COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT (MHSA) ANNUAL UPDATE FY 2022-23
EXECUTIVE SUMMARY

A. MHSA Background Information

In Fiscal Year (FY) 2020-21, 170,077 unique clients in Los Angeles County received a direct mental health service through programs and services funded by the Mental Health Services Act (MHSA). The MHSA funded by Proposition 63, was passed by the Californian electorate in November 2004 and became state law on January 1, 2005. The Act required a one percent (1%) tax on personal incomes above one million dollars ($1M) to expand mental health services and programs serving all ages.

Once MHSA was written into law, the Welfare and Institutions Code (WIC) Section 5847 required county mental health programs in California to prepare and submit a Three-Year Program and Expenditure Plan ("Three-Year Plan" or "Plan") followed by Annual Plan Updates for all MHSA programs and expenditures. In Los Angeles County, the Plan provides an opportunity for the Department of Mental Health (LACDMH) and its stakeholders to review its existing MHSA programs and services to evaluate their effectiveness. Through the Plan's required Community Planning Process (CPP), LACDMH, engages a broad array of stakeholders that provide feedback and input on existing MHSA programs and services which allows LACDMH an opportunity to propose and incorporate new programs and services that meet the diverse needs of all communities served. Changes made to the Plan, through the CPP must comply with MHSA regulations, as well as relevant State requirements.

MHSA is made up of five components: Community Services & Support; Prevention & Early Intervention; Innovation; Capital Facilities & Technological Needs and Workforce Education & Training.

Community Services & Support

Community Services & Support (CSS) is the largest component of the MHSA. The CSS component is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus, which includes concepts of recovery and resilience, integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is also a large part of the CSS component. Services include:

- Full Service Partnership
- Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration Services RRR);
- Alternative Crisis Services (ACS);
- Housing Services;
- Linkage to County-Operated Functions/Programs (Linkage); and
- Planning, Outreach, and Engagement Services (POE).

Prevention & Early Intervention

The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects and programs. The components are as follows:

- Early Intervention
- Prevention
- Stigma and Discrimination
- Suicide Prevention

Innovation

The MHSOAC controls funding approval for the Innovation (INN) component of the MHSA. The goal of Innovation is to increase access to underserved groups, increase the quality of services, promote interagency collaboration and increase access to services. Counties select one or more goals and use those goals as the primary priority or priorities for their proposed Innovation plan. The programs are as follows:

- INN 2: Community Capacity Building to Prevent and Address Trauma
- INN 3: Help@Hand (formerly Technology Suite)
- INN 4: Transcranial Magnetic Stimulation (TMS)
- INN 5: Peer Support Specialist Full Service Partnership
- INN 7: Therapeutic Transportation (TT)
- INN 8: Early Psychosis Learning Healthcare Network
- True Recovery Innovation Embraces Systems that Empower (TRIESTE)

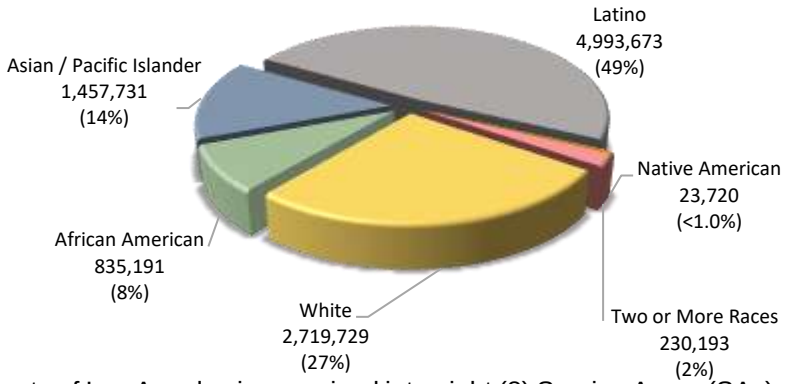
Workforce Education & Training

The goal of the Workforce Education & Training (WET) component is to develop a diverse workforce. Clients and families/caregivers are given training to help others by providing skills to promote wellness and other positive mental health outcomes, they are able to work collaboratively to deliver client-and family-driven services, provide outreach to unserved and underserved populations, as well as services that are linguistically and culturally competent and relevant, and include the viewpoints and expertise of clients and their families/caregivers.

B. Los Angeles County Demographics

The County of Los Angeles is the most populated in the United States (US), with an estimated 10,260,237 residents in Calendar Year (CY) 2019. According to California's census data, in Los Angeles County, the Latino group is the most represented race/ethnicity, and the Native American group is the smallest.

Figure 1. Los Angeles County (N=10,278,834)



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). At the SA level, White residents (including non-Hispanic, European Americans, and Middle Eastern Americans) are the largest in SA 2 and SA 5. In contrast, Latinos are the largest group in all other SAs.

Table 1. Total Population by Race/Ethnicity and Service Area, CY 2019

SA	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,148	15,464	181,754	1,922	125,684	11,300	397,272
Percent	15.4%	3.9%	45.8%	0.48%	31.6%	2.8%	100.0%
SA 2	77,002	254,680	909,678	4,703	943,807	58,441	2,248,311
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,409	507,240	846,574	3,720	358,478	35,040	1,814,459
Percent	3.5%	28.0%	46.7%	0.21%	19.8%	1.9%	100.0%
SA 4	59,582	206,948	616,104	2,619	285,102	21,416	1,191,772
Percent	5.0%	17.4%	51.7%	0.22%	23.9%	1.8%	100.0%
SA 5	37,299	91,134	110,277	1,184	398,949	28,378	667,220
Percent	5.6%	13.7%	16.5%	0.18%	59.8%	4.3%	100.0%
SA 6	275,338	19,164	717,130	1,825	25,738	11,503	1,050,698
Percent	26.2%	1.8%	68.3%	0.17%	2.4%	1.1%	100.0%
SA 7	39,210	119,386	974,630	3,344	168,786	15,589	1,320,945
Percent	3.0%	9.0%	73.8%	0.25%	12.8%	1.2%	100.0%
SA 8	222,204	243,714	637,526	4,403	413,188	48,525	1,569,560
Percent	14.2%	15.5%	40.6%	0.28%	26.3%	3.1%	100.0%
Total	835,191	1,457,731	4,993,673	23,720	2,719,729	230,193	10,260,237
Percent	8.1%	14.2%	48.7%	0.23%	26.5%	2.2%	100%

Data source: ACS, US Census Bureau and Hedderson Demographic Services, Calendar Year 2019. Some totals and percentages reflect rounding

Table 2. Population by race/ethnicity and Service Area

Ethnic Group	Highest	Lowest
African-American	SA 6 (33%)	SA 5 (4%)
Asian/Pacific Islander	SA 3 (35%)	SA 6 (1%)
Latino	SA 7 (20%)	SA 5 (2%)
Native American	SA 2 (20%)	SA 5 (5%)
White	SA 2 (35%)	SA 6 (1%)
Two or More Races	SA 2 (25%)	SA 1 (5%)

SA 1 – Antelope Valley
SA 2 – San Fernando Valley
SA 3 – San Gabriel Valley
SA 4 – Metro Los Angeles
SA 5 – West Los Angeles
SA 6 – South Los Angeles
SA 7 – East Los Angeles County
SA 8 – South Bay

In addition to the racial and ethnic diversity, LACDMH also serves residents across their lifespan. Figure 2 and Table 3 below provide a snapshot of the population breakdown by age group based on the SAs.

Figure 2. Total Population by Age Group CY 2019

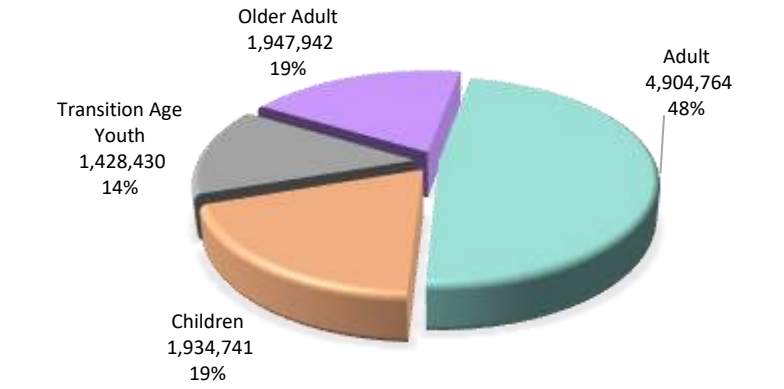


Table 3. Total Population by Age and Service Area, CY 2019

SA	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	104,022	13,206	34,450	176,405	24,364	44,825	397,272
Percent	26.2%	3.3%	8.7%	44.4%	6.1%	11.3%	100.0%
SA 2	486.825	60,627	152,108	1,085,643	147,042	316,066	2,248,311
Percent	21.7%	2.7%	6.8%	48.3%	6.5%	14.1%	100.0%
SA 3	390,614	54,138	131,937	837,009	119,711	281,050	1,814,459
Percent	21.5%	3.0%	7.3%	46.1%	6.6%	15.5%	100.0%
SA 4	239,083	26,350	69,744	643,006	64,200	149,389	1,191,772
Percent	20.1%	2.2%	5.9%	54.0%	5.4%	12.5%	100.0%
SA 5	119,662	23,038	40,973	334,647	41,382	107,518	667,220
Percent	17.9%	3.5%	6.1%	50.2%	6.2%	16.1%	100.0%
SA 6	298,631	38,452	90,823	477,317	50,349	95,126	1,050,698
Percent	28.4%	3.7%	8.6%	45.4%	4.8%	9.1%	100.0%
SA 7	329,651	40,947	103,494	610,331	72,824	163,698	1,320,945
Percent	25.0%	3.1%	7.8%	46.2%	5.5%	12.4%	100.0%
SA 8	361,487	43,443	109,466	740,406	98,813	215,945	1,569,560
Percent	23.0%	2.8%	7.0%	47.2%	6.3%	13.8%	100.0%
Total	2,329,975	300,201	732,995	4,904,764	618,685	1,373,617	10,260,237
Percent	22.7%	2.9%	7.1%	47.8%	6.0%	13.4%	100%

C. MHSA Client Counts, FY 2020-21

COMMUNITY SERVICES AND SUPPORTS

Number of Unique Clients Served: 135,232
Number of New Clients Served: 35,499

Table 4. CSS clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	9,098	2,410
SA 2 – San Fernando Valley	22,613	5,886
SA 3 – San Gabriel Valley	19,146	5,952
SA 4 – Metro Los Angeles	25,458	6,801
SA 5 – West Los Angeles	7,837	1,918
SA 6 – South Los Angeles	21,682	4,727
SA 7 – East Los Angeles	12,465	2,953
SA 8 - South Bay	27,189	6,940

Table 5. Number of unique clients served through CSS by age group and Average MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	24,408	22,917	72,752	18,872
Average MHSA Cost	$195,844,453.30	$135,016,574.60	$381,253,396.18	$90,581,063.20

Table 6. Number of unique clients served through CSS by Ethnicity

Ethnicity	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
Number of Clients Served	23,998	27,373	49,468	6,831	1,087	1,276
Percentage	18%	20%	37%	5%	1%	1%

Table 7. Number of unique clients served through CSS by ethnicity and Service Area

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 1 (9,098)	2,141	2,890	2,496	127	50	616
Percent	24%	32%	27%	2%	1%	7%
SA 2 (22,613)	6238	1910	7876	826	76	1,338
Percent	28%	8%	35%	8%	0.34%	6%
SA 3 (19,146)	268	1655	6246	1,541	84	815
Percent	14%	9%	33%	8%	0.44%	4%
SA 4 (25,458)	4,301	5,133	9,248	1,589	218	990
Percent	17%	20%	36%	6%	1%	4%
SA 5 (7,837)	2,679	1,668	1,427	222	40	414
Percent	34%	21%	21%	3%	1%	5%
SA 6 (21,682)	969	8,866	7,676	171	212	690
Percent	4%	41%	41%	1%	1%	3%
SA 7 (12,465)	1,372	804	6,189	393	134	669
Percent	11%	6%	6%	3%	1%	5%

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 8 (27,189)	4,622	6,724	8,461	1,794	101	1,475
Percent	17%	25%	31%	7%	0.4%	5%

Table 8. Number of unique clients served through CSS by Primary Language

Primary Language	English	Spanish	Farsi	Vietnamese	Korean	Mandarin	American Sign Language	Pilipino, Tagalog	Other
Number of Clients Served	106,987	18,668	611	406	601	381	58	235	6,573
Percentage	79%	14%	0.45%	0.30%	0.44%	0.28%	0.04%	0.17%	5%

Full Service Partnership (FSP)

Table 9. Number of unique clients served by age group and Average MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	3,777	2,915	7,618	1,993
MHSA Average Cost	$17,954	$13,405	$14,642	$11,373

Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures.

Table 10. Service Area Full Service Partnership Slots as of 2/14/22 (Master Slot Allocation Reports)

Service Area	Number of Children Slots (0-17)	Number of Wraparound Slots	Number of Adult Slots (18+)	Number of Homeless Slots
Service Area 1	103	60	380	70
Service Area 2	386	110	854	100
Service Area 3	360	70	845	70
Service Area 4	451	60	1209	420
Service Area 5	36	0	524	160
Service Area 6	531	120	1045	300
Service Area 7	390	60	705	70
Service Area 8	381	40	1304	170
Countywide	15	0	229	0

Table 11. Countywide Full Service Partnership Slots as of 2/14/21

Countywide FSP Program	Number of Slots
Intensive Field Capable Clinical Services (IFCCS)	510
Assisted Outpatient Program (AOT)	300
Integrated Mental Health Team (IMHT)	300

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Table 12. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	21,110	18,696	60,206	16,175
MHSA Average Cost	$5,972	$4,642	$3,861	$3,885

Prevention and Early Intervention

Number of Unique Clients Served: 42,784
Number of New Clients Served: 23,277

Table 13. Number of unique clients served by age group and MHSA cost

Age Group	Child	TAY	Adult	Older Adult
Number of Clients Served	27,025	9,002	6,609	1,027
MHSA Average Cost	$3,915	$3,794	$3,072	$3,243

Table 14. PEI clients served by Service Area

Service Area	Number of Clients Served	Number of New Clients
SA 1 – Antelope Valley	2,850	1,560
SA 2 – San Fernando Valley	7,288	3,807
SA 3 – San Gabriel Valley	7,042	4,068
SA 4 – Metro Los Angeles	6,231	3,890
SA 5 – West Los Angeles	1,626	931
SA 6 – South Los Angeles	5,249	3,334
SA 7 – East Los Angeles	6,185	3,882
SA 8 - South Bay	7,020	3,807

Table 15. Number of unique clients served by Ethnicity

Ethnicity	Latino	White	African American	Asian Pacific Islander	Native American	Multiple Races
Number of Clients Served	19,181	3,701	3,779	1,058	210	1,760
Percentage	45%	9%	9%	2%	1%	4%

Table 16. Number of unique clients served by ethnicity and Service Area

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
SA 1 (2,850)	484	675	1,040	18	16	213
Percent	17%	24%	36%	1%	1%	7%
SA 2 (7,288)	986	280	4,009	182	11	434
Percent	14%	4%	55%	3%	0.15%	6%
SA 3 (7,042)	474	232	2,250	225	17	147
Percent	7%	3%	32%	4%	0.24%	2%
SA 4 (6,231)	474	335	3,318	300	15	170
Percent	8%	5%	53%	5%	0.24%	3%
SA 5 (1,626)	281	225	496	37	4	59

Service Area	White	African American	Latino	Asian/ Pacific Islander	Native American	Multiple Races
Percent	17%	14%	31%	1.14%	0.25%	4%
SA 6 (5,249)	142	1,069	2,378	30	109	108
Percent	3%	20%	45%	0.29%	2%	2%
SA 7 (6,185)	385	156	3,079	78	32	254
Percent	6%	3%	50%	1%	1%	4%
SA 8 (7,020)	549	887	2,976	201	8	401
Percent	8%	13%	42%	3%	0.11%	6%

Table 17. Number of unique clients served by primary language

Primary Language	English	Spanish	Korean	Unknown/Not Reported	Other
Number of Clients Served	32,413	9,051	119	634	686
Percentage	76%	21%	0.28%	1.48%	1.60%

Data Source for Figures 1-2 and Tables 1-3: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019. Data Source for Tables 4-17: Direct service claiming as of 12/1/2021. Cost is based on Mode 15 services and not inclusive of community outreach services, client supportive services or invoiced services.

D. Covid-19 Impact on Mental Health Services

The LACDMH MHSA Three Year Program and Expenditure Plan, Fiscal Years 2021-22 through 2023-24 sheds light on the significant impact the COVID-19 outbreak had on residents and communities within the County noting:

- increased demand for critical mental health services due to increased stress and isolation across populations
- increased housing and economic disparities for communities of color
- significant capacity/staff shortages for the mental health and health safety nets to meet the needs of those most vulnerable populations
- Widespread rising COVID infection rates prompting the need for temporary and/or permanent business and clinic closures

The third year of the pandemic reflects improvements in the County's ability to control infection rates, hospitalizations, and to provide social services and economic assistance to those in need.

LACDMH has developed and executed several strategies to continue to adapt, including:

- Increased use of technology, including telehealth and telepsychiatry, and virtual groups and celebrations to ensure clients have access to care
- Regular phone check ins with clients and/or their families
- Implementation of a peer/volunteer run warm line for those seeking to reach out by phone to stay connected
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion
- WebEx court hearings when possible for clients involved in the justice system
- Continued street outreach to clients experiencing homelessness
- Resumed outreach and engagement teams with increased COVID-19 safety measures

E. Fiscal Year-2022-23 Budget Projection Changes

Tables 18-23 show the difference of what was projected for FY 2022-23 in the Three Year Program and Expenditure Plan, Fiscal Years 2021-22 through 2023-24, and what is now projected in the MHSA Annual Update FY 2022-23.

Table 18. Community Services and Supports

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Full Service Partnership	$302,391,232	$299,567,466	$(2,823,767)	(1) Overall reduction in services due to the pandemic and difficulties to retain staff offset by funds allocated to maintain the Flexible Housing Subsidies Pool for housing vouchers provided to mental health clients for rent.
Outpatient Care Services	$636,564,407	$569,476,324	$67,088,083)	(2) Overall reduction in services due to the pandemic and difficulties in retaining staff.
Alternative Crisis Services	$139,819,715	$165,520,546	$25,700,832	Reflects the operating cost for the new Crisis Residential Treatment Programs (CRTP) at the Restorative Villages.
Planning Outreach & Engagement	$7,108,451	$6,464,668	$(643,783)	Same as (2) above
Linkage Services	$28,322,985	$34,901,893	$6,578,907	Reflects projection of additional Linkage services based on current utilization.
Housing	$ 35,073,361	$35,144,049	$70,688	Same as (1) above
CSS Administration	$38,865,316	$43,284,429	$4,419,113	Same as (2) above
TOTAL	**$1,188,145,468**	**$1,154,359,375**	**$(33,786,093)**	

Table 19. Prevention and Early Intervention

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Suicide Prevention	$ 22,302,998	$22,302,998	$ -	
Stigma & Discrimination Reduction	$366,250	$366,250	$ -	

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Prevention	$43,564,826	$50,513,488	$6,948,662	Primarily reflects the addition of 311 positions for universal promoters which will serve as community promoters to provide outreach and education and the one-time extension of My Health LA (MHLA) Agreement with Department of Health Services (DHS) for mental health prevention services provided in a primary care setting.
Early Intervention	$198,997,562	$188,002,410	$(10,995,152)	Reflects the overall reduction in services due to the pandemic and difficulties in retaining staff.
Outreach	$8,368,989	$ 38,688,869	$30,319,880	Primarily reflects continuation of funding for the Los Angeles Unified School District (LAUSD) and Los Angeles County Office of Education (LACOE) for Community School Initiatives (CSI) and the transition of the Innovation Community Capacity Building project.
PEI Administration	$14,343,578	$15,640,011	$1,296,433	Reflects the change in administrative costs based on the projected cost of the projects.
TOTAL	**$287,944,203**	**$315,514,026**	**$ 27,569,823**	

Table 20. Innovation

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Inn #2 - Community Capacity Building	$ 14,700,000	$ -	$(14,700,000)	Continuation of CANS programming with PEI funding.
INN # 3 - Technology Suite	$6,321,028	$ -	$(6,321,028)	Reflects the completion of the project. DMH is currently in discussions with the California Mental Health Services Authority (CalMHSA) for additional services that may be provided.
Inn # 4 - Transcranial Magnetic Stimulation Center	$1,150,726	$1,150,726	$ -	Reflects the continuation of this project in FY 2022-23.
Inn #7 - Therapeutic Transportation	$ 3,387,415	$5,467,999	$2,080,584	Reflects the expansion of teams in partnership with Los Angeles City Fire Department.
Inn # 8 - Early Psychosis Learning Health Care Network	$492,709	$492,709	$ -	Reflects the continuation of this project in FY 2022-23.
Hollywood 2.0 Project (formally known Trieste)		$5,439,504	$5,439,504	Reflects the implementation of True Recovery Innovation Embraces Systems That Empower (TRIESTE) / Hollywood 2.0 Project
INN - Administration	$ 4,176,000	$2,310,671	$(1,865,329)	Reflects the change in administrative costs based on the projected cost of the projects

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
TOTAL	**$ 30,227,878**	**$14,861,609**	**$ (15,366,269)**	

Table 21. Workforce Education and Training (WET)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
UCLA Affiliation Agreement	$7,135,501	$6,417,864	$(717,637)	Reflects scheduled reduction of one-time services.
Financial Incentive Programs	$3,873,084	$3,873,084	$ -	
Stipend Program for MSWs, MFTs, AND NPs	$3,063,600	$3,063,600	$ -	
Charles R. Drew Affiliation Agreement	$2,011,394	$2,309,058	$297,664	Reflects an increase in the services provided in the residency program.
Funds Assistant Behavioral Sciences Consultants (6 FTEs), for Post-Docs at Harbor-UCLA	$510,000	$ -	$(510,000)	Reflects the elimination of this funding as the fellows being funding with a different funding source, as they provide direct mental health services.
Intensive MH Recovery Specialist Core Training Program	$440,000	$ 440,000	$ -	
Interpreter Training Program	$ 80,000	$80,000	$ -	
Learning Net System 2.0	$250,000	$250,000	$ -	
Navigators (Health and Housing)	$200,000	$ 400,000	$ 200,000	Reflects an expansion in the Health Navigation training program.
Continuum of Care Reform / Staff and Resource Parents Training	$500,000	$500,000	$ -	
Parent Partner Training and Parent Volunteers Project	$320,000	$320,000	$ -	
Peer Focused Training	$ -	$400,000	$400,000	Reflects funding for Peer focused training.
Med. School Affiliation at Harbor	$260,000	$260,000	$ -	
UCLA Medical School Affiliation Agreement (MSAA)	$126,000	$136,000	$10,000	Reflects an increase in cost for services provided by UCLA.
Licensure Preparation Program (MSW, MFT, PSY)	$250,000	$250,000	$ -	
Administrative Overhead	$1,412,379	$1,501,578	$89,199	Reflects the change in administrative costs based on the projected cost of the projects.

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
TOTAL	**$20,431,958**	**$20,201,184**	**$(230,774)**	

Table 22. Capital Facilities/Technological Needs (CFTN)

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change	Description
Tenant Improvement / Capital Facilities		$5,000,000	$5,000,000	Reflects funding for new and/or existing facilities to continue to modernize and develop welcoming building to meet the goals of the mental health services delivered in Los Angele County.
Modern Call Center	$3,500,000	$3,500,000	$ -	Reflects the continuation of this project in FY 2022-23.
CFTN - Administration	$350,000	$2,150,000	$1,800,000	Reflects the change in administrative costs based on the projected cost of the projects
TOTAL	**$3,850,000**	**$10,650,000**	**$6,800,000**	

Table 23. Summary by Program

Program	Original Projections as of June 2021	Updated Projections as of March 2022	Change
Community Services and Supports (CSS) Plan	$1,188,145,468	$1,154,359,375	$(33,786,093)
Prevention and Early Intervention (PEI) Plan	$287,944,203	$315,514,026	$27,569,823
Innovation	$30,227,878	$14,861,609	$(15,366,269)
Workforce, Education and Training (WET) Plan	$20,431,958	$20,201,184	$(230,774)
Capital Faculties / Technology Needs(CFTN) Plan	$3,850,000	$10,650,000	$6,800,000
TOTAL	**$1,530,599,507**	**$1,515,586,193**	**$(15,013,313)**

F. Disparities

Based on feedback from Underserved Cultural Communities (UsCC) groups, LACDMH reviewed the data it collects to more comprehensively capture the racial, ethnic, cultural and disability status of the clients its serves.

Race and Ethnicity:

LACDMH will now be reporting the racial and ethnic status, including primary language spoken, of the clients served at a more granular level and will publish a public-facing dashboard on its website.

Sexual Orientation and Gender Identity (SOGI)

The County has finalized data collection fields for gender identity and sexual orientation. LACDMH has been working to ensure that recent federal requirements are consistent with County reporting prior to modifying its electronic health record and requiring that of contractors. The Department's subject matter expert on SOGI has developed training materials for staff on collecting this information and will finalize once data fields are finalized.

Services for Clients with Disabilities

- The number of clients who report their primary language as American Sign Language (ASL) will now be reported. Current data has clients who report their primary language as ASL is .03% of clients served.
- The ACCESS Center Help Line is in the process of transitioning to 711, the California Relay Service, to assist callers who are deaf or hard of hearing. This will replace the antiquated TTY-TTD system. Informational materials will be disseminated upon adoption of 711.

In the first quarter of calendar year 2022, LACDMH will begin participating in a multi-county learning collaborative, informed by the outstanding work of Solano County and comprised of training from the University of California, Davis (UC Davis) Center for Reducing Disparities on applying the Culturally and Linguistically Appropriate Standards (CLAS) to populations that we specify and to utilize quality improvement approaches to reduce disparities. LACDMH views this opportunity as a vehicle for the disparities reduction efforts and as a way to strengthen community voice.

G. Updates on Actions Approved in the MHSA Three Year Program and Expenditure Plan FYs 2021-22 through 2023-24

FSP Redesign

As part of the previous Three-Year Plan, FSP programs and services were developed to provide comprehensive mental health services to clients requiring intensive treatment. Services are provided by a multi-disciplinary team based on a specific number of client slots. Services provided to clients enrolled in FSP may include, but are not limited to, 24/7 crisis response (in-person when needed); ongoing intensive mental health treatment; housing services; employment services; and co-occurring mental illness and substance use treatment services. Adult FSP Services aim to help Clients, those adults enrolled in Adult FSP Services, increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care and emergency room visits and hospitalizations. For those Clients that are homeless, Adult FSP Services will help them transition from street to home by providing immediate and on-going assistance with securing and maintaining housing. Child/Young Adult (YA) FSP Services include but are not limited to individual and family counseling, 24/7 assessment and crisis services, Intensive Care Coordination (ICC), and Intensive Home Based Services (IHBS). The intent of these services is to help Clients and/or families increase their ability to function at optimal levels. Existing FSP programs serve children and young adults between the ages of 0-20 and adults (21+).

LACDMH transformed the FSP program so that we can best support our highest acuity outpatient consumers on the path to recovery and well-being. This effort included:

- Changed the eligibility criteria to be more focused on those most in need of FSP care;
- Changed the FSP service model to utilize a multidisciplinary team/population approach, rather than individual caseloads and "slots;"

- Began the integration of all specialty FSP programs into one FSP model (with the exception of Housing FSP which transitioned to housing support);
- Lowered client to staff ratios;
- Added funding for additional staffing to enable Child FSP programs to provide Intensive Care Coordination (ICC) & Intensive Home Based Services (IHBS);
- Provided enhanced training and technical assistance to support FSP providers in achieving desired outcomes;
- Enhanced services and supports to ensure successful transitions between levels of care;
- Centralized the authorization, enrollment, and disenrollment processes for FSP to ensure that those highest needs clients are able to access the FSP services;
- Standardized rates to bring contracted provider staff salaries closer to parity with their counterparts in the LACDMH clinics, as a part of LACDMH's broader rate-setting exercise; and
- Changes to the FSP contracts to add incentives for providers to help their clients achieve critical life outcomes, moving our system towards performance-based contracting; and
- Using data, and consumer & provider feedback to drive continuous improvement.

These changes were incorporated into the Service Exhibits within the contracts, which were included in the new Legal Entity agreements that were executed on July 1, 2021. The transformed FSP program was launched on July 1, 2021. Because this program redesign is new for both LACDMH and contract providers, we plan to work with existing FSP providers to pilot this new model over the next 3 years. Lessons learned from this pilot will inform the rebid of FSP contracts for FY 2024-25.

24/7 Access Modernization Project

The approved funding shift allows the Department to engage with a consultant to modernize the existing antiquated Call Center into the hub in accessing services with the DMH system of care. The Call Center will provide end-to-end assistance in an efficient and client-focused manner utilizing an agent and client centered design. Project goals are as follows:

- Reduce the number of software applications used by agents by developing a single view with end-to-end care visibility in order to best meet the needs of the caller
- Allow for integration with other systems (e.g., law enforcement) for receiving, assessing, triaging and mounting non-law enforcement responses to crises cross our communities
- Provide integration technology between the Call Center and service providers (including crisis response) in order to reduce time-to-care, maximize service capacity and improve coordination of services
- Develop self-service capabilities and alternative access-points designed by feedback from the community
- Automate call and client analytics to ensure the Call Center is meeting the needs of the community and responding in a timely manner.

On September 28, 202, DMH posted a solicitation to secure the services of a vendor for the ACCESS Call Center Modernization Project. A bidders conference was held on October 5, 2021. As of February 2022, DMH has received multiple bids for this solicitation and is in the evaluation process. This evaluation process is anticipated to be completed no later than spring 2022.

Mental Health Treatment Beds and Housing Capacity

LACDMH recommended a two-year pilot, long with strategies to expand and improve mental health bed capacity and service quality throughout the system, to procure up to 500 mental health treatment beds of varying types based on available funding. In the last two years, LACDMH arranged for access to up to 239 beds when they became (or will become) available, of which 160 beds were utilized. In implementing the bed pilot, DMH went approximately $9.9 million dollars over budget utilizing one-time Sales Tax Realignment. In order to continue to move patients and allow continuous and efficient system flow, ongoing funding above the $25 million in Sales Tax Realignment revenues set aside in the FY 2019-20 Final Adopted Budget by LACDMH is required. This bed pilot was implemented in the context of the COVID-19 pandemic and as such, it was executed in combination with the County Continuity of Operations: Surge Plan.

G. Proposed Changes in the MHSA Annual Update FY 2022-23

Innovation 2: Community Capacity Building to Prevent and Address Trauma

This Innovation project was posted to the LACDMH website on February 27, 2015 and approved by the OAC on May 28, 2015. Due to the time-limited nature of MHSA-Innovations, this project is scheduled to end on June 30, 2022.

This project centers on building the capacity of the community to identify and support community members at risk of trauma or experiencing trauma. The project aims to utilize the assets of the community to test 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. In June 2020, LACDMH integrated community mental health workers (community ambassadors) into the INN 2 project.

The concept of the Community Ambassador Network (CAN) leverages existing networks of trusted community-based providers and organizations to have the right people in the right place at the right time to provide necessary resources to those in need. The development of the CAN through Innovations 2 has allowed LACDMH to expand our behavioral health workforce, in partnership with community based organizations, to hire and train 326 community ambassadors. As of 12/6/2021, 321 individuals have been part of the CAN. The CAN intern project was introduced a year ago as a collaborative project with the Department of Public Social Services (DPSS), the INN 2 team and the California Work Opportunity and Responsibility to Kids (CalWORKs) team. Funded by DPSS, CAN Interns expand the reach and supports available within communities by members of the community.

The Los Angeles County Board of Supervisors approved nine (9) lead agencies and ten (10) projects, two (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 selected specific strategies based on their community's interests and needs. 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.

COVID-19 has resulted in a critical need for mental health services, and the 321 individuals that have been part of the CAN have allowed DMH to build capacity, provide trauma-informed targeted outreach and resources to communities at higher risk. In addition, by leveraging existing relationships and partnerships, each lead agency was able to identify available resources and connect with community members with needed supports (i.e., housing, food, mobile shower units, hot meals, rental and utility assistance and a multitude of linkages).

Innovation 2: Outcomes

Specifically, the following process and summative outcomes were achieved by the Innovations 2 program:

- There were 8,077 registered participants, with 68% (5,499) of all participants were enrolled in INN 2 during the pandemic. Most participants in INN 2 are families with young children between the ages of 0-5 (25.2% of participants), intergenerational families (23.2% of participants) and TAY (22.3% of participants).
- Through nearly 10,700 community events, outreach and social media posts, 560,268 community members were reached, 18,000 meals provided, 9,865 individuals vaccinated for COVID-19 and PPE provided to nearly 14,000 individuals.

- The CAN Participants demonstrated a stronger understanding of the relationship between trauma and mental health, significant improvements in resilience, and improved ability to cope with stress.
- Over the past year, 93% of the 29,587 linkages to community resources and supports were successful. Despite the impact of the COVID-19 pandemic, linkages increased substantially from the prior year.
- During FY 2020-2021, there were a total of 14,219 outreach and engagement efforts, representing a substantial increase compared to the prior year of the project.
- Through Learning Sessions, partners learned how to engage a wider net of at-risk community members to provide support.
- Participants enrolled in INN 2 during the COVID-19 pandemic, reported feeling significantly more connected with the community, and utilized more approach coping skills after three months of INN 2 activities.
- Participants reported feeling significantly more resilient after 9 months of participation in INN 2.
- Based on data from the Conner-Davidson Resilience Scale (CD-RISC-10) participants who enrolled in INN 2 during the past year of the pandemic, reported no decline in their resilience despite the significant amount of stress communities experienced over the course of the past year.
- In addition, based on the Inclusion of Community in Self (ICS) Scale, INN 2 participants reported a significant increase in their connection to the community, relative to the baseline score.
- Community members engaged with INN 2 and the Community Ambassadors also reported significant improvement in Approach Coping scores, based on The Cope Inventory.
- Partnership rosters within the community increased by 13% as INN 2 partnerships expanded to include new organizations and community members. Specifically, the INN 2 networks averaged 57 partners in February 2021, compared to 51 partners last year (February 2020) and 36 partners in March 2019 (baseline assessment). On key factor responsible for the stronger community partnerships has been the addition of the Community Ambassador Network.

Innovation 2: Proposed Budget
An annual budget of $22,489,000 using Prevention and Early Intervention funding.

Capital Facilities

Capital Facilities component funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. The additional funds will address the current and anticipated needs of both public mental health service facilities and administrative space. Space utilization at all facilities is currently at maximum capacity. To the extent possible, DMH will utilize these funds to continue to modernize and develop welcoming facilities that will move its mental health system toward the goals of wellness, recovery, and resiliency; and will also help to expand the opportunities for accessible community based services for clients and their families, promoting the reduction in disparities in underserved groups.

Innovation – Hollywood 2.0 Pilot Project

LACDMH was approved to receive MHSA Innovation funding from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to test a new and comprehensive approach to providing services to individuals in the Hollywood area suffering from severe and persistent mental illness, as a result, experiencing chronic homelessness, incarceration and or repeated hospital use. The Hollywood 2.0 Pilot Project is a modification of the MHSA Innovations project Trieste, which was approved by the MHSOC in May of 2019 prior to the pandemic. The project is based on LACDMH's fiscal projections and the anticipated CalAim program. The Hollywood 2.0 pilot aims to provide our most vulnerable residents with relentless

engagement and enhanced access to treatment functioning as tools to facilitate individuals with connection to people, place, and purpose in life. Hollywood 4WRD (4 Walls, a Roof and a Door), a grassroots public-private coalition, will serve as the engagement body for the Hollywood 2.0 Pilot Project. The primary purpose of the Hollywood 2.0 Pilot Project is to establish a variety of recovery-oriented resources that promote an integrated, community-based approach in the delivery of novel programs and services that enhance the client's abilities to lead fulfilling lives in their neighborhood. The project is proposed for 5 years.

The Hollywood 2.0 pilot represents an opportunity for the County to leverage MHSA Innovation funding, partner with local community leadership, and use existing local assets to build out a rich array of resources that will strengthen clients' ties to the Hollywood community. Such resources include a robust infrastructure of facilities and a system of care that offers both services and opportunities to support a highly vulnerable community in new and exciting ways.

Hollywood 2.0 will allow the Department to develop novel programs and services that willenhance client's abilities to lead fulfilling lives and feel connected to their surroundingneighborhood. New programs such as Supportive Employment and Supportive Education services will provide clients with opportunities to learn life skills while simultaneously connecting them to agencies and employers in the Hollywood area. By providing the Pilot's clients with a chance to find purpose in their daily lives and make meaningful connections to others in their community, Hollywood 2.0 embraces the Department's belief in clients' ability to manage their life successfully, which is a key element of recovery.

Staffing for Hollywood 2.0 will be identified for assignment to Full-Service Partnership (FSP) (6-7 staff) and Homeless Outreach Mobile Engagement (HOME) teams dedicated to the project. The proposed annual budget is $100,000.

Hollywood has one of the County's most concentrated populations of unhoused individuals suffering from profound brain illness(es) and languishing in the streets. Aside from putting in place resources needed to address this crisis, the goal of the Hollywood 2.0 project is to leverage the significant momentum and buy-in across the Hollywood community. As part of our plan to expand the current footprint and establish new resources in Hollywood to create service arrays, the pilot will leverage a few key evolving reform efforts, including the Full-Service Partnership (FSP) Redesign, (HOME) Outpatient Conservatorship Pilot (HOME pilot), Peer Resource Center replication (including clubhouse type programming) and Alternative Crisis Response (ACR) initiatives.