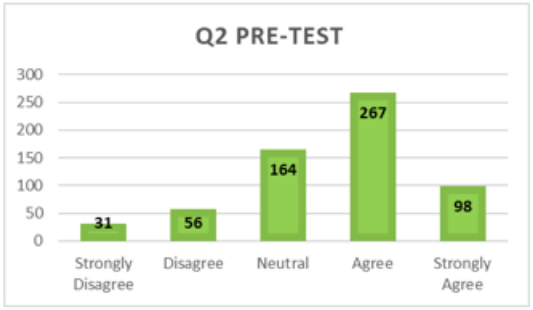


48% Agree or Strongly Agree

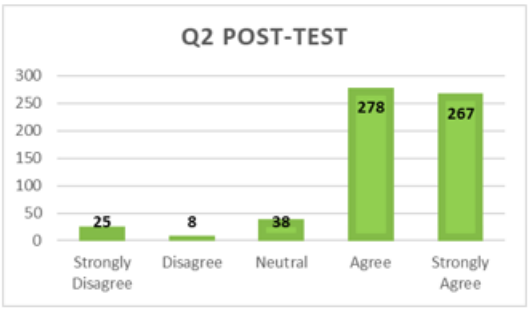


85% Agree or Strongly Agree

2. I know some things that I can do to help a person if I suspect that he or she may be feeling suicidal.



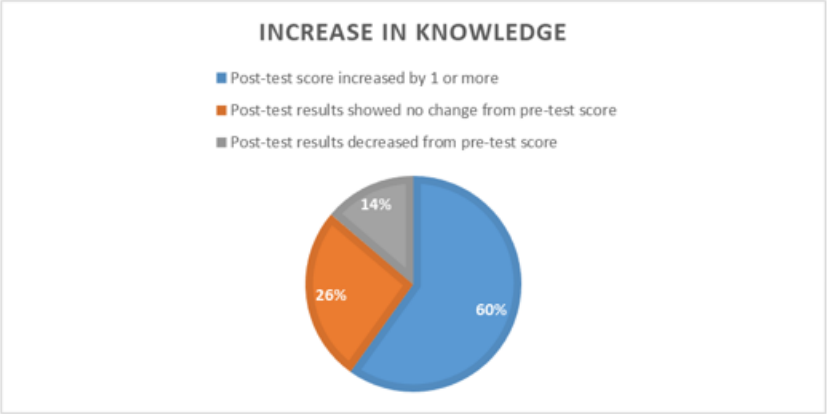
59% Agree or Strongly Agree



89% Agree or Strongly Agree

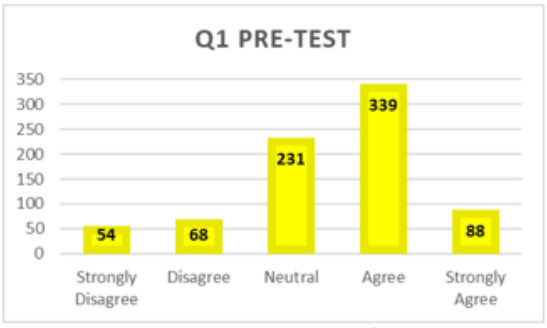
Suicide Among Youth and Older Adults – SA 7
(N=616)

1. Suicides among young people are much more common than suicides in the older adult population (those who are senior citizens).
2. Among the young population between ages 15 and 24, suicide is the third leading cause of death.
3. A teenager does not want to discuss his feelings with an adult, so if you talk to him, you risk pushing him further toward suicide.
4. When a depressed person's mood suddenly lifts and they appear happy, it means they are out of danger and there is no reason to worry about suicide.
5. Two out of every three people who kill themselves were suffering from depression before they did so.
6. Over half of the people who commit suicide use firearms as the method.

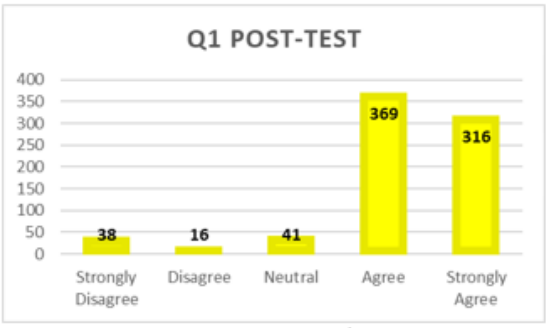


Depression Symptoms and Treatment – SA 7
(N=780)

1. I am able to recognize some of the signs and symptoms of depression.

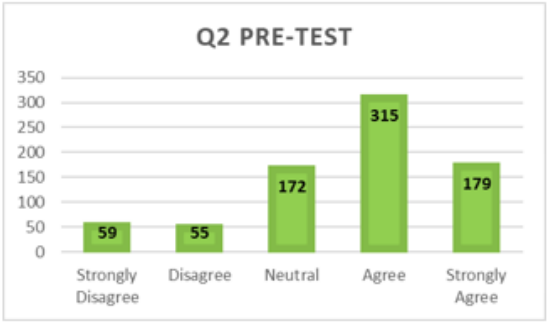


54% Agree or Strongly Agree

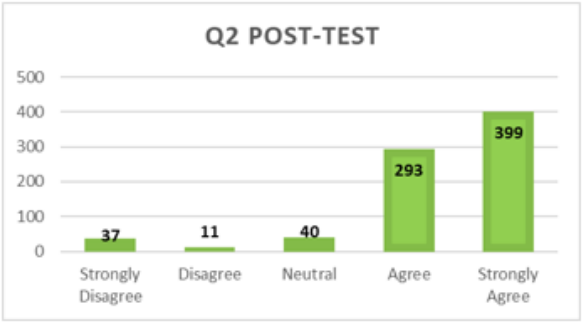


88% Agree or Strongly Agree

2. I know some things that I can do to help a person if I suspect that he or she may be feeling suicidal.



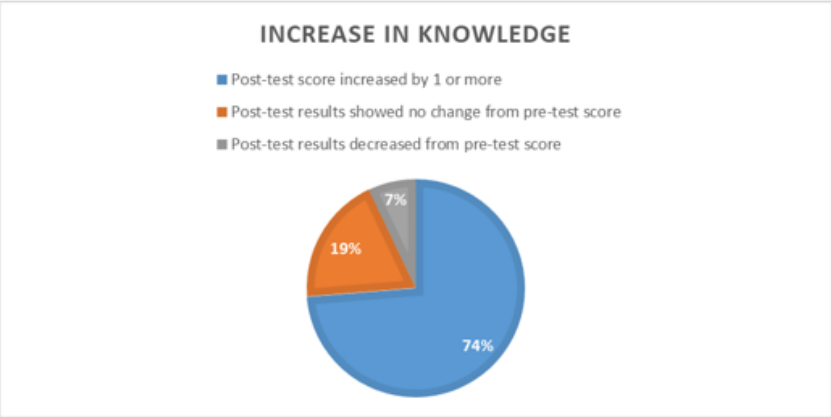
63% Agree or Strongly Agree



89% Agree or Strongly Agree

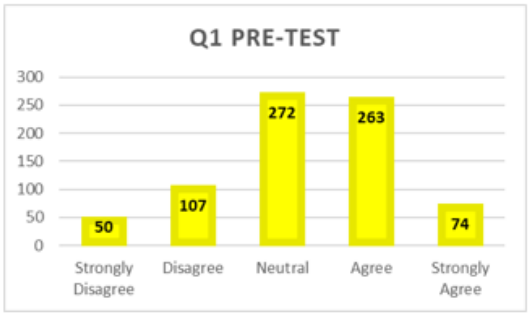
Depression Symptoms and Treatment – SA 7
(N=780)

1. Depression in the United States affects men and women in about equal numbers.
2. Depression is often mistaken as a physical problem, because it can include fatigue, aches and pains, or changes in sleep and eating habits.
2. In addition to 4 other symptoms, a person must suffer from feelings of sadness and/or emptiness for at least two weeks to Be diagnosed with a Depressive Disorder.
4. If other relatives in your family have had Depressive Disorder, you are more likely to develop it as well.
5. It is not necessary to seek treatment for depression, as it will go away on its own if you just give it some time.
6. Depression can be caused by a chemical imbalance in the brain.

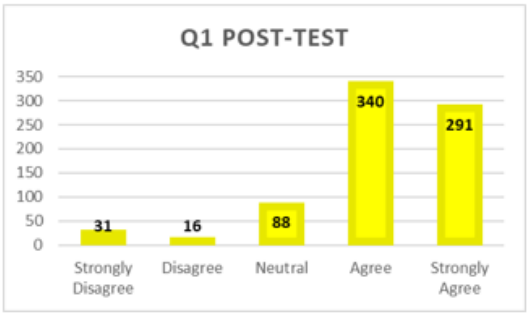


Anxiety Disorders Symptoms and Treatment – SA 7
(N=766)

1. I can recognize the signs and symptoms of an Anxiety Disorder.

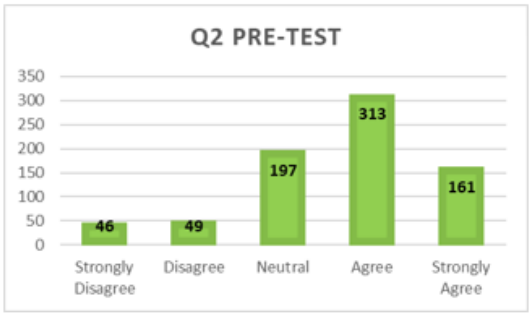


44% Agree or Strongly Agree

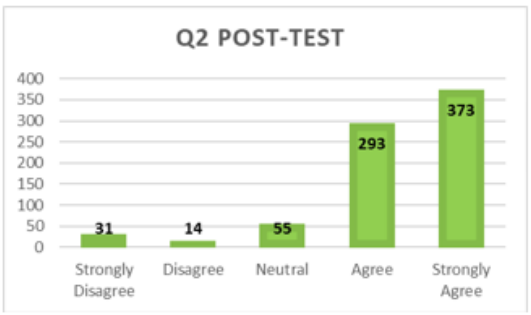


82% Agree or Strongly Agree

2. If I thought that I, or a friend or relative was developing an Anxiety Disorder, I would seek treatment at a mental health clinic, or encourage that person to seek treatment.



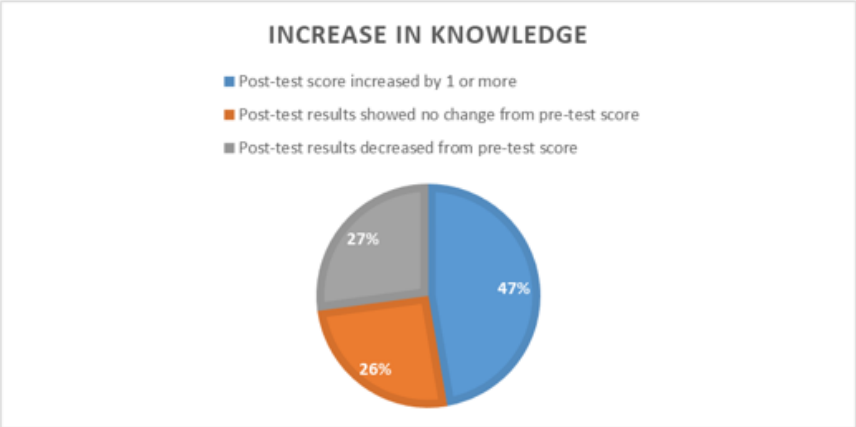
62% Agree or Strongly Agree



87% Agree or Strongly Agree

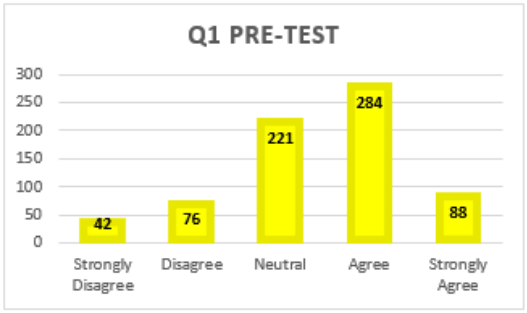
Anxiety Disorders Symptoms and Treatment – SA 7
(N=766)

1. Anxiety is not a normal emotion.
2. Anxiety Disorders are not that common in the United States.
3. More men than women suffer from Anxiety Disorder.
4. Panic Disorder starts with unexpected panic attacks, followed by at least a month of worry about having another attack.
5. Panic Disorder symptoms are most often emotional and rarely include physical symptoms.
6. Social Phobia (fear of embarrassing social situations such as dating, public speaking, or eating in public) is the most common form of phobia.

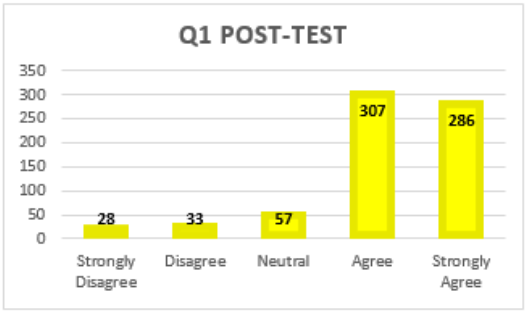


Family Domestic Violence – SA 7
(N=711)

1. I know the symptoms and behaviors which indicate that a person may be being exposed to familial violence.

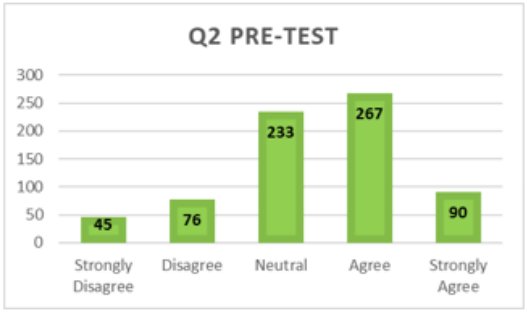


52% Agree or Strongly Agree

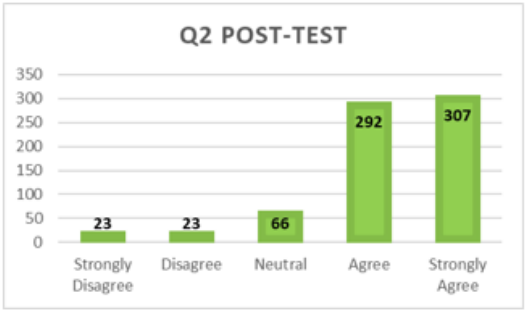


83% Agree or Strongly Agree

3. If I suspected or knew that a person was a victim of domestic violence I would encourage that person to seek mental health services.



50% Agree or Strongly Agree



84% Agree or Strongly Agree

Program Name	Evaluation Plan/ Outcome Tool
Asian American Family Enrichment Network (AAFEN)	AAFEN Pre and Post Survey
Active Parenting	RAND Parents Survey
American Indian Life Skills (AILS)	RAND Youth Survey
ARISE	RAND Youth Survey RAND Adult Survey
Boys and Girls Club Project LEARN	TBD
Childhelp Speak Up and Be Safe	RAND Youth Survey
Commercial Sexual Exploitation of Children and Youth (CSECY) Training	Pre/Post Evaluation
Domestic Violence and Intimate Partner Violence Services	Under development
Erika's Lighthouse: A Beacon of Hope for Adolescent Depression	Suicide Prevention Survey RAND Youth Survey
Guiding Good Choices	RAND Parents Survey
Heathy IDEAS (Identifying Depression, Empowering Activities for Seniors)	RAND Adult Survey
Incredible Years (Attentive Parenting)	RAND Parent Survey
Incubation Academy	Under development
LAUSD Pilots	RAND Youth Survey
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and 2-Spirit (LGBTQI2) Services	Under development
Library Project	Children's Library Program Record (5-15) Library Program Survey Record (16+)
Life Skills Training (LST)	RAND Youth Survey
Love Notes	RAND Youth Survey RAND Adult Survey
Making Parenting a Pleasure (MPAP)	RAND Parents Survey
Mindful Schools	RAND Youth Survey RAND Adult Survey
More than Sad	RAND Youth Survey RAND Parents Survey Suicide Prevention Survey
Nurse Family Partnership (NFP)	Strengths and Difficulties Questionnaire(Less than 18), BASIS-32 (18 +), ASQ-3, ASQ:SE-2, PHQ-9, IPV, PSI-4-SF), PAPF, ACES
Olweus Bullying Prevention Program	Under development
Parks After Dark	Under development
Peacebuilders	RAND Youth Survey
PEI Supportive Housing Services	Under development
Permanency Partners Program (P3) and Family Prevention Project	Under development

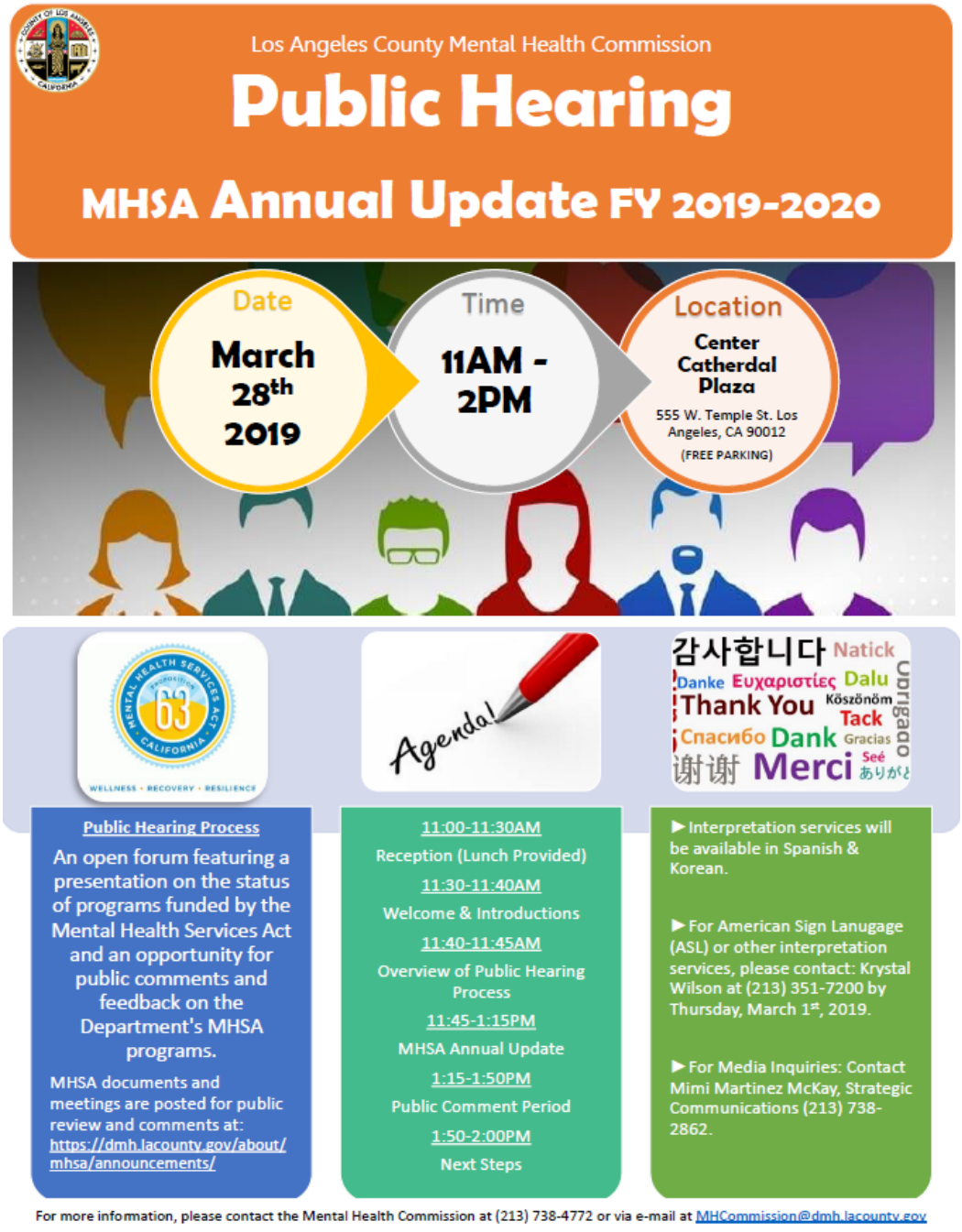
Program Name	Evaluation Plan/ Outcome Tool
Permanency Partners Program (P3) and Family Prevention Project	Under development
Positive Action	RAND Youth Survey
Positive Parenting program (Triple P) Levels 2 and 3	RAND Parents Survey
Project Fatherhood	RAND Parents Survey
Psychological First Aid (PFA)	RAND Youth Survey RAND Parents Survey RAND Adult Surveys
Residential Vocational Training Program	Under development
Safe Schools Ambassadors	RAND Youth Survey
School, Community, and Law Enforcement (SCALE) Program	SCALE Pre/Post Survey
Second Step	Under development
Senior Reach	Under development
Shifting Boundaries	RAND Youth Survey
Substance Use Disorder –Trauma Informed Parent Support (SUD-TIPS)	Under development
TAY Drop-In Center Targeted Outreach & Engagement Strategies	Under development
Teaching Kids to Cope	RAND Youth Survey RAND Adult Survey
Veterans Community Colleges Outreach and Case Management Services	Under development
Veterans Mental Health Services	Under development
Veterans Service Navigators	Under development
Veterans Community Colleges Outreach and Case Management Services	Under development
Why Try Program	Under development
Youth Diversion and Development (YDD)	Under development

MHSA Annual Update FY 2019-2020

Public Review and Comment Period: February 22, 2019 – March 24, 2019

MHSA Annual Update Public Hearing: March 28, 2019, 11 a.m. to 2 p.m.

- Executive Summary
- Full Annual Update Report
- Online Feedback Survey
- Comment Form – English (PDF)
- Comment Form – Spanish (PDF)



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

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

MHSA Annual Update – Fiscal Year 2019-20

Public Hearing

March 28, 2019

11:00 am – 2:00 pm

Cathedral of Our Lady of the Angels

555 W. Temple Street, Los Angeles, CA 90012

AGENDA

11:00 am – 11:30 am	Lunch	
11:30 am – 11:45 am	Welcome	Jonathan E. Sherin, M.D., Ph.D. Director
11:45 am – 12:00 pm	Key Clinical Operations ▪ Urgent Care Centers ▪ HOME Team ▪ Crisis Services	Curley Bonds, M.D. Chief Deputy Director, Clinical Operations
12:00 pm – 12:15 pm	Housing Investments	Maria Funk, Ph.D., Program Manager III
12:15 pm – 12:30 pm	Schools: Prevention Platforms	Kalene Gilbert, LCSW, Program Manager III
12:30 pm – 1:00 pm	Public Comment and Questions	Public and Mental Health Commission
1:00 pm – 1:40 pm	Overview of Fiscal Year 2019-20 Annual Update	Debbie Innes-Gomberg, Ph.D., Deputy Director
1:40 pm – 2:00 pm	Public Comment and Questions	Public and Mental Health Commission
2:00 pm	Adjourn	

Mental Health Services Act Annual Update Fiscal Year (FY) 2019-20

Debbie Innes-Gomberg, Ph.D.

March 28, 2019

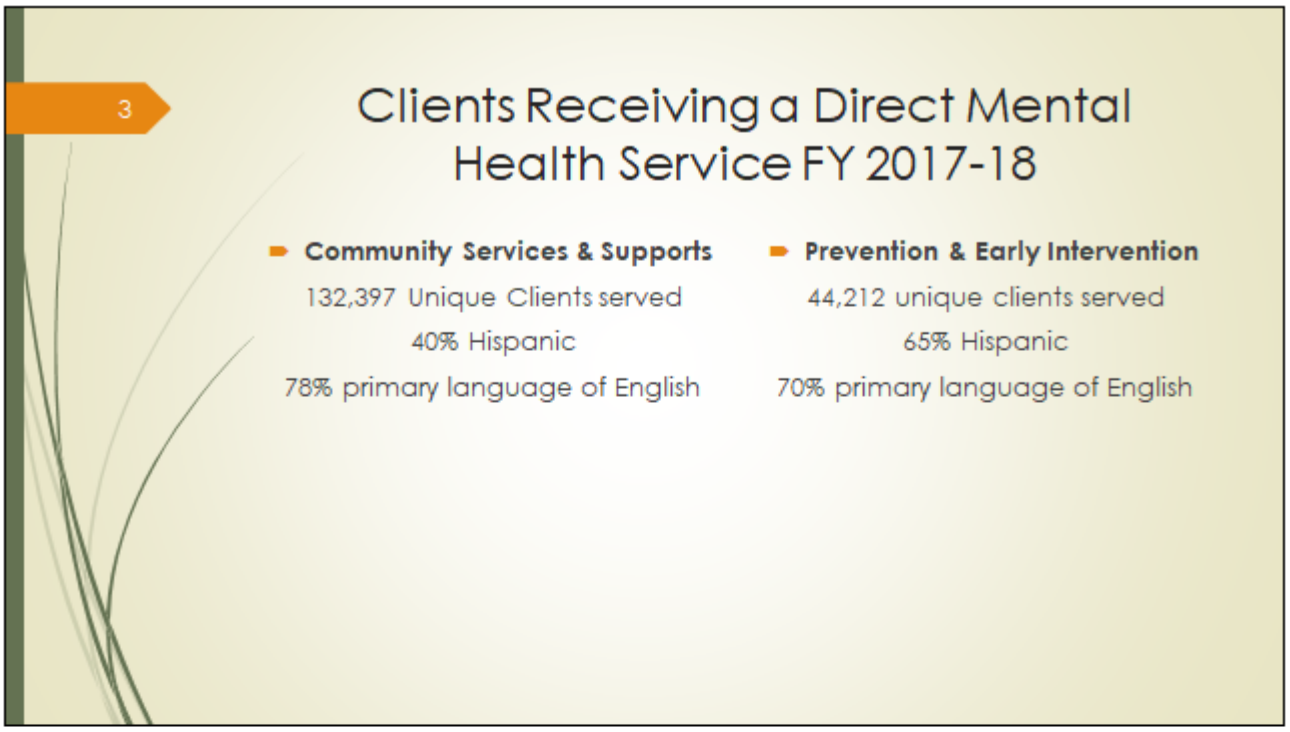
1

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

2

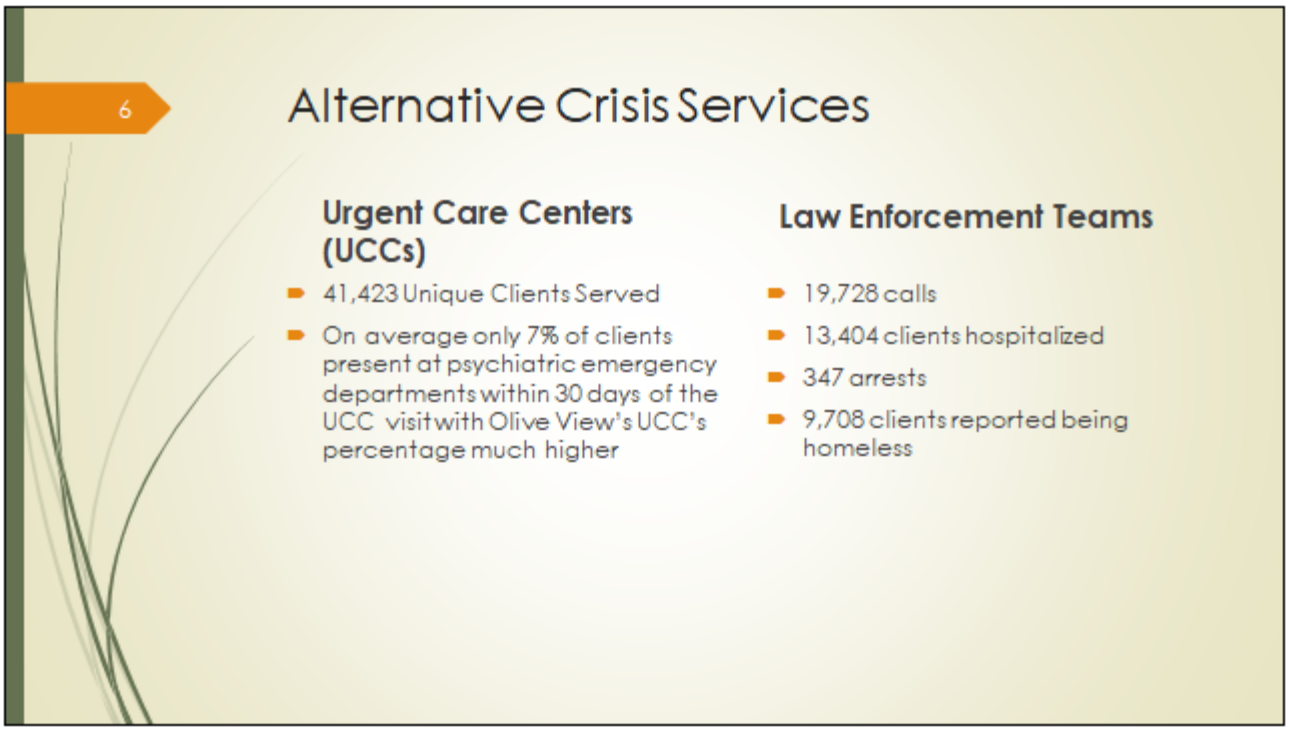
MHSA Annual Update Goals/Purpose

- The Mental Health Services Act (MHSA) stipulates that counties shall prepare and submit a MHSA Three-Year Program and Expenditure Plan with Annual Updates
- The Plan requires a 30 day public comment period and a Public Hearing
- Mental Health Director and County Auditor Controller certification as to compliance with laws and regulations
- The plan must be approved by the Mental Health Commission and adopted by the Board of Supervisors
- Information and data presented is from the prior Fiscal Year- 2017-18


3
Clients Receiving a Direct Mental Health Service FY 2017-18
Community Services & Supports
132,397 Unique Clients served
40% Hispanic
78% primary language of English
Prevention & Early Intervention
44,212 unique clients served
65% Hispanic
70% primary language of English


4
Accomplishments
Housing:
As of June 30, 2018, Los Angeles County Department of Mental Health has a total of 1,439 units.
During FY 2017-2018, the Department invested in 366 units.
Enhancing Prevention work
Stigma and Discrimination Reduction:
Outreached to 35,198 individuals and these individuals participated in these activities including Mental Health First Aid training and the WhyWeRise campaign.

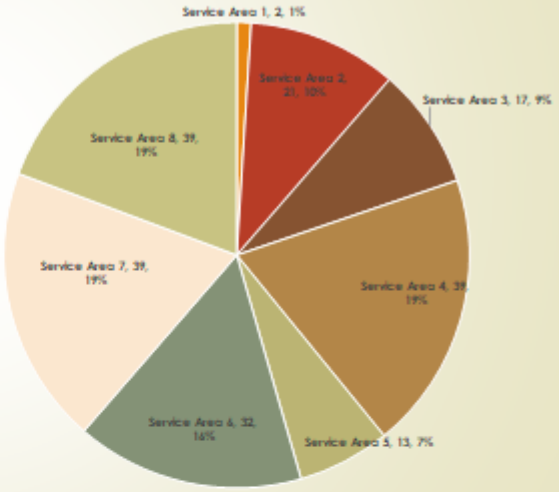

Community Services & Supports (CSS)
5
Planning, Outreach & Engagement (POE)
Alternative Crisis Services
Full Service Partnership (FSP)
Recovery, Resilience and Reintegration (RRR)
Housing
Linkage Services


6
Alternative Crisis Services
Urgent Care Centers (UCCs)
41,423 Unique Clients Served
On average only 7% of clients present at psychiatric emergency departments within 30 days of the UCC visit with Olive View's UCC's percentage much higher
Law Enforcement Teams
19,728 calls
13,404 clients hospitalized
347 arrests
9,708 clients reported being homeless

7

Alternative Crisis Services: Enriched Residential Services

- 202 FSP referrals received
- Service Area 6 receives the most amount FSP referrals
- Service Area 1 receives the least amount of FSP referrals



8

Full Service Partnership (FSP)

	FY 2016-17	FY 2017-18
Unique Clients Served		
Child	3,491	4,081
TAY	1,873	2,619
Adult	6,019	6,007
Older Adult	1,322	1,566
Average Cost Per Client		
Child	$14,877	$16,647
TAY	$12,000	$12,306
Adult	$11,469	$11,995
Older Adults	$8,725	$8,900

9

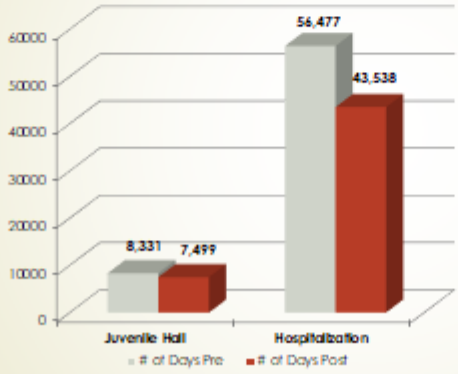
Reasons for Leaving FSP by Age Group

Child (1,850)	TAY (908)	Adult (1,418)	Older Adult (385)
• **56% Met Goals and graduated!** • 17% discontinued Participation • 9% Moved • 6% Lost Contact	• **34% Met Goals and graduated!** • 21% Discontinued Participation • 18% Lost Contact • 10% Moved	• **27% Met Goals and graduated!** • 18% Discontinued Participation • 21% Lost Contact • 11% Moved	• **46% Met Goals and graduated!** • 6% Deceased • 20% Discontinued Participation • 11% Lost Contact • 6% Moved

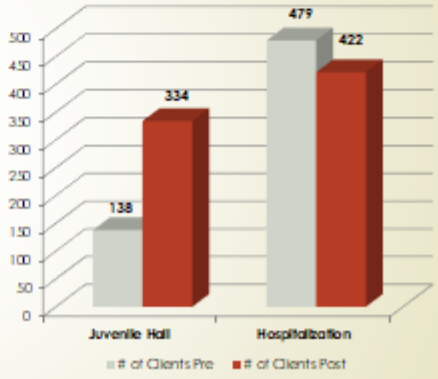
10

Child FSP Outcomes

Impact on Residential Post-Partnership



- 23% reduction in days hospitalized
- 10% reduction in days in juvenile hall

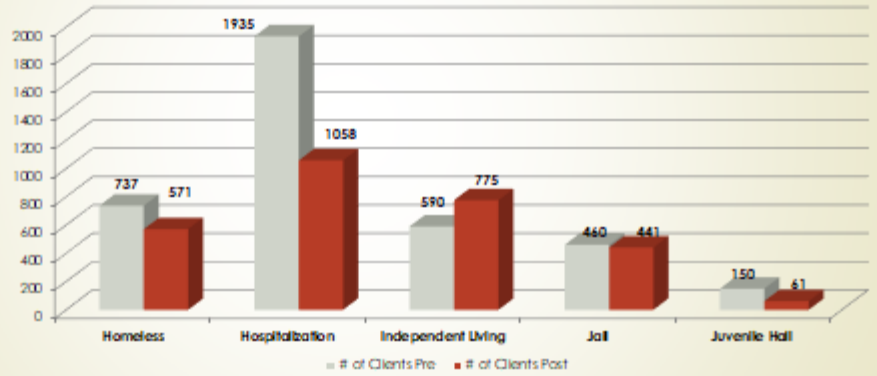


- 12% reduction in the number of clients hospitalized
- 142% increase in the number of clients in juvenile hall

11

TAY FSP Outcomes

Impact on Residential Post-Partnership

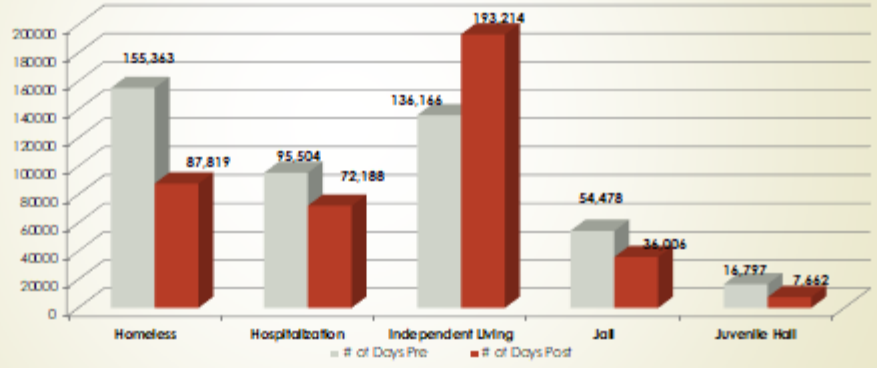


- 23% reduction in clients homeless
- 45% reduction in clients hospitalized
- 4% reduction in clients in jail
- 60% reduction in clients in juvenile hall
- 31% increase in clients living independently

12

TAY FSP Outcomes

Impact on Residential Post-Partnership

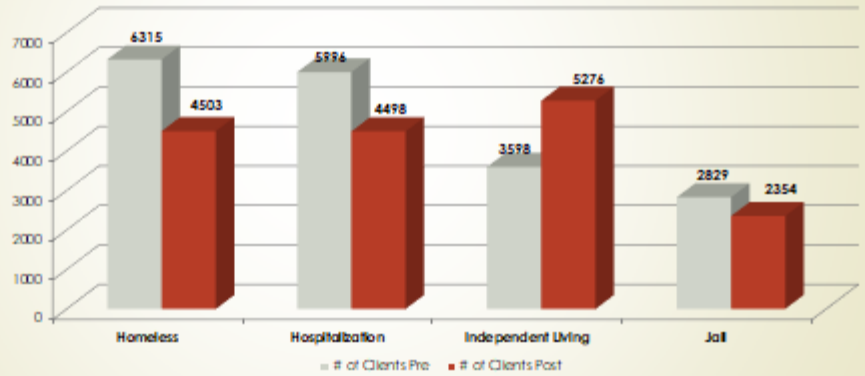


- 43% reduction in days homeless
- 24% reduction in days hospitalized
- 34% reduction in days in jail
- 41% increase in days living independently
- 54% reduction in days in juvenile hall

13

Adult FSP Outcomes

Impact on Residential Post-Partnership

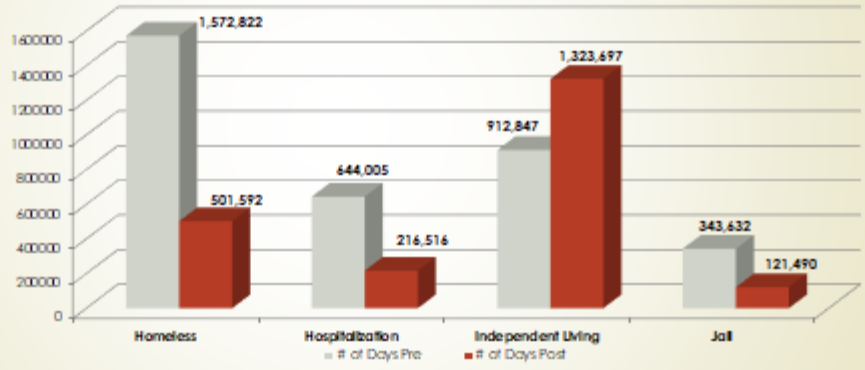


- 29% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently

14

Adult FSP Outcomes

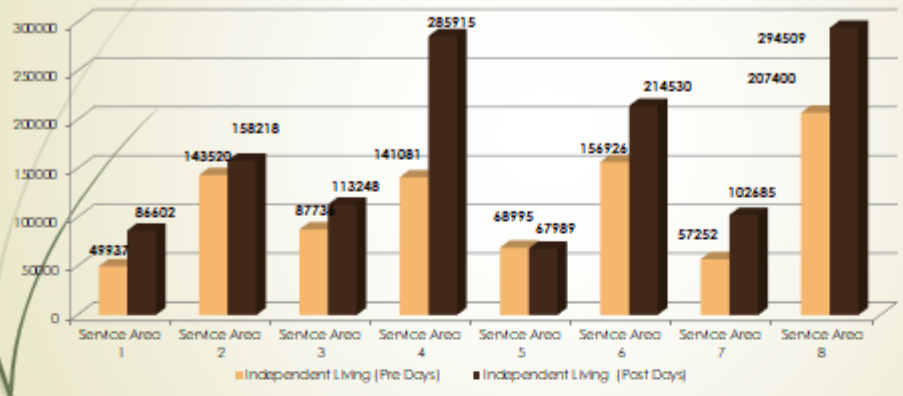
Impact on Residential Post-Partnership



- 68% reduction in days homeless
- 66% reduction in days hospitalized
- 45% increase in days living independently
- 65% reduction in days in jail

15

Residential Outcomes by Service Area: Adult Independent Living

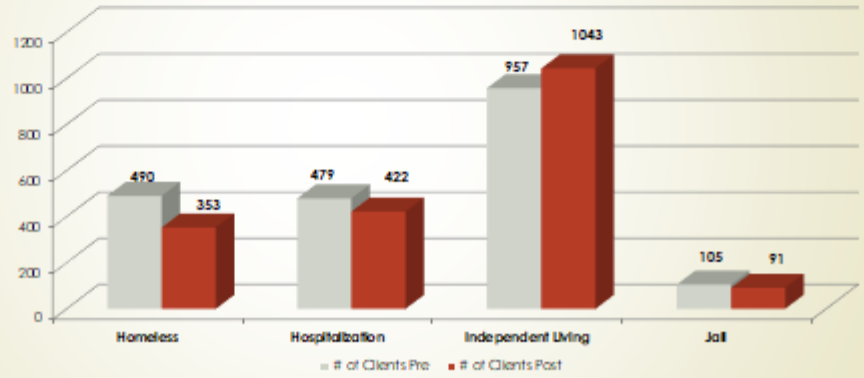


- Service Area 4 has the most percent increase in days living independently, 125%

16

Older Adult FSP Outcomes

Impact on Residential Post-Partnership

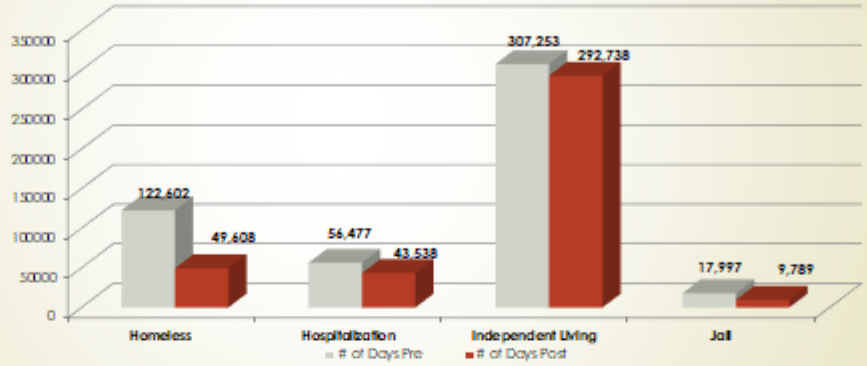


- 28% reduction in clients homeless
- 12% reduction in clients hospitalized
- 13% reduction in clients in jail
- 8% increase in clients living independently

17

Older Adult FSP Outcomes

Impact on Residential Post-Partnership



- 60% reduction in days homeless
- 23% reduction in days hospitalized
- 5% reduction in days living independently
- 45% reduction in days in jail

18

Optimizing FSP in Fiscal Year 2019-20

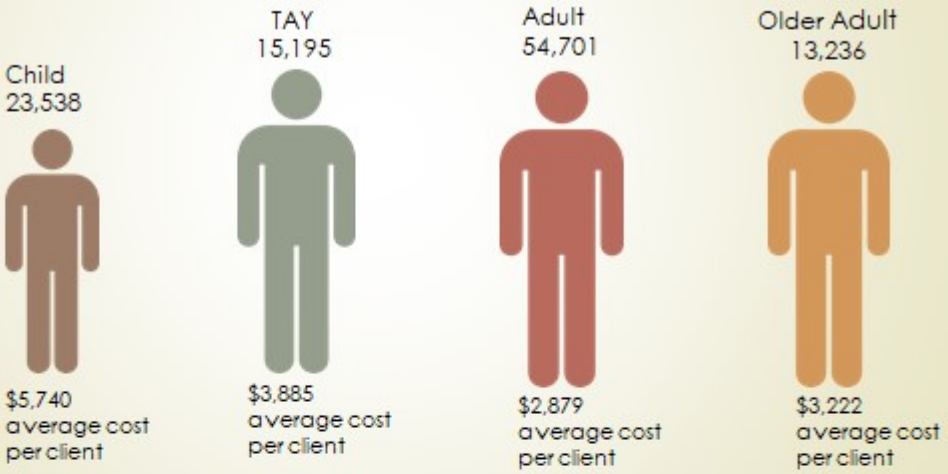
- Third Sector
  - Best practices
  - Team-oriented
  - Performance benchmarks

19

Recovery, Resilience, and Reintegration (RRR)

Community-Based Services, Clinic-Based Services, and Wellbeing Services

Unique Clients Served:



20

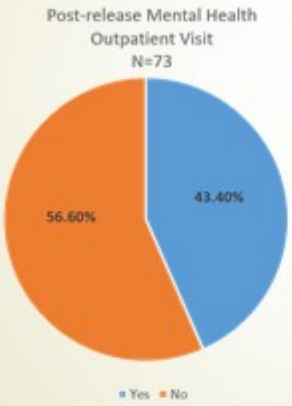
RRR: Peer-run Respite Care Homes (PRRCH)

- Locations
  - Hacienda of Hope in Long Beach
  - SHARE! in Monterey Park
- 393 Guests were served
- Average length of stay was 10 days
- 78% of guests reported making progress towards a personal goal and working towards it during their stay
- 88% of guests are involved in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, or other similar self-help programs
- 49% of guests spend at least 3-6 hours per week in a meaningful role in their community (working, volunteering, attending school, etc.)

21

Linkage Services

- **Jail Linkage**: 639 unique clients served



Of those individuals who had a post-release mental health outpatient visit, 28.8% received outpatient mental health services within 2 months of release

- **Service Area Navigation**
  - 2,273 client contacts
  - 63% of their work is in linking clients to FSP

22

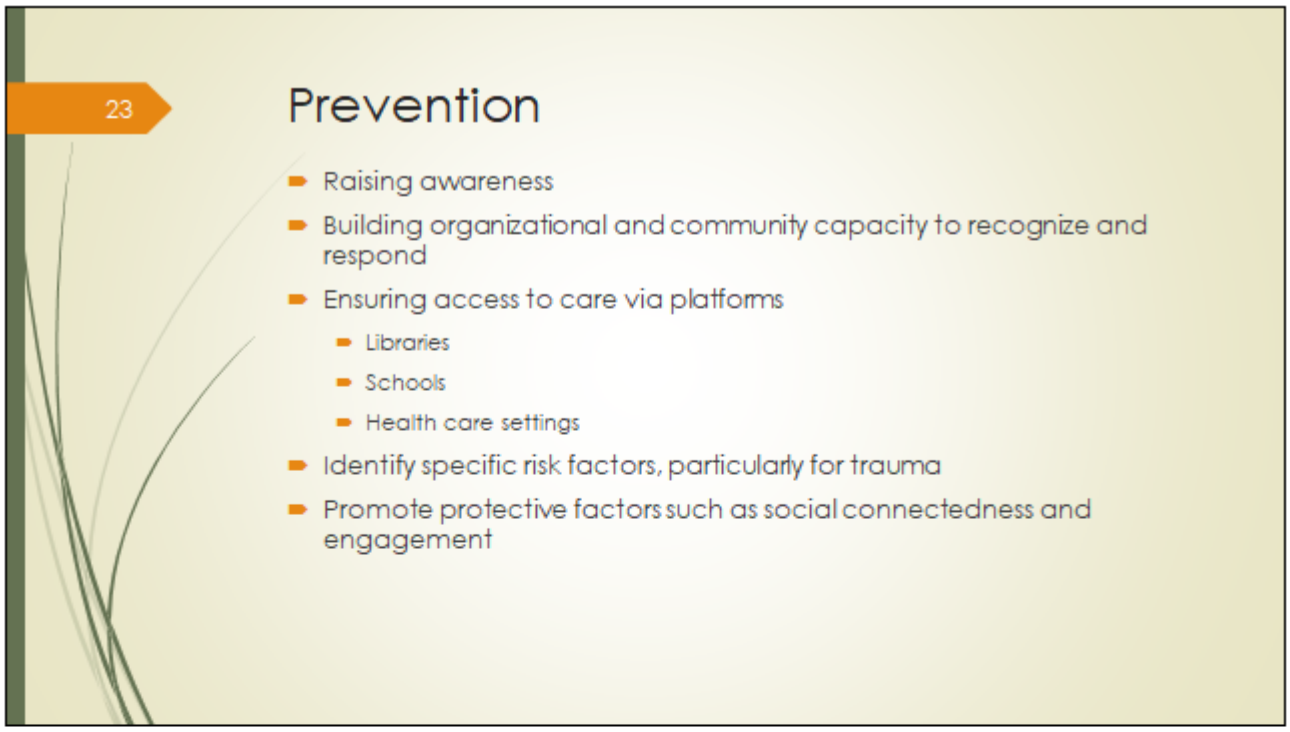
Planning, Outreach and Engagement

Service Area Outreach & Engagement

- Community Resource Fairs
- Clergy Breakfasts
- Library Outreach
- Back to School Night
- Job and Resource Fairs
- LAPD National Night Out
- Parks after Dark
- Law Enforcement Resource Fair
- College Fairs

Underserved Cultural Communities

- African/African American
- American Indian/Alaska Native
- Asian Pacific Islander
- Eastern European/Middle Eastern
- Latino
- Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two Spirit


23
Prevention
Raising awareness
Building organizational and community capacity to recognize and respond
Ensuring access to care via platforms
Libraries
Schools
Health care settings
Identify specific risk factors, particularly for trauma
Promote protective factors such as social connectedness and engagement


24
Prevention Services Overview
Focus
Trauma
Depression
Anxiety
Duration of Untreated Psychosis
Suicide Prevention
Services
Skill Building
Education
Training
Building awareness
Consultation
Direct mental health services
Target Population
0-5 and families
High risk populations
Under-served Cultural Communities
Caregivers
First responders
School-aged youth
Transition Age Youth
Immigrants
Educators
County partners
Location
Schools/colleges
Healthcare settings
Health Neighborhoods
Libraries
Parks
Places of Faith
On-line platforms

25

Stigma and Discrimination Reduction (SDR)

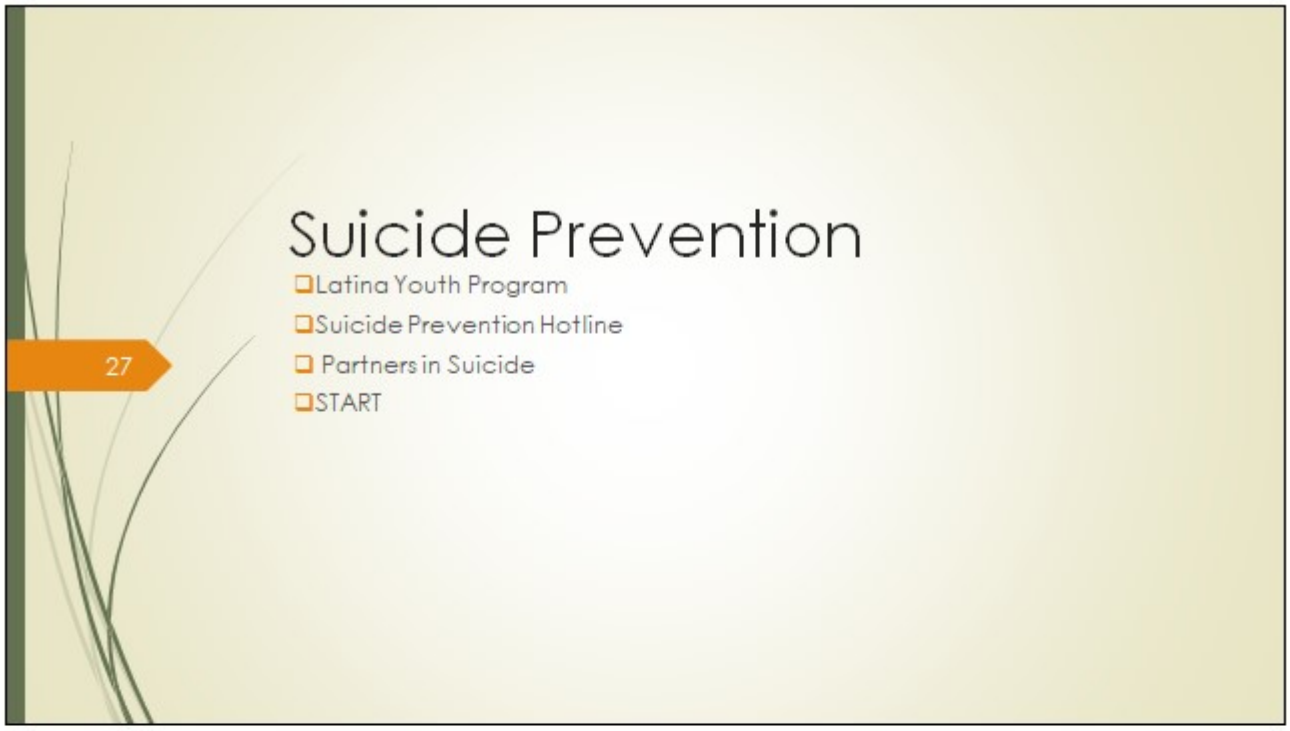
- 72,753 Outreach Contacts
- Mental Health First Aid (MHFA), Older Adults Mental Health Wellness and WhyWeRise Campaign

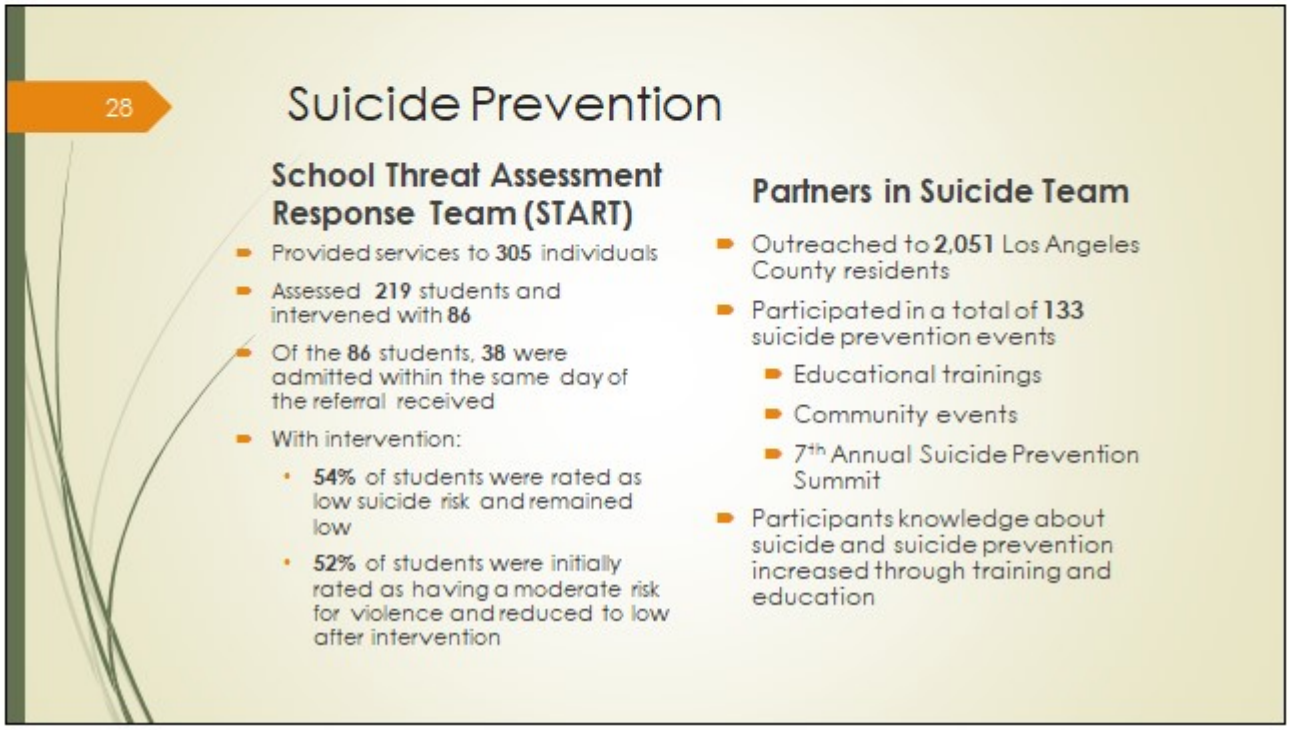
26

SDR: Mental Health Promoters/Promotores Program

- 73 promoters
- 197 community events
- 4,287 presentations conducted
- 37,555 participant contacts

- Helping someone with a mental illness increased to **68%**
- Likeliness to seek mental health services for themselves or a family member increased to **36%**

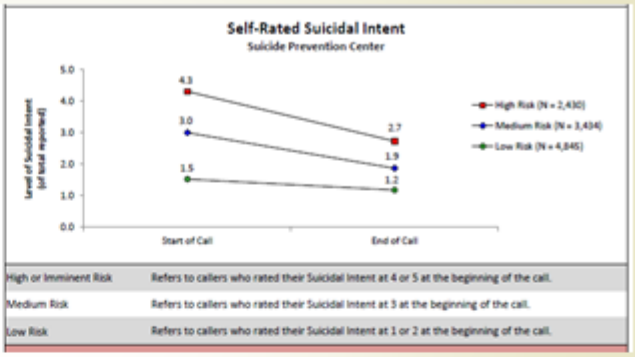

Suicide Prevention
Latina Youth Program
Suicide Prevention Hotline
Partners in Suicide
START
27


28
Suicide Prevention
School Threat Assessment Response Team (START)
Provided services to 305 individuals
Assessed 219 students and intervened with 86
Of the 86 students, 38 were admitted within the same day of the referral received
With intervention:
54% of students were rated as low suicide risk and remained low
52% of students were initially rated as having a moderate risk for violence and reduced to low after intervention
Partners in Suicide Team
Outreached to 2,051 Los Angeles County residents
Participated in a total of 133 suicide prevention events
Educational trainings
Community events
7th Annual Suicide Prevention Summit
Participants knowledge about suicide and suicide prevention increased through training and education

29

Suicide Prevention Hotline

24/7 crisis hotline responded to a total of **99,574** call, charts, and texts, including Spanish-language crisis hotline services to **10,418**



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.

- Callers who rated their suicidal intent as high or imminent risk at the start of the call showed a **59% reduction in their intent by the end of the call.**
- Callers who rated their suicidal intent as medium risk at the start of the call showed a **58% reduction in their intent by the end of the call.**

30

Early Intervention

- 44,212 clients served
- 89% child and TAY
- Focus of Treatment:
  - Depression, Anxiety, Trauma, Severe Behavioral Conduct, and Improving Parenting Skills to Reduce Disruptive Behavior in Children

33

Workforce Education and Training (WET) Stipend Program for Psychologist, MSWs, MFTs and Psychiatric Nurses

- All stipends awarded
- 87 Marriage and Family Therapists (MFTs) students
- 92 Masters in Social Work (MSW) students
- 74% of all recipients identified from populations recognized as un- or under- served
- 70% spoke a threshold language
- 6 post-doctoral fellows were also funded

34

Capital Facilities and Technological Needs

Capital Facilities

- Olive View Medical Center
  - Completion date April 2021
  - 10,000 square feet Mental Health Wellness Center
  - Will provide outpatient services for adult, family and older adult
  - Will include treatment of co-occurring disorders, psychological and vocational assessment services, group and family therapy

Technological Needs

- Digital Workplace: Video Conferencing/Webcasting Expansion
  - Expand webcasting in the Department by using Skype.
  - Goal is to save on travel time and increase productivity.

35

Budget: Community Services and Supports

Programs	Estimated Funding
Full Service Partnerships	$317,021,980
Recovery, Resilience & Reintegration	$217,504,523
Alternative Crisis Services	$83,170,575
Planning Outreach & Engagement	$21,595,085
Linkage Services	$19,771,800
Housing	$40,908,022
Administration	$40,756,009
Total	**$576,727,116**

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Budget: Prevention and Early Intervention

Programs	Estimated Funding
Suicide Prevention	$6,229,745
Stigma Discrimination Reduction	$22,878,000
Prevention	$95,948,754
Early Intervention	$109,214,804
Outreach	$628,663
Administration	$14,166,518
TOTAL	**$249,066,484**

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Budget: Innovation FY 2019-20

Programs	Estimated Funding
Community Capacity Building	$21,000,000
Technology Suite	$6,400,000
Technology Suite 2.0	6,603,971
Mobile Transcranial Magnetic Stimulation	$724,028
Peer Support Specialist Full Service Partnership	$2,454,601
Therapeutic Transportation	$6,807,536
Early Psychosis Learning Health Care Network	$963,740
Ongoing Focused Support for Conservatees Living in the Community	$3,176,500
Administration	$2,145,877
TOTAL	**$50,276,253**

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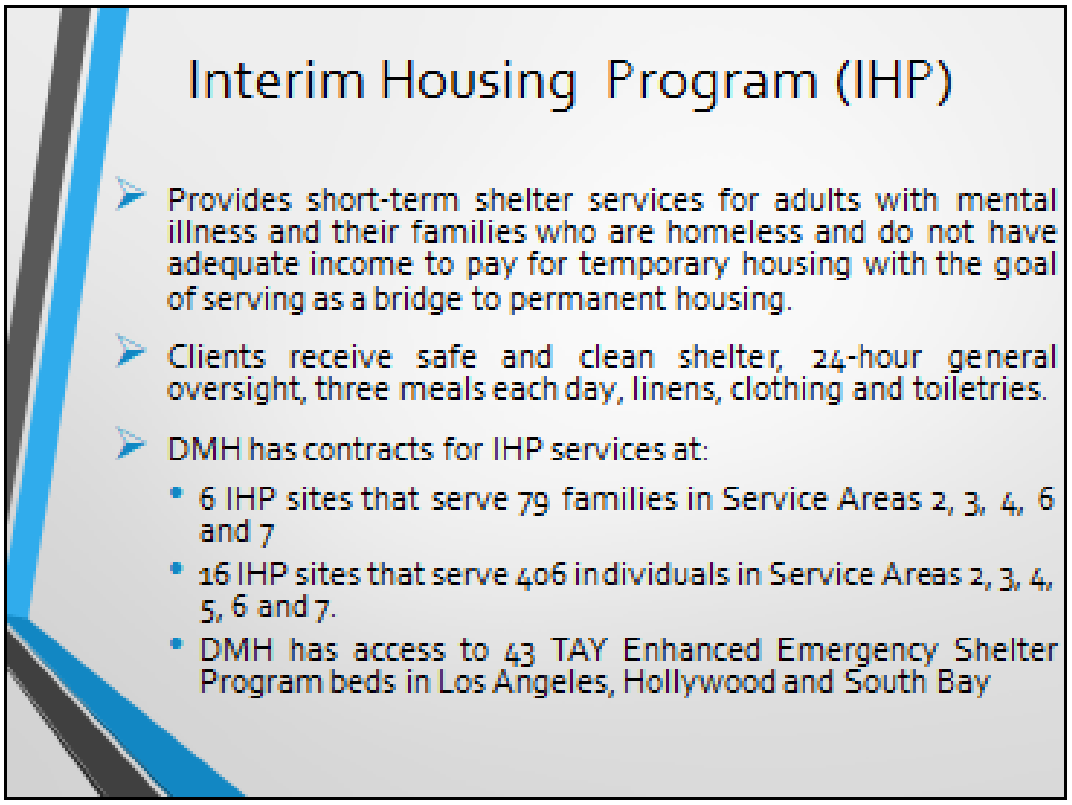
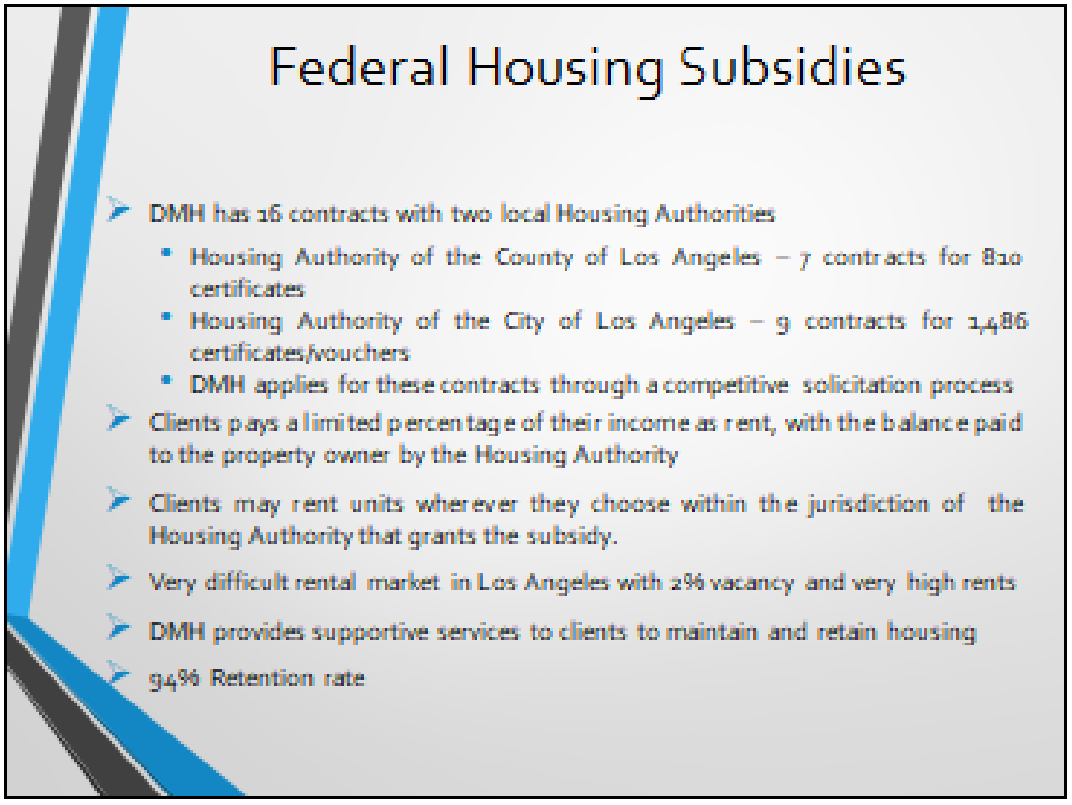
Estimated Budget (in Millions)

	CSS	PEI	INN	WET	CFTN	PR
Prior year unspent $	$254.6	$198.5	$141.8	0	$3.5	$160.7
FY 19/20 $	$448.9	$112.2	$29.5			
Transfers	($30.4)			$21.9	$8.5	
PR transfer	$11.1	$33.1				($44.2)
Available $	$684.2	$343.9	$171.3	$21.9	$12	
Expenditures	$576.7	$249	$50.2	$21.9	$12	
Unspent $ Balance	$107.5	$94.4	$121	0	0	$116.4


DMH Housing Investments
Maria Funk, Ph.D., Chief
Countywide Housing, Employment and Education Resource Development (CHEERD)

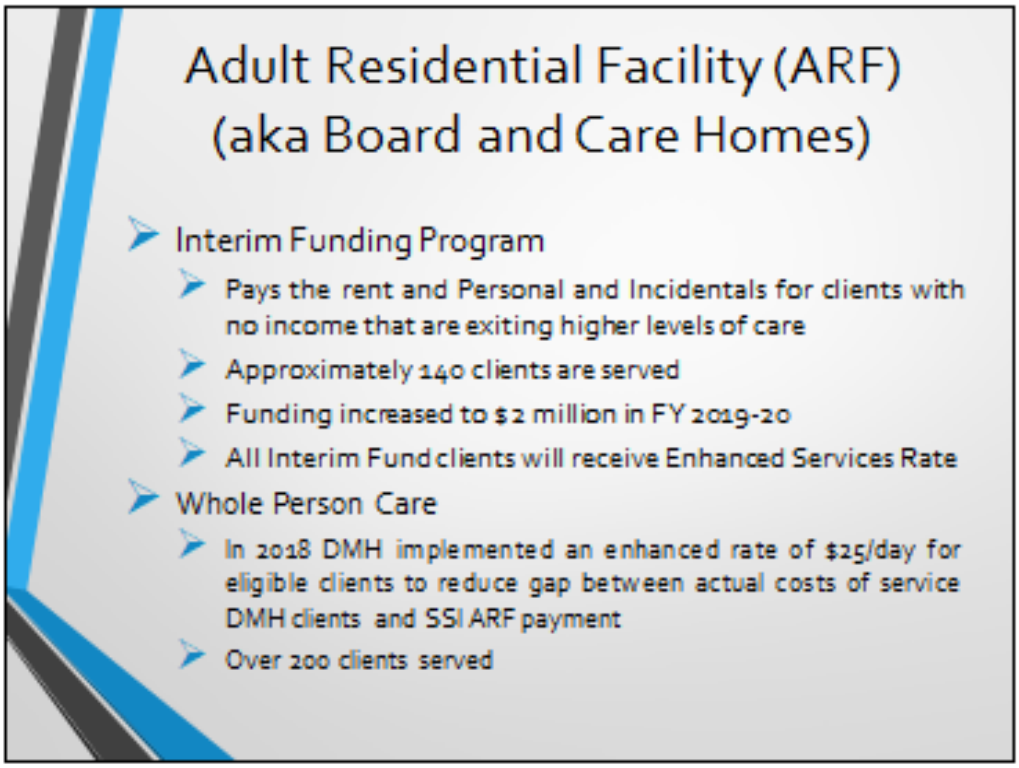

DMH's Approach to Ending Homelessness for our Clients
Develop specialized community-based programs that target the homeless population (e.g., Homeless and Housing FSP, Integrated Mobile Health Team-FSP, Homeless Services Teams, HOME).
Participate in collaborative efforts to end homelessness (County of Los Angeles' Homeless Initiative and Measure H).
Increase DMH's portfolio of housing resources

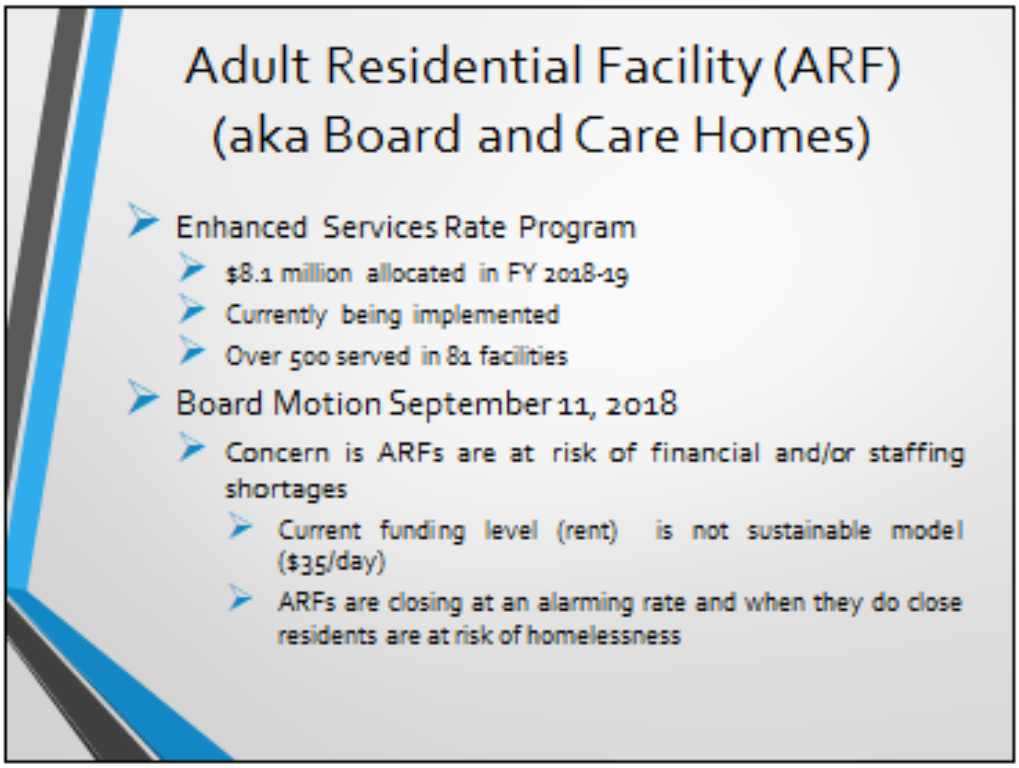

Interim Housing Program (IHP)
Provides short-term shelter services for adults with mental illness and their families who are homeless and do not have adequate income to pay for temporary housing with the goal of serving as a bridge to permanent housing.
Clients receive safe and clean shelter, 24-hour general oversight, three meals each day, linens, clothing and toiletries.
DMH has contracts for IHP services at:
6 IHP sites that serve 79 families in Service Areas 2, 3, 4, 6 and 7
16 IHP sites that serve 406 individuals in Service Areas 2, 3, 4, 5, 6 and 7.
DMH has access to 43 TAY Enhanced Emergency Shelter Program beds in Los Angeles, Hollywood and South Bay

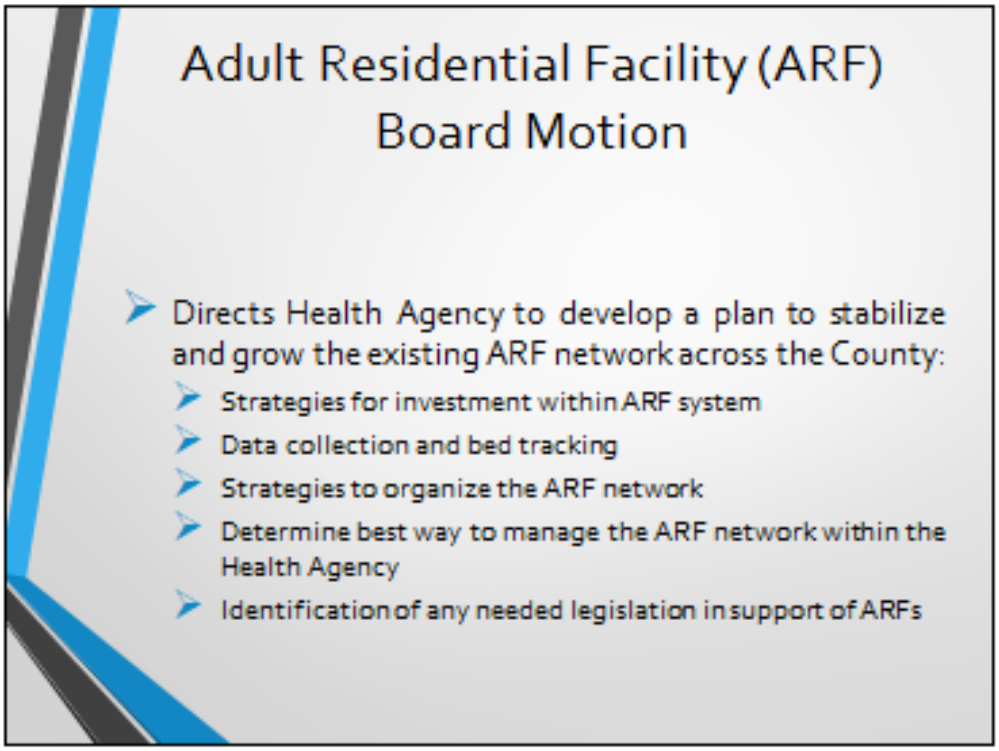

Federal Housing Subsidies
DMH has 16 contracts with two local Housing Authorities
Housing Authority of the County of Los Angeles – 7 contracts for 810 certificates
Housing Authority of the City of Los Angeles – 9 contracts for 1,486 certificates/vouchers
DMH applies for these contracts through a competitive solicitation process
Clients pays a limited percentage of their income as rent, with the balance paid to the property owner by the Housing Authority
Clients may rent units wherever they choose within the jurisdiction of the Housing Authority that grants the subsidy.
Very difficult rental market in Los Angeles with 2% vacancy and very high rents
DMH provides supportive services to clients to maintain and retain housing
94% Retention rate

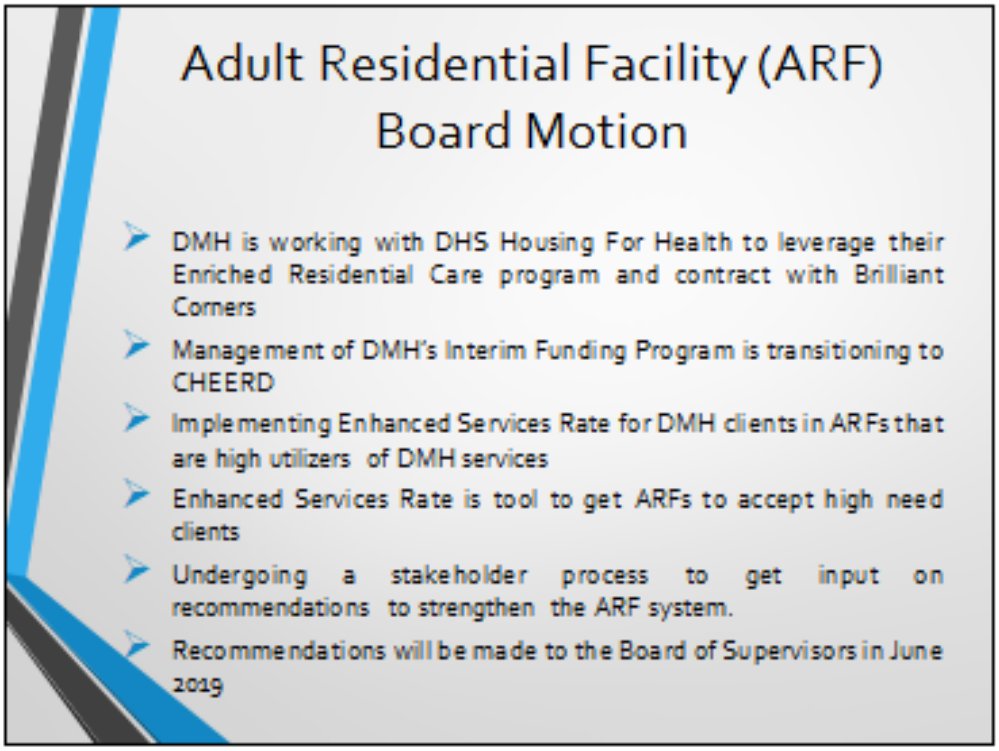

Housing Assistance Program
Provides clients with limited or no income with the funds necessary to move into housing from homelessness or prevent eviction.
Utility Assistance
Eviction Prevention
Security Deposits
Ongoing Rental Assistance (average 10 months)
Household Goods (furniture, housewares, linens and appliances)
$2.2 million in expenditures in FY 2017-18 provided 1,160 households


Adult Residential Facility (ARF)
(aka Board and Care Homes)
ARFs are an important housing resource for those that need care and supervision
Commonly known as Board and Care Homes
Licensed by the State Community Care Licensing
Adult Residential Facilities
Residential Care Facilities for the Elderly


Adult Residential Facility (ARF)
(aka Board and Care Homes)
Interim Funding Program
Pays the rent and Personal and Incidentals for clients with no income that are exiting higher levels of care
Approximately 140 clients are served
Funding increased to $2 million in FY 2019-20
All Interim Fund clients will receive Enhanced Services Rate
Whole Person Care
In 2018 DMH implemented an enhanced rate of $25/day for eligible clients to reduce gap between actual costs of service DMH clients and SSI ARF payment
Over 200 clients served


Adult Residential Facility (ARF)
(aka Board and Care Homes)
Enhanced Services Rate Program
$8.1 million allocated in FY 2018-19
Currently being implemented
Over 500 served in 81 facilities
Board Motion September 11, 2018
Concern is ARFs are at risk of financial and/or staffing shortages
Current funding level (rent) is not sustainable model ($35/day)
ARFs are closing at an alarming rate and when they do close residents are at risk of homelessness


Adult Residential Facility (ARF) Board Motion
Directs Health Agency to develop a plan to stabilize and grow the existing ARF network across the County:
Strategies for investment within ARF system
Data collection and bed tracking
Strategies to organize the ARF network
Determine best way to manage the ARF network within the Health Agency
Identification of any needed legislation in support of ARFs


Adult Residential Facility (ARF) Board Motion
DMH is working with DHS Housing For Health to leverage their Enriched Residential Care program and contract with Brilliant Corners
Management of DMH's Interim Funding Program is transitioning to CHEERD
Implementing Enhanced Services Rate for DMH clients in ARFs that are high utilizers of DMH services
Enhanced Services Rate is tool to get ARFs to accept high need clients
Undergoing a stakeholder process to get input on recommendations to strengthen the ARF system.
Recommendations will be made to the Board of Supervisors in June 2019

MHSA Funded
Capital Development of Permanent Supportive Housing (PSH)

- Provides capital and operating funds for the development of PSH for individuals and their families with a serious mental illness
- DMH currently partnering with 28 developers of PSH
- Developments target transition-age youth, adults, older adults and families and are in every Service Area and Supervisorial District
- Mental health and case management services are provided to clients living in MHSA-funded units through an integrated team that includes staff from the following programs:
  - DMH's Housing Full Service Partnership (FSP)
  - DHS's Intensive Case Management Services (ICMS)
  - DPH Substance Abuse Prevention and Control's Client Engagement and Navigation Services (CENS)

MHSA-Funded Capital Development of PSH

ALLOCATION OF MHSA FUNDING
2008 - Present

Allocation	Capital Development	Use of Funds	Underwriter
$18.75 Million	Mental Health Housing Program	Alternative Housing Model	CDC*
$15 Million	Mental Health Housing Program	Capital/Veterans Only	
$81.25 Million	Mental Health Housing Program	Capital	
$155 Million	Special Needs Housing Program	Capital/ Operating Subsidy	CALHFA**
	MHSA Housing Program		
$270 Million	**= Total Allocation**		

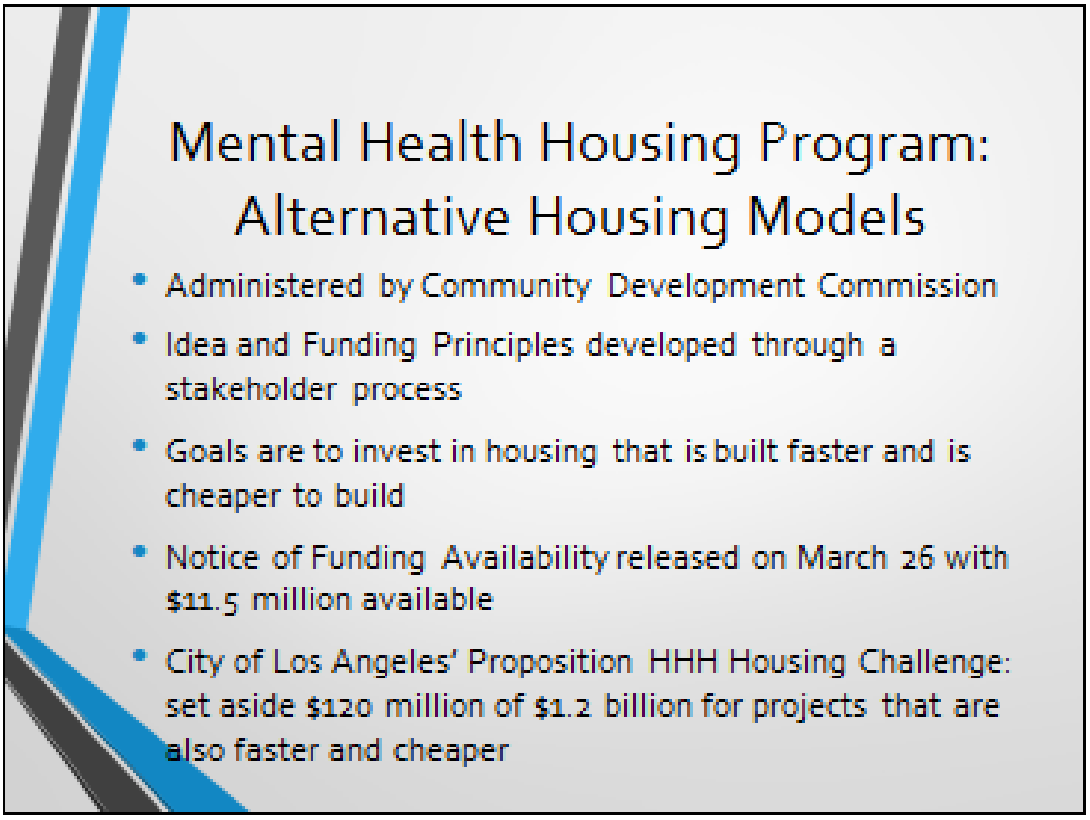
* Los Angeles County Community Development Commission
** California Housing Finance Agency

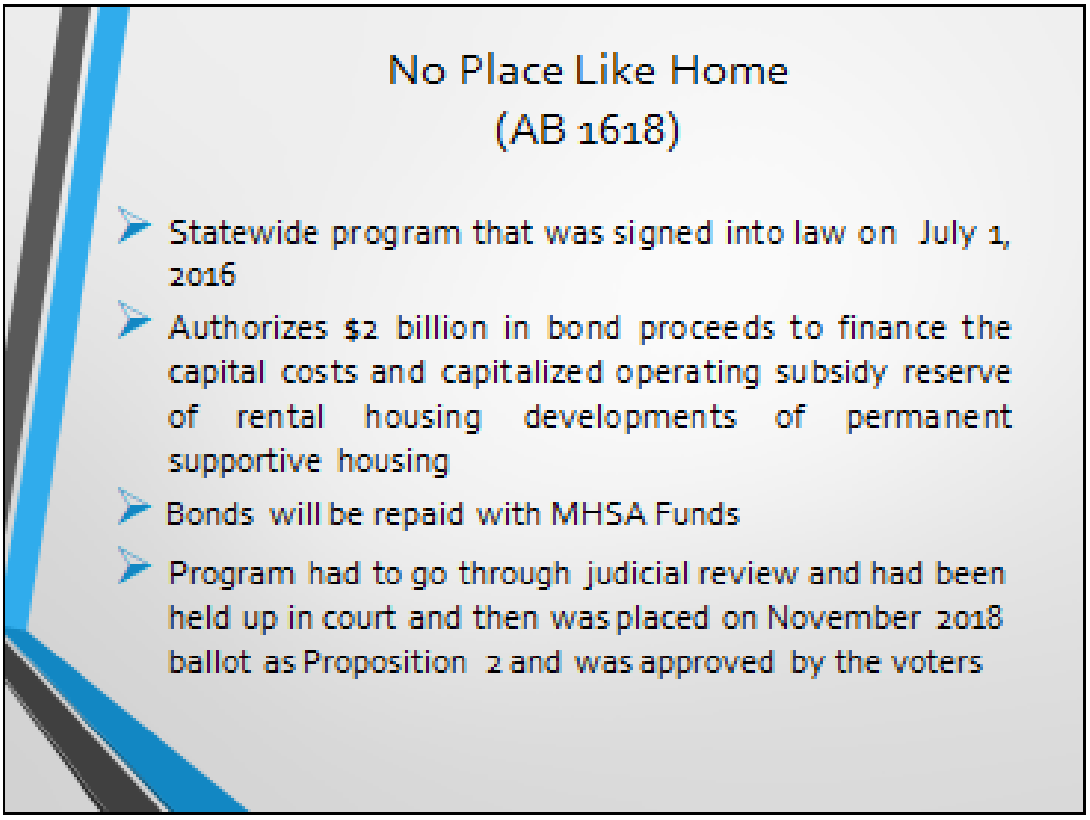
MHSA-Funded Capital Development of PSH

MHSA-FUNDED UNITS – OCCUPIED AND IN PIPELINE (as of 9/1/18)		
Target Population	**Number of Developments**	**Number of Units**
Transition Age Youth	13	167
Adults	30	615
Older Adults	12	250
Families	15	407
Total	**70**	**1,439**

MHSA-Funded Capital Development of PSH

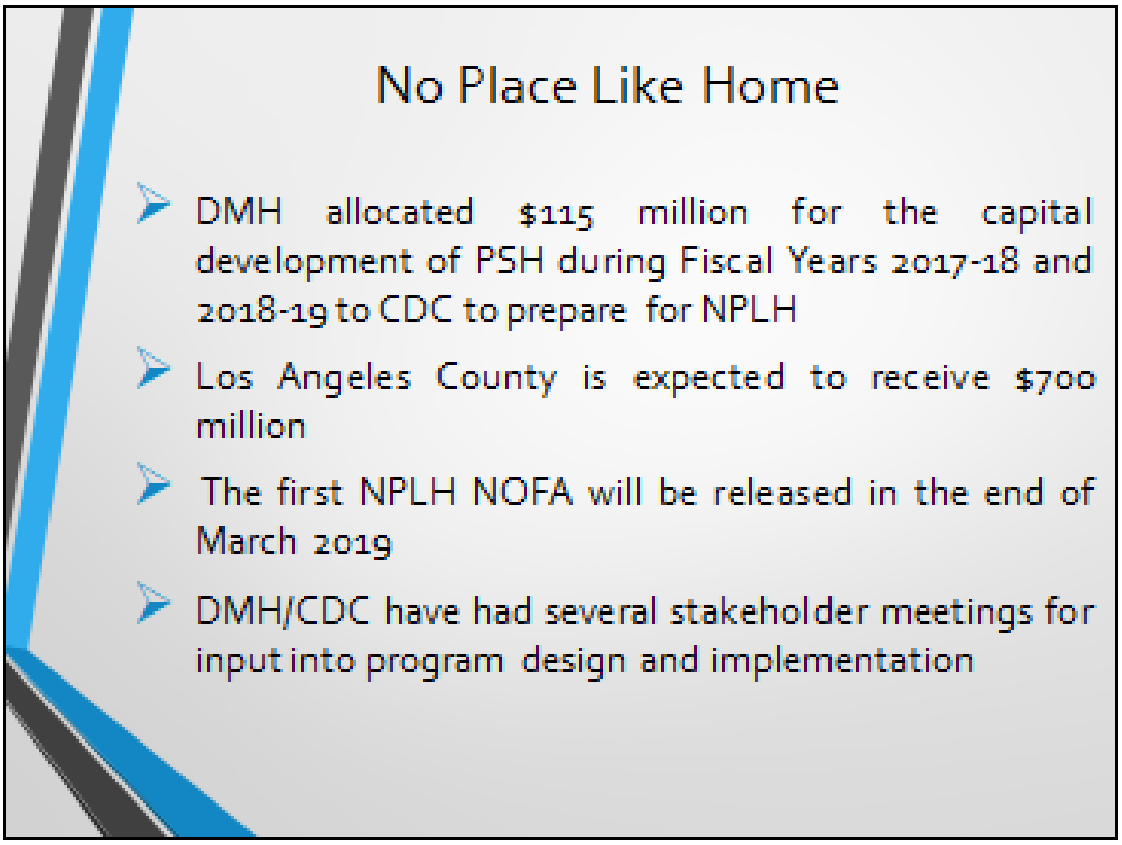
OCCUPIED MHSA-FUNDED UNITS BY SERVICE AREA (as of 9/1/18)		
Service Areas	**Number of Developments**	**Number of Units**
1	1	12
2	9	216
3	1	10
4	11	328
5	3	44
6	6	122
7	1	15
8	5	90
Total	**37**	**837**


Mental Health Housing Program:
Alternative Housing Models
Administered by Community Development Commission
Idea and Funding Principles developed through a stakeholder process
Goals are to invest in housing that is built faster and is cheaper to build
Notice of Funding Availability released on March 26 with $11.5 million available
City of Los Angeles' Proposition HHH Housing Challenge: set aside $120 million of $1.2 billion for projects that are also faster and cheaper


No Place Like Home
(AB 1618)
Statewide program that was signed into law on July 1, 2016
Authorizes $2 billion in bond proceeds to finance the capital costs and capitalized operating subsidy reserve of rental housing developments of permanent supportive housing
Bonds will be repaid with MHSA Funds
Program had to go through judicial review and had been held up in court and then was placed on November 2018 ballot as Proposition 2 and was approved by the voters


No Place Like Home
Target Population
Homeless
Chronically homeless
At risk of chronic homelessness is defined as:
Persons exiting institutions that were homeless prior to entering the institution.
Transition-age youth experiencing homelessness or with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system
Adults living with a diagnosis of Serious Mental Illness or children or adolescents with a Serious Emotional Disturbance


No Place Like Home
Program administered by California Department of Housing and Community Development
Counties with over 5 % of the state's homeless population can apply to be an Alternative Process County which allows them to administer the funds locally
With support of the Board of Supervisors, Los Angeles applied to be an Alternative Process County with funds to be jointly administered by Los Angeles County's Community Development Commission and DMH


No Place Like Home
DMH allocated $115 million for the capital development of PSH during Fiscal Years 2017-18 and 2018-19 to CDC to prepare for NPLH
Los Angeles County is expected to receive $700 million
The first NPLH NOFA will be released in the end of March 2019
DMH/CDC have had several stakeholder meetings for input into program design and implementation

L.A. COUNTY DEPARTMENT OF MENTAL HEALTH – MHSA PUBLIC HEARING (Q&A)
LOS ANGELES, CA
3/28/19
TRANSCRIPTION

HEARING COMMENCED AT 11:40 A.M. FIRST QUESTION AND ANSWER PERIOD BEGAN AT 12:30 PM.

Welcome and presentations from Dr. Bonds (Key Clinical Operations), Dr. Funk (housing investments) and from Ms. Gilbert (prevention efforts in schools).

AUDIENCE MEMBER: Good afternoon. My name is Barbara Wilson. I just have a quick question about board and care homes reimbursement. When we have a resident, who is placed in a licensed board and care home on interim funds or some other kind of funding. Once the client is approved for Social Security disability, or SSI, is -- what is the proper protocol if any for the department to get reimbursed for the money that they have expended? Is that just free money? And I have a client now that is in that situation.

Mark Funk: There is a form that people fill out when they apply for Social Security that repays the departments that are helping pay for their rent. Generally, the Department of Public Social Services gets paid first and then another department like DMH if we were paying that we would be paid second. We actually do not get that much funding back.
Under the homeless initiative the County has been looking more at that and been working together as a county to determine which departments should be kind of in-line to first and second and third to get the funding back.

AUDIENCE MEMBER: If my client is prepared to pay the money back but I've had real trouble trying it find out who to talk to get it done.

MARIA FUNK, Ph.D.: Can we talk off-line Barbara, let me get the details and I'll get back to you.

JONATHAN SHERIN, M.D.: Thanks Barbara I mean for me the big issue request MHSA money is we're trying to figure out how to use MHSA money to try to improve the conditions in the existing network to correct the business model and to expand board and cares across Los Angeles County.

AUDIENCE MEMBER: Thank you for all the work that you're doing I'd really like to recognize the just the fact isn't that there's been a great deal of improvement I can see in the last just couple of years since you've and on board so I thank you. Dr. Funk I wanted to acknowledge you made the comment about the resources that are available when people move into their facilities and that. I just wanted to let you know that if there's any possibility that you can look into maybe another alternative person that you get those from, the resources really are for the money that you're paying, they're not good.
Secondly I just wanted to say, it would really be wonderful that we look into making the more diverse population of people who with lived experience who are advocating and including part of your commission that were also looking to make sure that these monies are being allocated to support people with compensation, and that also as we're talking about empowering people with lived experiences that we're looking at the whole person and their whole needs when it comes to housing and living in public housing and sometimes the intersection of public housing and being penalized while you're trying to be empowered are working, you know, they're not working together. People, you know, on GR or SSI often times can be penalized for just, you know, getting an extra dollar, maybe even a threat of losing their housing so we really need to work as far as legislation that helps support the needs of people with lived experience to empower them to continue to move up and not penalizing them for making an extra buck or two, here and there. Thank you.

AUDIENCE MEMBER: Hi I was wondering because of these new housing and school programs you mentioned are going to be contacting a whole new segment of consumers so I'm wondering how are you going get these consumers involved in the stakeholder planning process? Because they are very underrepresented at these meetings.

JONATHAN SHERIN, M.D.: As Maria said we actually have been trying tried to be pretty aggressive in getting together a group to do exactly that. We have a housing advisory group that we meet with to talk about how the monies are being used.
That's how the alternative housing model and themes were developed, and what we're using to guide our relationship with the CDC. And if there are people that want to be involved that don't know about that, let us know.

AUDIENCE MEMBER: Hi – What is CDC?

JONATHAN SHERIN, M.D.: Community Development Commission.

AUDIENCE MEMBER: I was wondering, if we were going to have the privilege of having housing for people who have emotional problems or mental health problems, that is it would be a good idea if it's possible to have a psychiatrist and a therapist, those two things, and the building of the housing complex, this way people.

JONATHAN SHERIN, M.D.: The question was when we have housing wouldn't it be great to have in-services kind of built in to the program to the facility. I think in some areas we do that and when you talk about board and cares that's something we want to have done and want to do better. I wanted to push as much of our services out into the community as we can. One of the things that in I think in county and in bureaucracy is we talk about is oh we want to build a new program we want to hire all is this staff and where are we going to put them? And I want to say no it's not about our square footage, there's a lot of square footage in L.A. County, let's use it.
MARIA FUNK, Ph.D.: Can I add we agree that's really important and when we started our housing FSP those staff are at the housing that is where they work and it does include the licensed clinical staff, and psychiatry services. So, if the services such as psychiatrists are not able to go there then the staff will take you to the psychiatrist but our model and goal is to have them come to you and the rest of the staff are definitely on-site so thank you for that.

AUDIENCE MEMBER: My name is Tiffany Duverney Smith and during the housing presentation, adult residential facilities were mentioned and at present, the State of California reimburses facilities at the rate of $35 per resident, per day and it's not enough to provide adequate care and maintenance of these facilities. So, adults who suffer from serious mental illness end up losing their homes and care, and in many cases, they become homeless incarcerated, and hospitalized is so I'm supporting Barbara Wilson who had the microphone not too long ago. She has a petition that we can all sign if we are registered voters and it's to support an increase in the rate of reimbursement to licensed adult residential facilities who serve people with severe mental illness.

JONATHAN SHERIN, M.D.: Thanks for that I think we're all aligned on that and a petition would be great we'll bring it up to the state and there is a spot bill that was created to deal with this issue.

AUDIENCE MEMBER: My name is (inaudible), and I've immensely from department -- DMH, from DMH and full services partnership and I was on Skid Row. I end up benefiting at South Los Angeles mental health. I would like for you guys to invest more in peer advocates, and people that you have trained because I've -- I have every certificate that you guys offer. And, I plan -- well I've started my own organization and I like to do outreach and I'd also like for you to require that the people that you have on staff that are previously homeless have ongoing therapy. Because I've had people -- because of my passion, send me nasty emails stalking me, and also sorts of things and when I look on their profile if says DMH, with no shirt on. I think we need to regulate some of their employees more, as well as oversight for these agencies because I went to hot (inaudible) because my employment was cut off and I asked for help. And do you know they had me leave out the reason why I needed help? And then they wrote in whatever they wanted and denied me. I've heard so many complaints about hot -- when I talk to people on the streets, because I (inaudible) they tell me how they were mistreated. And I'm tired of it. I don't want to hear, I want something done, I want some oversight because my people are dying. And not only are they dying, they're dying outside my back door because I live where an encampment is.

JONATHAN SHERIN, M.D.: Just with respect to the peer workforce which I was talking about earlier in this bill SB10 and the addition of Paris Meyer on to our leadership attempt, we take this very seriously. When we want to say is, we're trying to build a pipeline, recruit, hire, deploy and continue to support those with lived experience who are doing work all over Los Angeles County and, that we would assume that that would be a part of it that's built into our plan.
I would say across the different disciplines but certainly with the peer workforce which will be new and will be expanding I think in a significant way.

AUDIENCE MEMBER: I'm Kevin White from the San Fernando Community Mental Health Center, I have a question with regard to housing developments particularly for the burgeoning aging population the seniors who are on fixed incomes. And, who are -- have specific mental health diagnoses, I was wondering in the pipeline are there plans for more housing development specifically for this demographic? Not only are they on a fixed income but because of the disability, they're limited in earning income and along with other renters in the L.A. County market are being priced out with no options to go. So, with all of the housing development that is being planned and I'm specifically service spa into it -- I'm wondering how many of those (inaudible) are being set aside for seniors. And the oncoming seniors?

JONATHAN SHERIN, M.D.: We're all on our way, right? Um ... it's a great question, you know, and whether it's by service area or supervisorial district or age group or diagnosis this is a point of contention across the board. One of the things that I don't think we do a great job with is assessing need in an objective way and having that need drive our deployment of resource. Those are things that we're working on, and we're working on them not just in isolation as one department but across the departments with a CEO. We would certainly hope that we're going to be deploying resources, geographically and population-wise in a way that meets the need as best we can.
The unfortunate thing is I don't think -- you know, there's a massive number of people who have housing stability issues and who have a mental health challenges and dictionaries, challenges, and we have I believe we have a way to go as a steward to meet needs depending on where the priorities are. So, we -- we're aware of what you're describing, we're trying our best to figure out how to deploy things in the most fair and objective way.

And so, what can we do to do something now? For mothers with children which is one of the questions that I have for you.

AUDIENCE MEMBER: First, I wanted to tell you guys -- because I didn't believe in MHSA in the beginning when I first saw and they were publicizing it. I was probably the No. 1 person against it. But, after sitting here today and being in your last meeting that I was at, I'm, it I've changed my mind. I think that you guys are onto some very good ideas on how we can take care of our communities here, I see the passion that many of you on the board have. And I just commend you for that and that's hard for me to say because I never think that I'm wrong. I just wanted to say you guys are doing a great job but what we have are some very immediate problems that I'm kind of faced with on a daily basis. I am one of our persons that's on the street from Skid Row to San Pedro to Santa Ana, it doesn't matter wherever there's homeless people or people in need, God just kind of points me in that direction and I like to be there but what I'm finding now is I have mothers with children that have mental issues and some of these mothers have six kids, some have ten, some have four. I'm getting these calls because I have a program that says we have housing for mothers with children. But it's taken me a week, sometimes two weeks to get these families off the streets.

And then, secondly, you know there's a short window when we're dealing with people under substance abuse. If someone calls me and says hey pastor, I'm ready, I'm ready to get off the streets. But if I don't have a bed for them, and a place for them to go at that moment then -- I can call them back in 15 minutes later and that I say oh pastor it's too late I already got high. So, I know you guys are doing a great job. But is there some sort of funding that we can work with, some of the people who are currently doing great jobs with the people that they get in helping them to get off of drugs and/or substance abuse or just whatever their problem is, is there a way that we can have beds available for them on a now basis? Because we have a now problem and I know you guys are working on it but, I'm saying right now, today, when I leave out of here, I need 100 beds.
Is there something we can do about that?

MARIA FUNK, Ph.D.: So regarding your first question about families with minor children, I can say that with Measure H there's been a lot of conversation and the Board of Directors is very concerned because just in a year we've seen a doubling of families that are homeless with minor children so there's been a lot of conversation about increasing resources, increasing immediate resources, help people get off the streets.
We've had on to use motels because we don't have enough interim housing for families like you said we don't want people to be on the streets for two weeks like you were saying, your experience has been while trying to find a -- funding recommendations for 2020 there will be an increase in funding for prevention with families of $5 million and we're also looking at increasing interim housing so we can accommodate more families.
There's a workgroup going on right now translated a board motion related to families and trying to increase resources and strategies and recommendations that will go back to the board to address this very issue on so it's very concerning, we agree and the county overall is trying to increase access for resources for families to help them get off the streets.

JONATHAN SHERIN, M.D.: One of the areas that I think we as a county report adequately invested in is the faith-based community as a place to provide short-term solutions and immediate near-term. I go to town halls frequently and people are saying get them off of my street, I can't go out to the park with my kid. .The issue is it's a collective problem so it's got to be a collective solution. We have to get neighborhoods and people in the business sector to get involved and take ownership of a much larger challenge. NIMBY is a powerful, powerful force. And, you know, a part of it is education and kind of the ignorance of not knowing how to participate. But we have to get people to share ownership of our societal challenges in order for us to succeed. As you know we look for areas where we're not adequately leveraged and I would say the faith-based community is one of them. We have to implore you know our communities, our citizens, our people that are living here for whatever reason, to be a part of the solution.

AUDIENCE MEMBER: Hello, thank you, I want to thank everybody that has come here today. And especially some of the guest speakers who have spoken. I'd like to talk in regard to the teen suicidal rate. As one of the gentlemen speakers had mentioned before -- sorry ... teens are left to lay on gurneys and wards for two days.

There's no place for them.

And this is ridiculous. There's a definite need in Antelope Valley to have facilities for the teens. This is not an option. There are plenty of locations -- we've got San Fernando Valley, we've got Antelope Valley, we have -- these teens are left on gurneys they're just like veggies. The places they send them to are far away, they're remote, the closest one was Chino, the worst was Del Amo Torrance regional center, and once they are released, DCFS does come by, they see what looks to being to be a perfect family, perfect home. All good, this is has got to be stopped there's got to be some follow-up by psychiatrists. This is not optional, this has to be mandatory somehow because if you were in the family court system, this would not be optional. You would have to attend; the child would have to attend. Insurance loopholes need to be stopped. I know for a fact that once this person attempted suicide four times, insurance said you have to wait four months until your next insurance kicks in. This child suffered. I want to tell you very much thank you, thank you for starting to implement the START program, the School Threat Assessment Response Team program. This has to go out to Antelope Valley, not just L.A. County. This has to be in cooperation with teachers, principals -- I know many of them in the Little Rock area are anxious to help. The other thing is we have a plenty of land out there. If you have to do eminent domain, do that. You have to get facilities for our teens.

CURLEY BONDS, M.D.: Thank you so much for your comments, the passion shows through in your voice. And I'll let you know that there has not been a stakeholder meeting that's county-wide that I've been to where Antelope Valley hasn't come up and certainly, I realize that we need to do more. And it is on our radar trying to get urgent care centers set up there, trying it get more resources there and as you mentioned, all the psychiatrists although they're not the only specialists it's very difficult because there's a nationwide shortage of them but we do have incentives to try to recruit people to that area.

We've also done some other things in terms of trying to increase our number of psychiatrists overall but until we get more, we're working to connect them using Telepsychiatry, we do have a chief of psychiatry Dr. Ruskin who's so we can provide help -- even if the we've learned that Telepsychiatry is a nice option that can be equal in terms of outcomes. But, when you mention the other services, I think we're changing our approach to things we've been very centralized but starting next month our leadership team will be visiting each of the service areas on the Mondays in April to hear directly from the provide providers and those who are doing the services there where the gaps because they know, they're with you, and with we can't solve everything from sitting in our offices at headquarters so we're going to be in the streets, in the trenches listening to what's going on so we hear more of this. To quote Dr. Sherin earlier, nimbyism is a very powerful force and we're all preaching to the choir, we know where all the gaps are but we need to be at those meetings where people are saying we don't want a sheltered, we don't want a resource or respite -- I just want to make one last comment as I sit here I'm listing all the different groups that have said we need more. There are older adults, there are teens, there are mothers with children, there are those with substance abuse problems -- I just wanted to be careful that set asides in general can make advocates come out.

We just need to make sure that the mental health is the thing that links all of these groups together and I think if we provide services for that then we won't run into fights with each other because everybody has their own, I guess you can call it pent group that they want to support so I think we need to think strongly and carefully how do we unite all of these services together underneath the umbrella that are disenfranchised and incentivized by illnesses that they did not choose to have.

JONATHAN SHERIN, M.D.: I think there's two more public comments and then we're going to move onto Debbie and there will be another period after Debbie speaks.

AUDIENCE MEMBER: Hi that was actually a perfect segue, my name is Tiffany and I'm here to go both on the record with an invitation and concern. I emancipated out of the foster care system where I was born to a schizophrenic mother, I was raised in a neighborhood and under circumstances to where the only therapy that I seen was the court mandated therapy that they forced me to while in care which was not a good or pleasant experience. I grew up in a neighborhood where the stigma attached to even wanting to get help implied that you were weak or that there was something wrong with you. It was a proclamation that there was something wrong instead of an investment in yourself. I had a personal journey of realizing that I spent 31 years of my life bootstrapping my trauma, succeeding my way away from my pain and with this realization that when I made it to my successful peak on the outside, there were some things on the inside that had not been dealt with that had not been faced and there's no way that I should have revert to the trauma of being a child when I'm a grown woman.
So, what came out of that, thank you all, what came out of that -- personal experience, it developed organically into a campaign. For me it take responsibility not just for my own mental health, physical health, emotional health but those of my community to let them see that if they look up to me that I can be the first commission tore come out of foster care and sit on the commission for children and families despite my schizophrenic mother, despite being raised in the projects, despite all those different things that they can too.

So, my invitation is for you all to partner with me as we with scale up what has been a community campaign, just by me sharing my personal narrative I have seven young people that have already engaged me in how do I sign up for therapy where do I go? I'm scaling that up to be a social media campaign, to recruit other individuals like myself to be on the frontline sharing that narrative and it sounds like it may also be a solution to some of the other concerns that -- how do we incorporate our stakeholders into that process? I have an opportunity and solution to do that and I'd love a chance to pitch it to somebody. Beyond that my concern is when we all line up and we and with our new people who are now open to this, what will they get when they get there?
Do we get the same therapist who scarred me when I was a child by telling the story of my molestation to my social worker who, chose not to open up to her it would be my fault this person molested somebody else? Which only re-traumatized me?
Will they get the intern training this they got like I got when I was 19 years old my grand her had just died my whole life was falling apart and I took the courageous decision to sign up for therapy? And it was a horrible experience.
I'm 31 now, barely building up the currently to go back. How do we scale up as a team and ensure that while we're bringing those people here they would get the same care you would receive if you needed therapy and that you would he send your children to because not one of your children would ever walk into one of these facilities that we get but the reality is we are just as deserving, if not more. While this campaign is not limited to ... while this paint is about limited to foster youth people of color, people in urban communities the reality is we have to lift up the least among us first and every single person in this room can benefit from some therapy and support and everything else so thou do we change is that stigma instead of condemning ourselves we're promoting posit and praising people for going to do that? So, I have an idea, I don't know who to talk is to about it, I would love to partner with you all and also any individual in the community that would like to be part of this I'm talking to you too.

AUDIENCE MEMBER: My name Rick Pulido I'm a parent advocate and -- also an educational coordinator here in the community organizing for the grassroots. I just want to thank you for the DMH for the Mesa update, Dr. Sherin right on time all of our commission exercise all these great folks here especially the peers are the ones are most deepest needs that you heard today folks. Couple of things I wanted to bring up and I think would be very beneficial. First of all, we do need a UCC so please and our shelters also but please consider that regardless of what you may think we do need an urgent care out in the SAAC 7 area. I'd also like to propose an MOU be made up by the county if you could for the parks and this is Kalene's point, the parks, libraries and schools -- we utilize those now and if we had an MOU it would be a lot easier to go to the libraries, specifically in the parks, because there's that notion of oh gosh, mental illness got to get back to you Rick our supervisor's got to review it, da-da-da so if there's a way we can collaborate that for the non-profits we would be way out of the ahead of the game.

Also, the one-stop shop that Dr. Sherin's been talking about for years now the board and cares, I believe that through the FSP and through the lady who's talking Maria about the housing we do have the A -- on the job trainings for peers right is there at the locations. They need to be able to -- OJT means on-the-job training, old -- very bill got me one of my first jobs in the City of Los Angeles. What it does is it gives me an opportunity, entry level, to let our folks get jobs. .Our peers like my son and all of us families here today, need an opportunity to be in the workplace. .Give them that shot and believe me, that is the key to them being successful as well as the housing in and the shelters. So lastly, thank you, lastly, I think the -- with Dr. Sherin is doing is excellent with the 550s building with the resource center. That peer resource center there should be one in he every SAAC area, now. We need them. We love them, keep up the good work, God bless you and go Dodgers.

AUDIENCE MEMBER: My name is Deborah Rogers and I'm going it take you back to the Antelope Valley. The Antelope Valley has a total of 100 beds in two different facilities. Now we're talking about an area that is like L.A., Little Rock, Lancaster, Palmdale, Quartz Hill, Roseland a very large geographical area that is a lot more populated than you down here in the urban area believe.
Our homeless shelters often deny the most mentally ill, beds. Because there's some (inaudible) will disrupt the other people in the shelter. We have had nine deaths in the last ten months. One of those people was actually in a shelter. He was a diabetic who was not allowed to even have individually wrapped packages of peanut butter crackers for his diabetes and died as a result of his diabetes in the shelter. The high amount of people that are homeless in this area, in our area, are drug abusers. Most of them are self-medicating. They have a mental illness. In order, though, to get into one of the few treatment facilities we have they must test and be clean at the time of entry, otherwise they are turned away. If you are home and as you are self-medicating, you are not going to be clean. And so, you are denied a substance abuse treatment bag. The mental -- the mental illness treatment, the mental health treatment that's given in these drug treatment facilities is minimum at best.They will assign you to a psychiatrist. He'll give you some medication. You'll see a therapist, really once every two months. If the medication isn't adequate, you still have to wait until three months to address that psychiatrist again. In your paper I read here under ... capital development, of permanent supportive housing. Your last bullet was about DPH substance abuse prevention control. That is the only place substance abuse was mentioned. Substance abuse is one of the main causes of homelessness, among the mentally ill because they are self-medicating. If the substance abuse is not addressed, and mind you I worked in this field for eight years -- if the substance abuse is not addressed, the mental illness will never be addressed because they will not take medications. They will not make therapy appointments. They will not leave the streets where the drugs are readily available to them. Substance abuse among our mentally ill homeless has to be a priority. Beds that allow the mentally ill in regardless of their symptomology, have to be a priority.

AUDIENCE MEMBER: Handout out to the advocates!

JONATHAN SHERIN, M.D.: Okay, thank you for all those very important points.
We're now at a point in the program where we're going to have Dr. Debbie Innes-Gomberg to come up to speak to us about a number of programs and go through a number of slides. And, I just -- before she does, I just want to recognized Debbie for all the work that she's done for this department, for her expertise which is recognized statewide around MHSA, it's the programming, the funding, the regulations, the stakeholder process. I think that Debbie's contributions to this county is really unparalleled in this arena. And after Debbie speaks, we'll be able to have additional public comments. So, Debbie come up here and accept a big round of applause.

DEBBIE INNES-GOMBERG, PH.D. Presented a high level overview of the Annual Update in the form of slides. Questions and answers resumed at 1:29 pm.

AUDIENCE MEMBER: Hi my name is Sabrina and I'm with South Bay. My question is, is the County, someone from County at that meeting yesterday mentioned that FCCS was transitioning I guess out of RRR but I guess when you spoke at our meeting, at our general meeting sometime like I can't remember which month but I thought that it was already phased out. Also, I wanted to know is SB182 what's its new title if we don't have that anymore?
DEBBIE INNES-GOMBERG, Ph.D.: The SB82 program is actually the Home program now and that's what Dr. Bonds was speaking of. Our first allocation of SB 82 funds expired and we are now funding it with MHSA. In terms of field capable clinical services or FCCS, you're right, we did phase it out a couple years ago and basically under Recovery Resilience, Reintegration, or triple RRR, that there's an option there to provide services where the client needs it so either in the field and in the clinic or in a variety of other settings.

AUDIENCE MEMBER: Hi I'm Peter M I wasn't diagnosed with autism until I was about 30 years old. So, I never knew, and as far as suicide prevention I did that one time in my apartment. There was another time I started feeling that way a couple times and I turned myself into the mission community hospital behavioral services. But I started to have suicidal thoughts by the time I was 16 years old and when I see and hear about all these mass shootings, sometimes people and as their family is to blame because sometimes the family doesn't believe in mental health or they can't afford it and then we wonder why shootings happen in the school. Is because there's a lot of bullying.
There's a lot of money out there but when I've gone to school in poor areas, I don't receive much of that money being spread around. And that's what usually leads to crime and robbery, rape, stealing, in a lot of poor areas. They're quick to put a liquor store, they're quick to allow weed shop there, but, where are the boys and girls club, after-school specials we need. Like in Detroit they had complaints that there were rats and mold and a lot of the schools, they're overcrowded.

What are we doing? If we say we want a better future then we better start allowing the ones that are going to be the next governors, the next CEOs to give them a better opportunity because I was walking and I live near Nordhoff and Van Nuys and since I've been living there, for the first time in I don't know how many years, they were -- I've been to Sepulveda the rich part there's a moment where they need a remodeling or need the streets fixed or there's been a hit-and-run, the ambulances show up but when I see it on the news where someone gets hit-and-run and they're just left there to die so what are you guys going to do about that? I know it's not very possible but we've got to do it, these are the people of our future.

If we say we want to improve schools and homelessness, then it's necessary to step up there and actually share the wealth, not only in areas where there's rich people but where it's where there's a lot of high crime where people are not going to make it under the age of 18, where somebody gets sexually abused and they don't know how to dealt with without substance abuse.

AUDIENCE MEMBER: Hi my name is Kathleen I'm a staff member at Los Angeles transitional Center where we have a no-reveal policy where we don't refuse service to anyone regardless of your substance abuse. In fact, we encourage it because we deal with all walks of life, we don't discriminate and our services are very far out. We have -- it's a religious-based program is what it is. We're trying to get individuals closer and get a better relationship with God because really that's the key. That's the key to the substance abuse.

Once we can get individuals on a different path turning their will over and letting god step in, that gives them a better opportunity to want to work with whatever their issues are. Our services are great, we're a non-profit organization. We have mandatory Bible study, mandatory church services. And like I said we don't discriminate to anyone. It doesn't matter how you come into our program. We're going to accept you, we're going to love you, we're going to cater you and we're going to help you get through the issues that you have. So, when they say that there are no programs out there that will accept people that are on drugs or at that time of entry, testing positive, there is some -- Los Angeles Transitional Center. All you have to do is take the time and get linked up with us. We're a great program, non-profit and we do accept all walks of life. It doesn't matter, we don't refuse service to anyone.

AUDIENCE MEMBER: Hi my name is Karen Masadonio and I just want to raise the awareness of the room just a little bit. When we use the word "Antelope Valley" it is so much more than L.A. County and Lancaster and Palmdale. I live in the Antelope Valley but I don't live in L.A. County. And, when I pick up my home phone and I dial 211 to get some information, the call is transferred to L.A. County. Which means even though I live some place else, L.A. County is picking up the cost. We had an incident last week that we had a call from Kern County that went to 911. The call was transferred to the L.A. County, the officer that heard the call, it was about shooting, they were saying they were going to kill me. He could hear the shots in the background. He couldn't do anything because of the artificial line. He had to refer it to Kern County sheriffs had to wait for them to come while he was on the phone listening. So, I want us to know that now in my belief system, is the time for L.A. County to step up and be a role model in the global community.

There's ten million people in this county, look at how many of us are in the room. Where is our micro learning? Where is our podcast? Where is our Facebook live? Where are the things that allow us to share the enormous amount of information and knowledge that we have with people that may never find their way through another channel?

So, I'm urging everybody in the room please start to think in terms of being a role model in a global society change, and living transparently so that every word we say, every presentation we make, is teaching people how to understand more so we can create the society we all want to live in with everybody's welcome.

AUDIENCE MEMBER: My name's Bill Callahan, I'm the president of peer action for change which is 1,000 members of consumers in mental health. I'm also a Skid Row Enterprises one of the co-founders and I'm a peer advocate with Pacific Asian counseling service. I just want to say something good. Yesterday you and I were both in Sacramento and we were both in the room. And you knew the feeling and I knew the feeling when that bill got passed, I remember when it was 1:90 -- people began to weep.
You almost wept when he got on the bus coming back there were DMH members there were us peers and they started to weep on the way back and people were saying how can we help each other? How can we get this message out? And the feel is because when peers speak, people listen. And that's what I most want to see. When you walk talk about, we rise, we have that same feeling because we feel each other and we see each other so I just want to thank you for that. Also, we're putting together speakers' bureaus that's part that of peer movement we're working with spa 8 for that speaker's bureau and we're getting some incredible voices. We're doing it with some other non-profit organizations, we have tremendous voices. And I think that's the most important thing. I told him the other day, I would rather have one Maya average lieu, than 1,000 meeting with stigma because that's how it gets removed. We rise is the same thing, right now we're doing ten murals, five are in Skid Row and five are in the art district, people are now lining up coming out and seeing that. So, of all the things I would like to do is when female speak, and you hear us, and you hear yourself, that's what happens most. And when you hear the best side of yourself, being spoken by someone like that, that's when it happens. So, I would wish that everybody will help us in supporting these things. You have come forward with the hard feeling, the heart is really effective not only when it is the heart but when you can actually hear it beating and you can feel it, that's what makes a difference. And peers are the very best of that.

AUDIENCE MEMBER: Hello good afternoon my nail is Wendy Campbell, and I'm glad to be here but most of us all I'm glad is to see my peers and I want to thank our district chief, Theion Perkins for having -- as many who have attended here as the number is eight so they seem to be enjoying themselves and I'm glad. Some other concerns, let me see how I can start this off. My last psychiatric appointment recently, my provider was very troubled with me. Because she sees I'm putting so much into everybody else.
And not enough in myself. And she's trying to help me to realize the importance of putting me first. Because, like she gave the analogy of a mother and their child -- the mother has to make sure she's okay, first, before she can administer any help to her child. And she said what you do is your child and that does make sense. But later afterwards, some reflection -- my mind had a flash back of when it was solo for -- so low for me that I didn't want to continue anymore in life. And that was because the pain was too great to bear. I felt that if I keep waking up every day the same way feeling miserable, there's no point, why bother? So, yes, I do need to balance better and do better for myself. However, it's that burden that fuels my passion. That makes me want to live. So, I don't know how, yet, if anyone could figure that out for me, let me know. But in the meantime, I keep pushing. I'm going to keep saying this until I find someone who's saying hey, you're right, that shouldn't happen again. So, the example I'm sharing happens a couple weeks ago I think now. I've already brought it to the Measure H oversight advisory board. I got a call 6:30 in the morning from a disabled veteran.
Who was telling me that they were being put out in the rain from this make-shift shelter?
I couldn't believe it either but I did what I could do to intervene and get the word out.
Be it as it may, all I can say now is that I hope it never happens again to them or to anybody else. There's got to be a better way that we can, you know, continue these -- let's continue to treat people humanely, let's not forget that. You never know that time may come when you might need someone's help and you're not in your right frame of mind. That being said, I'm having a great time taking -- training through Share and it's the peer -- peer workforce project and it's a new way of thinking. I'm really excited about it and I hope every service area will have a chance to get involved. I city see it as a movement, you know it's a very positive thing that we can work together collaboratively.
And the experience -- the lived experience is being valued and promoted. In my mind I'm just trying to remember everything before I go. I don't know, those are the main two things.

It would be helpful to have more timely communication because this last minute, oh guess what? We're having a public hearing or whatever else is going on. It's too hard for us out there in Antelope Valley and any other people from remote areas to all of a sudden get everybody excited and fishing out what staff and take off and so forth.

AUDIENCE MEMBER: Hello, I'm also there the Antelope Valley so I want to thank you for the transportation support. As you can see, you've got to hear a lot from voices in our community today. So, that's amazing. At our staff meeting I asked you a question about the unique client counts because your data is incorrect because we have not been giving our client counts. Since RRR do you have an answer for me?

DEBBIE INNES-GOMBERG, Ph.D.: Yes, you actually are reporting because you're billing COS.

AUDIENCE MEMBER: So that is how you're reporting?

DEBBIE INNES-GOMBERG, Ph.D.: We are capturing client encounters through the COS claiming.

AUDIENCE MEMBER: All right, thank you.

AUDIENCE MEMBER: Brit me Bias I'm with the mental health -- I'm looking at slide 3 it about folks who identify as Latino or Hispanic that are PEI versus CSS and I notice that in PEI there's about of 65% percent of folks who identify that way but then whether it gets to CSS it drops to 40% and I'm just curious. Are we take care of everybody to the extent they don't need the CSS folks that identify as Latino because I have in mind to a conference that I went to last week about the health care workforce and how we really need to develop people in the workforce who look like the people that they're going to be serving, most of whom are Latino in these categories. So, any comments on that?

DEBBIE INNES-GOMBERG, Ph.D.: Thank you, and I think the reason why we see that, we see this every year, is that the major difference between clients that are served in PEI and CSS is that 89 percent of clients in PEI are transition youth aged or children/families which probably means their parents are bringing them in so maybe there's a difference. CSS services, while available to all age groups, are a bit more weighted to adults. Adult stigma may play a role as well.

AUDIENCE MEMBER: Hi, my name's Ashley I'm a program coordinator at Project Return the Peer Support Network and also co-chair at SAAC 6 so I just want to raise the immediate need for training for welcoming staff security at our client -- our directly operated clinics. I think as we promote mental health and we're trying to invite community members to take part in mental health services, there really, really needs to be overall training that is inclusive with stakeholder input for the security that is initially welcoming these individuals to these clinics. I want to just kind of raise -- like I went to a clinic recently to celebrate in February, to celebrate Black History month and when I went in my coworker was asked to leave her compact outside because it had a mirror.
And I thought that was the most ridiculous thing for anyone to ask and then my other coworker had to -- was kind of treated like a criminal he was asked to lift up his pant legs because they wanted to see if he was hide anything had his socks.
They checked every individual key on his key chain and he even had to get a second opinion because a decorative key was too long. He had another individual who visited this clinic -- and South Bay mental health, this other individual went on a rainy day and was asked to leave her umbrella outside because they didn't trust her with an umbrella.
And that umbrella ended up getting stolen so she had to end up going home, luckily somebody else gave her an umbrella but can you imagine people barely going in to receive services being treated in that way.I can't imagine anyone wanting to come back.
And just that whole, I don't think anyone that's afraid to work with our population should be. And not to that -- there's so many people in our directly operated clinics and it's so unfortunate and it upsets me that our directly operated clinics that we are referring people to that we're saying this is the place you can get services, aren't providing the right and most welcoming services possible. And that's from the beginning of them walking to do door.

DEBBIE INNES-GOMBERG, Ph.D.: Thank you, you're raising a policy issue that I think was also raised at the last YourDMH meeting. At that meeting it was pointed out that staff are not subjected to the same rules as clients so we have to take a look at that.

I'm aware that it's after 2:00 and what I'm going to ask is that you can write down public comments but if you feel that you need to speak, we'll take two more people and we'll limit it to two minutes each.

AUDIENCE MEMBER: Hi my name is Mariko Kahn, I want to first of all thank you all the peers for all the comments, I'm learning a lot as the executive director of an agency and I hope you will feel welcome when you come to ours. I wanted to be a little bit more dry and -- and administrative, and but when I was looking at page 2, slide 3 I was thinking to myself the fact that we have 132,000 unique clients under CSS and only 44,000 under prevention -- it should be the reverse. So, I'm, you know I know this is from 17-18 so I want to again emphasize and support DMH's move to put more money into prevention because prevention is where it's at. And it's prevention not just early intervention and we're doing a great job with the step care, I want to thank DMH for making that possible. We're now able to see families without having to have a medical diagnosis, which is what they wanted to avoid to not be stigmatized. So, thank you very much.

DEBBIE INNES-GOMBERG, Ph.D.: I wanted to clarify what those numbers represent it's a direct mental health service to a direct mental health service so we're touching far more people in PEI than this 44,000.
AUDIENCE MEMBER: My name is Tiana I'm from Southwest College, historically Black, Brown college in the community I'm here on behalf of associated student organization in the theater department we've been doing social injustice theater winning awards three years just like the Lakers we have a very strong homeless population on campus and we've a lot of people that are mental health challenges, I am going to do a workshop about the mental health stigma and anything associated philanthropy if there's -- I'll be doing it in about four to six weeks, maybe you could give me your card or contact information if you want to be part of it. I also want it give a shout out to Lorenzo here who's cochair on the SAAC 6, SAAC 6 for inviting me to come out and speak today. Thank you for your time.

AUDIENCE MEMBER: Thank you for the opportunity to speak today my name is Maria and what I'm really advocating for are for older adults that is 55 years old or 50 years old and above who are willing to own their own units in leisure world but they are not able to put down a 99 percent asking down. So, they tend to be living in a small apartment where they can afford, you know, to own a unit for an affordable housing for 55 and above. Another concern that I have experienced in the clinic doctors where I was referred to a psychologist/specialist is that there is no appointment receptionist that can take care of your appointment directly to contact the provider. I have to wait and ask for the receptionist from the health care provider insurance and she, herself, was not able to help me to get hold of the psychologist. And one thing last for the schools, especially there was a research done on the schools in three big states -- New Hampshire, New York and also Chicago and California. And what happened there according to the group of doctors who presented at UCLA, the main concern is the standardization of the schools of public schools and lack of mental health providers. And so, support from -- for the students and that's why the students are getting low grades in class and was not able to cope up with the mental health problems and environmental health. Please help, thank you.

DEBBIE INNES-GOMBERG, Ph.D.: Maria thank you very much, thank you all for coming, if you have additional public comment, write it down and we'll include it.
Thank you so much, appreciate it.

HEARING ADJOURNS AT 2:10 P.M.

#1

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Saturday, February 23, 2019 7:27:27 AM
Last Modified: Saturday, February 23, 2019 7:37:16 AM
Time Spent: 00:09:48
IP Address: 76.91.8.152

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

The colors of the charts and tables are nice.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

It's way too long and no one could possibly read it all. Is this on purpose so it's impossible to know what's really going on? And why is there no information about how money is spent? Aren't you required to include that as well!

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Fair**
How MHSA programs are being implemented	**Fair**
How MHSA funding is being spent	**Poor**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

Make it shorter, make real sense and include the $!

Q5 What is your affiliation? (Check all that apply)

Client / consumer ,
Peer,
Advocate,
Family member of a client / consumer

Q6 What is your age?

30 to 39 years old

Q7 What ethnic groups do you identify with? (Check all that apply)

Caucasian,
Latino/Latina/Latinx,
Mixed/multi-ethnic

Q8 What is your Zip Code?

90248

Q9 If you would like us to contact you directly regarding your feedback, please provide your name and email below (optional)

Respondent skipped this question

#2

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, February 25, 2019 3:59:05 PM
Last Modified: Monday, February 25, 2019 4:01:06 PM
Time Spent: 00:02:00
IP Address: 159.83.168.250

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

Monies seemingly are being appropriated fairly.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

We need more shelters, everywhere. More Board and Cares.

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Good**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

Respondent skipped this question

Q5 What is your affiliation? (Check all that apply)

Client / consumer ,
Peer,
Advocate,
Family member of a client / consumer ,
LACDMH staff / employee

Q6 What is your age?

60 to 69 years old

Q7 What ethnic groups do you identify with? (Check all that apply)

Caucasian

Q8 What is your Zip Code?

90731

Q9 If you would like us to contact you directly regarding your feedback, please provide your name and email below (optional)

Respondent skipped this question

#3

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Tuesday, March 05, 2019 6:31:00 PM
Last Modified: Tuesday, March 05, 2019 6:36:53 PM
Time Spent: 00:05:53
IP Address: 47.151.133.6

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

Lots of good topline data about numbers served.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

WHERE IS THE BUDGET INFORMATION? We keep asking for this at meeting after meeting. Public spending like this should be transparent and accountable. How much of the 900 million dollars of MHSA money still remains unspent??? Should someone have to sue the county to get access to this information?

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Very Good**
How MHSA programs are being implemented	**Fair**
How MHSA funding is being spent	**Poor**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates? — Respondent skipped this question

Q5 What is your affiliation? (Check all that apply) — **Client / consumer**, **Advocate**

Q6 What is your age? — **40 to 49 years old**

Q7 What ethnic groups do you identify with? (Check all that apply) — **Mixed/multi-ethnic**

Q8 What is your Zip Code?

90068

Q9 If you would like us to contact you directly regarding your feedback, please provide your name and email below (optional) — Respondent skipped this question

#4

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Sunday, March 10, 2019 9:12:58 AM
Last Modified: Sunday, March 10, 2019 9:17:32 AM
Time Spent: 00:04:34
IP Address: 172.113.234.167

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

N/A

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

Way too complex for most audiences

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Poor**
How MHSA programs are being implemented	**Fair**
How MHSA funding is being spent	**Fair**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

Rethink this as a user friendly document. Simplify, add strategy and clear KPI's etc.

Q5 What is your affiliation? (Check all that apply) — **LACDMH staff / employee**

Q6 What is your age? — **40 to 49 years old**

Q7 What ethnic groups do you identify with? (Check all that apply) — **Mixed/multi-ethnic**

Q8 What is your Zip Code?

90026

Q9 If you would like us to contact you directly regarding your feedback, please provide your name and email below (optional) — Respondent skipped this question

#5

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Sunday, March 10, 2019 9:22:20 PM
Last Modified: Sunday, March 10, 2019 9:25:38 PM
Time Spent: 00:03:17
IP Address: 76.91.8.152

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

It's too long for me to be able to answer this question.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

It's too long to know what's really going on and how what is going on is meeting the needs in our communities.

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Poor**
How MHSA programs are being implemented	**Poor**
How MHSA funding is being spent	**Poor**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates?

Make it shorter and more targeted to what's going with these funds. And include information on the funds.

Q5 What is your affiliation? (Check all that apply) **Advocate, Family member of a client / consumer**

Q6 What is your age? **60 to 69 years old**

Q7 What ethnic groups do you identify with? (Check all that apply) **Caucasian**

Q8 What is your Zip Code?

90210

#6

COMPLETE

Collector: Web Link 1 (Web Link)
Started: Monday, March 11, 2019 7:14:20 AM
Last Modified: Monday, March 11, 2019 7:16:32 AM
Time Spent: 00:02:12
IP Address: 52.39.183.115

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

The reorganization of services for persons living with mental illness.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

Services not accessible to all persons living with mental illness in Los Angeles county.

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Very Good**
How MHSA programs are being implemented	**Very Good**
How MHSA funding is being spent	**Very Good**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates? **Respondent skipped this question**

Q5 What is your affiliation? (Check all that apply) **Mental health service provider**

Q6 What is your age? **50 to 59 years old**

Q7 What ethnic groups do you identify with? (Check all that apply) Other (please specify): African American

Q8 What is your Zip Code?

91101

#7

COMPLETE

Collector:	Web Link 1 (Web Link)
Started:	Monday, March 11, 2019 2:21:02 PM
Last Modified:	Monday, March 11, 2019 2:24:03 PM
Time Spent:	00:03:01
IP Address:	64.60.197.203

Page 1

Q1 What do you see as strengths to the FY 2019/20 Annual Update?

Demonstrating positive implementation and use of MHSA funding.

Q2 What do you see as weaknesses to the FY2019/20 Annual Update?

None

Q3 After reviewing the FY2019/20 MHSA Annual Update, please rate your understanding of the following

Overall ease and clarity of the information presented	**Very Good**
How MHSA programs are being implemented	**Good**
How MHSA funding is being spent	**Good**

Q4 Ideas on how to improve the presentation and content of future MHSA reports and updates? — **Respondent skipped this question**

Q5 What is your affiliation? (Check all that apply) — **Mental health service provider**

Q6 What is your age? — **60 to 69 years old**

Q7 What ethnic groups do you identify with? (Check all that apply) — **Caucasian**

Q8 What is your Zip Code?

93534

FY 2019-20 Annual Update

Public Comment Form

We Need to Hear From You!

The MHSA Annual Update is to communicate to stakeholdres any and all updates/changes to the previously approved Three Year Plan. You can review it here ▶ https://dmh.lacounty.gov/about/mhsa/announcements/
Your feedback will help planning, implementation and monitoring of mental health services in LAC. Please feel free to continue to provide feedback on the back of this form or attach a separate sheet of paper.

1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   More income towards housing
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   Meeting was too last minute! and it was hard for a lot of people to attend.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clairty of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   More need for navigation services for individuals with language barriers, such as Spanish, and other thresh old languages

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90063
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clairty of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90221
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clairty of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90221
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   Well layed out & organized. Enjoyed the data on outcomes
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   - Needs info/data about service capacity, need for mental health services (both Serious mental illness & those who could benefit from PEI, and gaps in care
   - Need info/data about patient satisfaction w/ care
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clairty of the information presented**
   ☐ Poor ☐ Fair ☑ Good ☐ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☑ Fair ☐ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☑ Fair ☐ Good ☐ Very Good ☐ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   Make connections bw funding, services provided & outcomes.

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90034
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify) Academic		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   Partnership w/ law enforcement
   Outcomes list was clear
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   No outcomes on removal of children from home or school failure
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☒ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   Signs to public hearing – many were lost.

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   Food Today
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   I still See homeless tents Why
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☒ Fair ☐ Good ☐ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☒ Fair ☐ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☒ Fair ☐ Good ☐ Very Good ☐ Excellent
   HHH Don't waste things
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   More Simple and concise.

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90220
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   The idea of helping people in crisis and those facing different challenges.
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   The re-enrollment of the program to licensed practitioners.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☒ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☒ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☒ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   The Chaplains should be part of this programs to partner with chaplains to help in the therapy process — Please involve Chaplains to help.

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90250
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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I heard you mentioned some professional but I did not hear you mentioned the Chaplains. Chaplains are important

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   LIKE THE EMPHASIS ON MORE OUTREACH IN PROGRAMS SUCH AS "HOME" BUT ALSO IN ALL PROGRAMS
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   HOPE TO SEE IN FUTURE THE INPUT OF CONSUMER AND FAMILIES ON PROGRAMS/SERVICES – WELL KNOWN OR SOME FORM OF EVALUATION.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☒ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   WHAT OTHER OUTCOMES ARE BEING CONSIDERED FOR EVALUATION
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
   THANKS FOR OVERVIEW OF DMH ACTIVITIES BY DR. SHERIN, DR. BINGS, MS. PENE AND MS. GILBOWS TO LEAD IN TO MHSA ANNUAL UPDATE HEARING

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90266
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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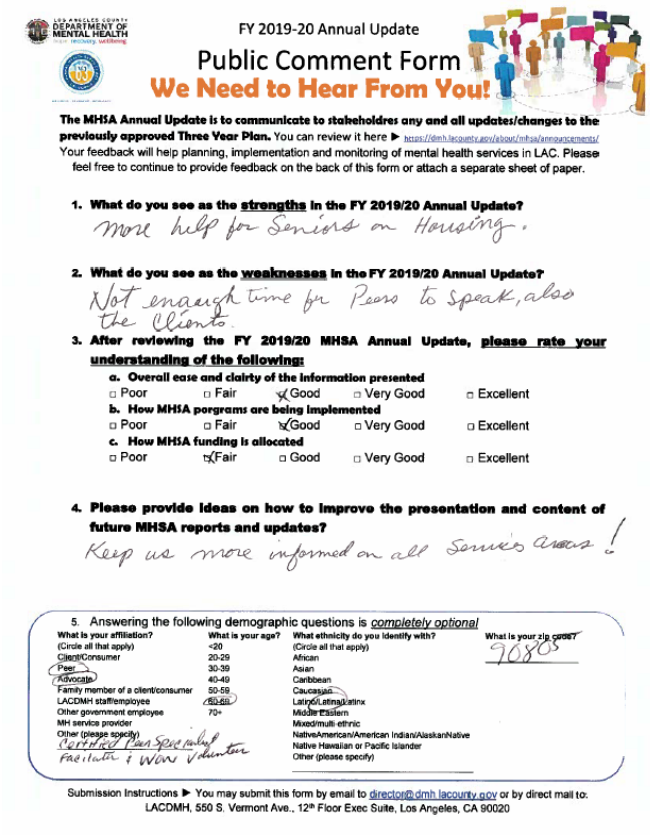

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   More help for Seniors on Housing.
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   Not enough time for Peers to speak, also the Clients.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☒ Good ☐ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☒ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☒ Fair ☐ Good ☐ Very Good ☐ Excellent
4. **Please provide Ideas on how to improve the presentation and content of future MHSA reports and updates?**
   Keep us more informed on all Services Areas!

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90805
(Peer)	20-29	Asian	
(Advocate)	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	(60-69)	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
Certified Peer Specialist Facilitator & WRAP Volunteer		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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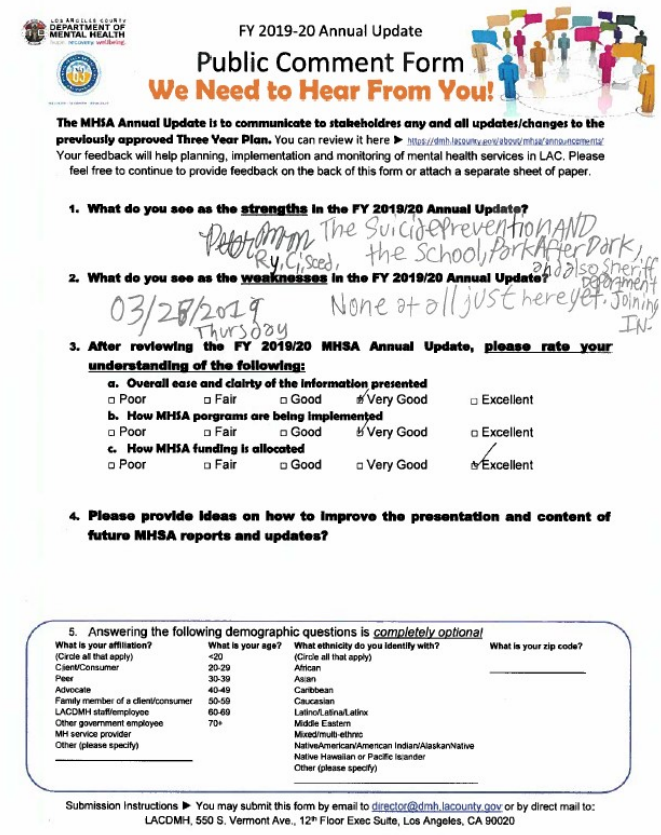

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   Peer Mentorship Revised, The Suicide prevention AND the School Park After Dark, also Sheriff Department Joining IN.
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   03/28/2019 Thursday None at all just here yet.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☒ Excellent
4. **Please provide Ideas on how to improve the presentation and content of future MHSA reports and updates?**

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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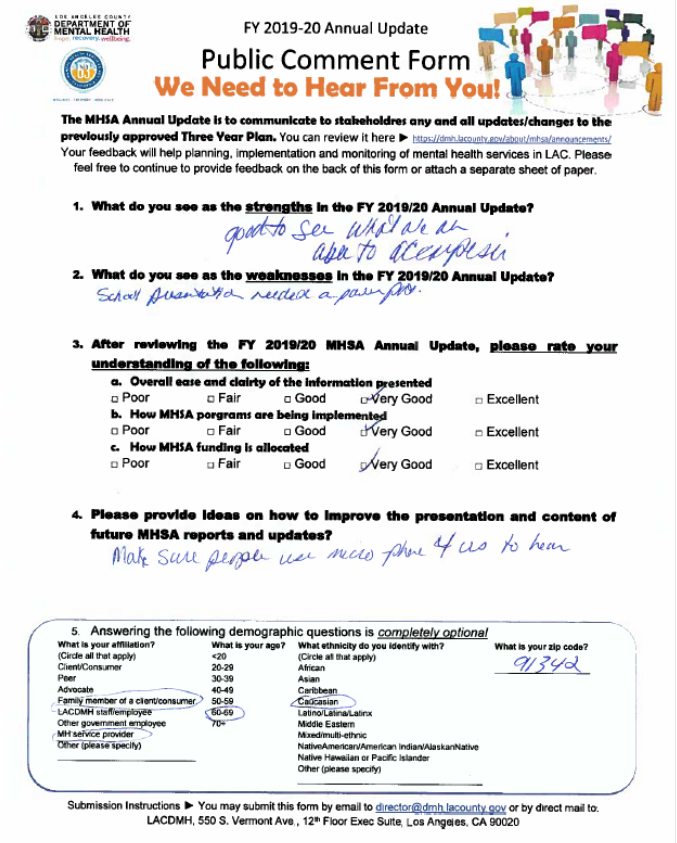

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
   good to see what are the apps to accessible
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
   School presentation needed a power point.
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☒ Very Good ☐ Excellent
4. **Please provide Ideas on how to improve the presentation and content of future MHSA reports and updates?**
   Make sure people use more than 4 us to hear

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	91342
Peer	20-29	Asian	
Advocate	30-39	Caribbean	
(Family member of a client/consumer)	40-49	(Caucasian)	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	(60-69)	Middle Eastern	
(MH service provider)	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
Peer Support Needs ongoing training
I like the ideas that were shared regarding on how to Address current LA Issues
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
Not enough trained service providers
Healthcare Navigation, Mental Health CPR
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☑ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent
Hoarding
Housing Spe
Hopics Need more Oversight NAM
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**
Goods given to participants is over priced! Pots, TVs Sofas. We should ask Manifactuers to partner with us. Give us the Housing Items at cost.

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90037
Peer ✓	20-29	Asian	
Advocate	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify)	

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1. **What do you see as the strengths in the FY 2019/20 Annual Update?**
Peer to peer Capital – to later coach peers – pilot if first Housing approaches to available housing opportunities for transitioning older adults especially those
2. **What do you see as the weaknesses in the FY 2019/20 Annual Update?**
- need on peer advocacy internship provisions,
- need to fill in the gaps, interpersonal charity, integrity and respect to individuals. Health net
3. **After reviewing the FY 2019/20 MHSA Annual Update, please rate your understanding of the following:**
   a. **Overall ease and clarity of the information presented**
   ☐ Poor ☐ Fair ☐ Good ☑ Very Good ☐ Excellent
   b. **How MHSA porgrams are being implemented**
   ☐ Poor ☐ Fair ☑ Good ☐ Very Good ☐ Excellent
   c. **How MHSA funding is allocated**
   ☐ Poor ☐ Fair ☑ Good ☐ Very Good ☐ Excellent
4. **Please provide ideas on how to improve the presentation and content of future MHSA reports and updates?**

5. Answering the following demographic questions is *completely optional*

What is your affiliation? (Circle all that apply)	What is your age?	What ethnicity do you identify with? (Circle all that apply)	What is your zip code?
Client/Consumer	<20	African	90049
Peer	20-29	Asian	
Advocate ✓	30-39	Caribbean	
Family member of a client/consumer	40-49	Caucasian	
LACDMH staff/employee	50-59	Latino/Latina/Latinx	
Other government employee	60-69	Middle Eastern	
MH service provider	70+	Mixed/multi-ethnic	
Other (please specify)		NativeAmerican/American Indian/AlaskanNative	
		Native Hawaiian or Pacific Islander	
		Other (please specify) Asian-American	

Submission Instructions ▶ You may submit this form by email to director@dmh.lacounty.gov or by direct mail to:
LACDMH, 550 S. Vermont Ave., 12th Floor Exec Suite, Los Angeles, CA 90020

1 More Oversight Hopics

Trainings — For Peer Staff. On going therapy Require ment.

- who can afford to buy a place of their own in Leisure World; the asking down payment to buy a unit there is 99%. 55 yo or 60 yo older adults wanted to own affordable housing but w/ minimal down payment.
- providers like clinic doctors have different approach in making appointments after a client is given a referral to an Specialist like Psychologist.
I can understand in urgent care situation where an appointment receptionist is available right away in clinic - when a client is referred w/ a Health net HMO insurance (medicare) the access to Psychologist was so difficult even w/ the help of Health net Receptionist on other line helping the client. No psychologist is available.

MHSAUPDATE19

Will there be a WET program targeting high school students?
- may help with stigma reduction
- exposure to the field

Maria Funk

Re: Interim Funds for B&C Case

What is the protocol for repayment of client funds to DMH once client is approved for SSDI/SSI.

Client is currently in Pathways, was formerly a Chadada which went Bankrupt so no one seems to be clear.

If no Repayment is required may I get a letter to client stating that reality so that we're absolved of future year of penalty?

Thank you

Barbara Wilson

How will the new housing and school programs get these new consumers included in the MHSA planning process?

We have a burgeoning population which is aging and along with other parents are being priced out of the market, and no evidence of many plans for housing for specifically for seniors

need TO increase SERVICES + loopholes on teen suicide prevention

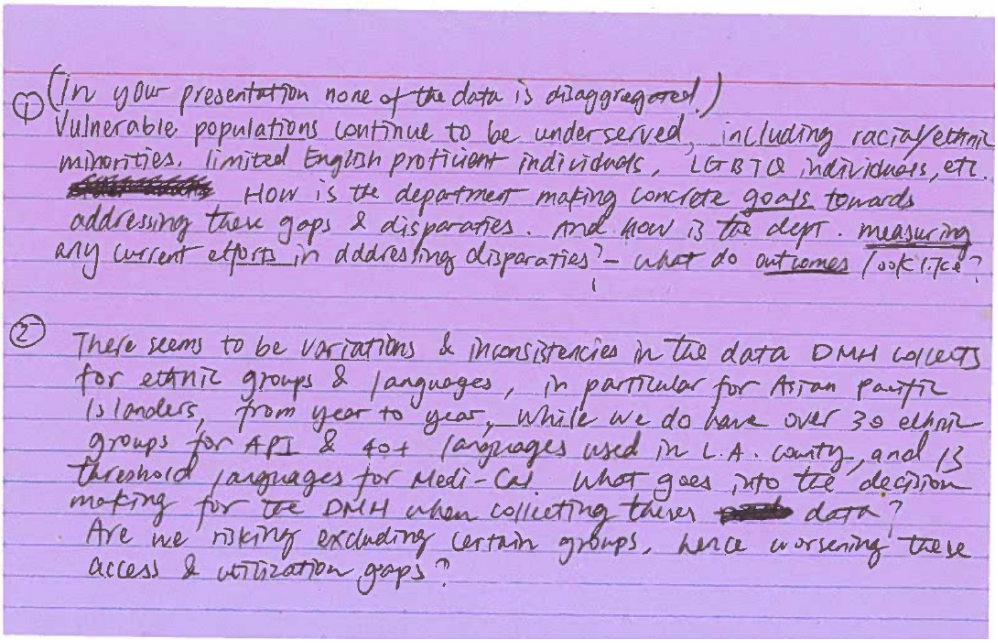
Rich Rubio – 310-567-07## cell

- UCC in SAC. #7
- M.O.U. w/ LACO Library Parks Schools
- B&C's O.J.T.'s for peers internships + work study
- 550 Resource Centers @ All SAC's 1-8

Seven hundred million

GET EVERYONE ON THE SAME PAGE

COMMUNITY SCHOOL INDENTATIVES, BRINGING IT TO THE CAMPUS
PUBIC SCHOOL
TRAUMA INFORMED SCHOOL
SCHOOL TEAMS



① (In your presentation none of the data is disaggregated.)
Vulnerable populations continue to be underserved, including racial/ethnic minorities, limited English proficient individuals, LGBTQ individuals, etc. How is the department making concrete goals towards addressing these gaps & disparities. And how is the dept. measuring any current efforts in addressing disparities? – what do outcomes look like?

② There seems to be variations & inconsistencies in the data DMH collects for ethnic groups & languages, in particular for Asian pacific Islanders, from year to year, while we do have over 30 ethnic groups for API & 40+ languages used in L.A. county, and 13 threshold languages for Medi-Cal. What goes into the decision making for the DMH when collecting these data? Are we risking excluding certain groups, hence worsening these access & utilization gaps?

TO OBTAIN ADDITIONAL INFORMATION CONTACT:

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