BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

49 May 21, 2024

JEFF LEVINSON
INTERIM EXECUTIVE OFFICER

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

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

May 21, 2024

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

Dear Supervisors:

**ADOPT THE DEPARTMENT OF MENTAL HEALTH'S
MENTAL HEALTH SERVICES ACT TWO-YEAR PROGRAM
AND EXPENDITURE PLAN
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)**

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Two-Year Program and Expenditure Plan for Fiscal Years 2024-25 and 2025-26.

IT IS RECOMMENDED THAT THE BOARD:

Adopt the Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Two Year Program and Expenditure Plan (Plan) for Fiscal Years (FYs) 2024-25 and 2025-26 (Attachment I). The MHSA Plan has been certified by the Director of Mental Health (Director) and the Auditor-Controller (A-C) to meet specified MHSA requirements in accordance with Welfare and Institutions Coder (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

In accordance with WIC Section 5847, DMH will prepare and submit the MHSA Plan to your Board for adoption. Board approval of the recommended action will allow DMH to submit the MHSA Plan to the State of California's Mental Health Services Oversight and Accountability Commission (MHSOAC) in accordance with WIC Section 5847.

Additionally, WIC Section 5848 requires DMH to post the draft MHSA Plan, for at least 30 days, for

the stakeholders and public to review and provide comments. As such, DMH posted the draft MHSA Plan on its website on February, 28 2024. At the close of the 30-day public review period, DMH and the Mental Health Commission convened a Public Hearing on March 28, 2024, where DMH presented the Plan to stakeholders and to the public. At the conclusion of the Public Hearing, the Mental Health Commission voted to approve the MHSA Plan.

Implementation of Strategic Plan Goals

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

FISCAL IMPACT/FINANCING

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. More specifically, AB 1467 amended the 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 are to be adopted by your Board and submitted to the MHSOAC and the State Department of Health Care Services. For FY 2024-25 the County will be submitting a Two-Year Plan in order to align the County with the State Department of Health Care Services timeline for MHSA plans.

The public hearing requirements referenced in WIC Section 5848 (a) and (b) have been fulfilled and are recorded in the MHSA Plan. The A-C and Director of DMH have both signed the MHSA Fiscal Accountability Certification Form included in the MHSA Plan.

In addition, the MHSA Plan for FY 2024-25 and FY 2025-26, contains a summary of MHSA programs for FY 2023-24, including clients served by MHSA program and Service Area as well as program outcomes.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Plan will ensure compliance with AB 1467 requirements and ensure clients have timely access to appropriate services.

Respectfully submitted,

LISA H. WONG, Psy.D.
Director

LHW:CDD:KN:RR:SK:ZW:atm

Enclosures

c: Executive Office, Board of Supervisors
Chief Executive Office
County Counsel

MHSA TWO YEAR PROGRAM AND EXPENDITURE PLAN

Fiscal Years 2024-25 through 2025-26

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

Posted for Public Review

February 28, 2024

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I. INTRODUCTION

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

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

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

II. DIRECTOR'S MESSAGE

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

Dear Residents and Partners,

Nearly 20 years after California voters overwhelmingly passed the Mental Health Services Act (MHSA) in 2004, we continue to see the ways in which it has positively impacted and engaged our County's diverse communities by providing services and resources to those in need. More than ever, the Los Angeles County Department of Mental Health (LACDMH) has created and expanded innovative ways to work through the challenges at its doorstep, including the mental health crisis facing our youth, the complex needs of people experiencing homelessness, and the critical shortage of public mental health workers. Clearly, we still have much work to do.

As the Director, I am truly grateful for the opportunity to serve the communities and residents in our care. Throughout my career, I have never forgotten my experiences working and caring for the most vulnerable people in Skid Row. That knowledge and valuable insight have provided me with a different perspective on the mental health care delivery system and its unique challenges. I also witnessed firsthand the compassion, empathy, and care we have as partners in healing and as providers of hope.
Through LACDMH's strategic planning and with valuable input from our stakeholder process, we have produced successful outcomes and continue to work on initiatives and programs which are focused on our priorities, including:

- Hosting recruitment and hiring fairs in service areas where there is great need;
- Expanding our award-winning Homeless Outreach and Mobile Engagement (HOME) program;
- Developing our Interim Housing Multidisciplinary Assessment and Treatment Team innovation program; and
- Working with School-Based Community Access Point (SBCAP) Administration to implement several prevention programs aimed at uplifting students and their well-being.

As we look towards the future, we continue our commitment to creating and maintaining successful collaborations with our stakeholders who are just as focused on helping communities and individuals overcome challenges, so we may all thrive and succeed. I am proud to say that, together, our hearts and minds remain dedicated to our overall mission of uplifting others, advancing equity, and strengthening communities.

With Gratitude,

Lisa H. Wong, Psy.D.
Director

510 S. VERMONT AVENUE, LOS ANGELES, CA 90020 | HTTPS://DMH.LACOUNTY.GOV | (800) 854-7771

III. EXECUTIVE SUMMARY

PREFACE

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

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

PLAN LAYOUT

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

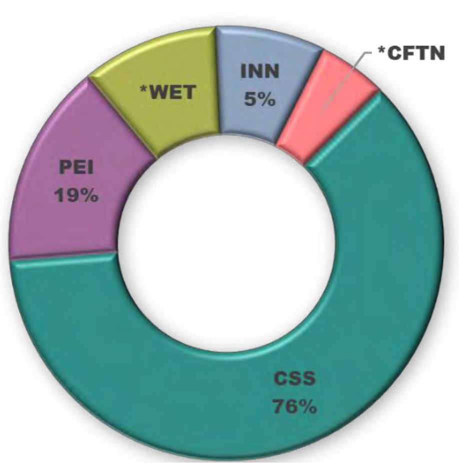
The information within this report is structured in the following sections:

- *MHSA Overview*
- *Development of the Annual Update*
- *DMH List of Recommendations for Funding Consideration*
  The Plan details significant changes that are either being proposed or will be explored within the next two fiscal years.
- *Actions Since the Last Annual Update*
  The purpose of this section is to capture any posted Mid-Year Adjustments that occurred after the adoption of the FY 2023-24 Annual Update.
- *Programs and Services by MHSA Component*
  The Plan provides relevant program outcomes specific to FY 2022-23 for programs previously approved.

IV. MHSA OVERVIEW

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

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



Community Services and Supports (CSS)

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

Prevention and Early Intervention (PEI)

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

Workforce and Education Training (WET)*

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

Innovation (INN)

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

Capital Facilities and Technological Needs (CFTN)*

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

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

V. DEVELOPMENT OF THE ANNUAL UPDATE

MHSA Requirements

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

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

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

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

The Los Angeles County submitted a COVID Extension Form for Fiscal Year 2020-21, which extended the Three Year Program and Expenditure Plan for Fiscal Years 2017-20 to include Fiscal Year 2020-21. This placed Los Angeles County on a track to submit a Two Year Plan for Fiscal Years 2024-25 through 2025-26. An annual update will be needed for Fiscal Year 2025-26.

County Demographics

Los Angeles County Population

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

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

Figure 1. Map of Los Angeles County Service Planning Areas

SA 1 is the largest geographical, but the least populated

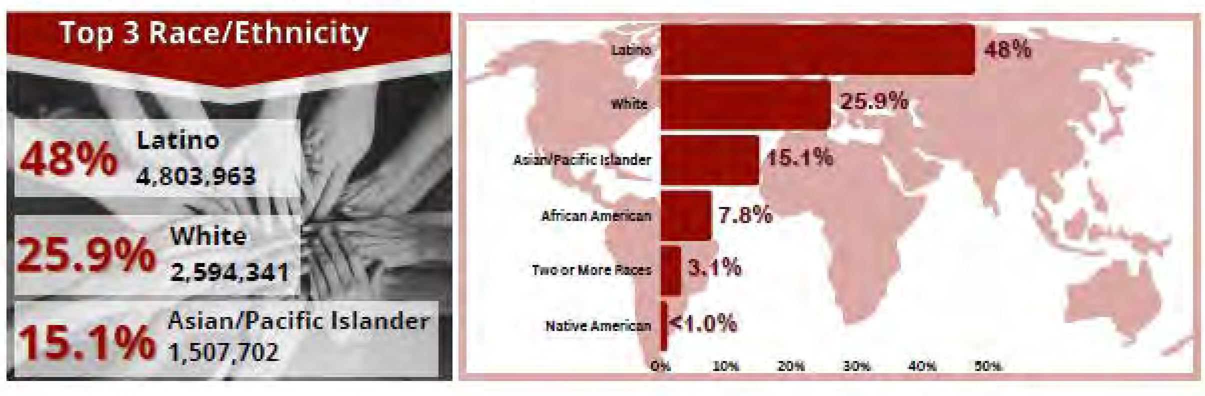
SA 2 is the most densely populated

SA 4 has the highest number of homelessness

SA 6 has the highest poverty rate in the county

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

Figure 2. Total Population by Race/Ethnicity



The next two tables provide the breakdown by race/ethnicity based on the SAs. Bold values shown in blue and brown represent the highest and lowest percentages, respectively, within each racial/ethnic group (Table 1) and across all SAs (Table 2).

Table 1. Population by Race/Ethnicity and Service Area

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	62,383	16,691	218,503	**1,471**	103,725	15,273	418,046
Percent	14.9%	4.0%	52.3%	**0.35%**	24.8%	3.7%	100.0%
SA 2	79,672	260,898	867,861	3,504	**918,778**	77,926	2,208,639
Percent	3.6%	11.8%	39.3%	0.16%	**41.6%**	3.5%	100.0%
SA 3	54,476	**546,511**	802,885	2,877	304,911	41,922	1,753,582
Percent	3.1%	**31.2%**	45.8%	0.16%	17.4%	2.4%	100.0%
SA 4	62,046	191,774	520,983	2,300	306,752	36,686	1,120,541
Percent	5.5%	17.1%	46.5%	0.21%	27.4%	3.3%	100.0%
SA 5	33,383	91,873	**105,216**	**952**	395,198	**38,168**	664,790
Percent	5.0%	13.8%	**15.8%**	**0.14%**	59.4%	**5.7%**	100.0%
SA 6	**235,154**	**24,396**	703,549	1,513	**32,713**	18,944	1,016,269
Percent	**23.1%**	**2.4%**	69.2%	0.15%	**3.2%**	1.9%	100.0%
SA 7	**38,727**	128,944	**950,243**	2,800	140,197	**20,138**	1,281,049
Percent	**3.0%**	10.1%	**74.2%**	0.22%	10.9%	**1.6%**	100.0%
SA 8	207,441	246,615	634,723	3,185	392,067	65,467	1,549,498
Percent	13.4%	15.9%	41.0%	0.21%	25.3%	4.2%	100.0%
Total	773,282	1,507,702	4,803,963	18,602	2,594,341	314,524	10,012,414
Percent	7.7%	15.1%	48.0%	0.19%	25.9%	3.1%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding.

Table 2. Population by Race/Ethnicity and Service Area

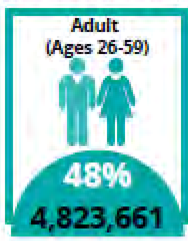
Race/Ethnic Group	Highest	Lowest
African American	SA 6	SA 5
Asian/Pacific Islander	SA 3	SA 1
Latino	SA 7	SA 5
Native American	SA 2	SA 5
White	SA 2	SA 6
Two or More Races	SA 2	SA 1

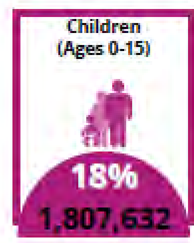
Service Areas

- 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 Tables 3 and 4 below provide a snapshot of the population breakdown by age group based on the SAs. Bold values shown in blue and brown in represent the highest and lowest percentages, respectively, within each age group (Table 3) and across all SAs (Table 4).

Figure 3. Total Population by Age Group





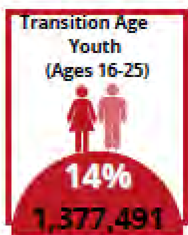
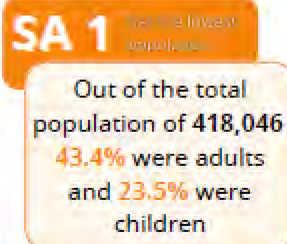


Table 3. Population by Age Group and Service Area

Service Area (SA)	0-15 years	16-25 years	26-59 years	60+ years	Total
SA 1	96,058	**69,473**	**181,543**	**68,972**	418,046
Percent	23.5%	**16.6%**	**43.4%**	**16.5%**	100.0%
SA 2	**389,938**	**285,219**	**1,063,968**	**469,514**	2,208,639
Percent	**17.7%**	**12.9%**	**48.2%**	**21.3%**	100.0%
SA 3	303,349	243,208	811,066	395,959	1,753,582
Percent	17.3%	13.9%	46.3%	22.6%	100.0%
SA 4	157,283	117,989	628,240	217,029	1,120,541
Percent	14.0%	10.5%	56.1%	19.4%	100.0%
SA 5	**85,539**	86,954	339,179	153,118	664,790
Percent	**12.9%**	13.1%	51.0%	23.0%	100.0%
SA 6	231,070	172,510	469,180	143,509	1,016,269
Percent	22.7%	17.0%	46.2%	14.1%	100.0%
SA 7	257,060	193,466	596,356	234,167	1,281,049
Percent	20.1%	15.1%	46.6%	18.3%	100.0%
SA 8	285,335	208,672	734,129	321,362	1,549,498
Percent	18.4%	13.5%	47.4%	20.7%	100.0%
Total	1,807,632	1,377,491	4,823,661	2,003,630	10,012,414
Percent	18.1%	13.8%	48.2%	20.0%	100.0%

Data source: ACS, US Census Bureau, and Hedderson Demographic Services, prepared by DMH Chief Information Office Bureau (CIOB) in May 2022. Some totals and percentages reflect rounding



SA 2 has the highest population

Out of the total population of 2,208,639 48.2% were adults and 21.3% were older adults

Table 4. Population by Age and Service Area

Age Group	Highest	Lowest
Children (0-15)	SA 2	SA 5
Transition Age Youth (16-25)	SA 2	SA1
Adult (26-59)	SA 2	SA 1
Older Adult (60+)	SA 2	SA 1

Service Areas

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

SA 2 has the highest population for all age groups

SA 1 has the lowest population for Transition age youth, adult, and older adult

Table 5. Population by Gender and Service Area

Service Area (SA)	Male	Female	Total
SA 1	206,513	211,533	418,046
Percent	49.4%	50.6%	100.0%
SA 2	1,093,609	1,115,030	2,208,639
Percent	49.5%	50.5%	100.0%
SA 3	854,807	898,775	1,753,582
Percent	48.7%	51.3%	100.0%
SA 4	579,602	540,939	1,120,541
Percent	51.7%	48.3%	100.0%
SA 5	321,775	343,015	664,790
Percent	48.4%	51.6%	100.0%
SA 6	497,397	518,872	1,016,269
Percent	48.9%	51.1%	100.0%
SA 7	629,722	651,327	1,281,049
Percent	49.2%	50.8%	100.0%
SA 8	758,117	791,381	1,549,498
Percent	48.9%	51.1%	100.0%
Total	4,941,542	5,070,872	10,012,414
Percent	49.4%	50.6%	100.0%

10,012,414
Total Population

49.4% Male

50.6% Female

Top 3 Service Areas

SA 2 2,208,639 — 50.5% Female / 49.5% Male

SA 3 1,753,582 — 51.3% Female / 48.7% Male

SA 8 1,549,498 — 51.1% Female / 48.9% Male

Population Enrolled in Medi-Cal

This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, age, and gender.

Approximately **40%** of the Los Angeles County population makes up the Medi-cal Eligible population.

Figure 4. Distribution of Race/Ethnicity among Los Angeles County's Medi-Cal Eligibles

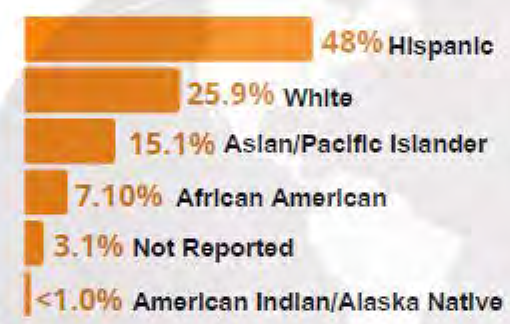


Figure 5. Age Group Distribution among Medi-Cal Eligibles

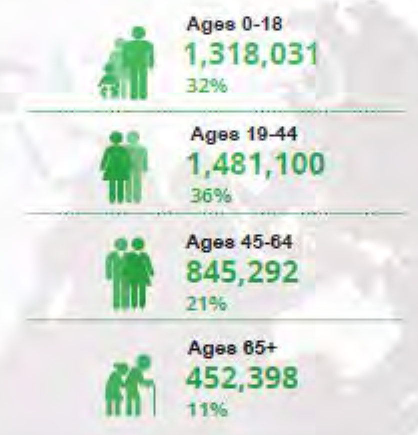


Table 6. Primary Language of Population Enrolled in Medi-Cal Threshold Language CY 2021

Language	Jan-Oct Average	Average %
English	2,358,716	57.65%
Spanish	1,375,105	33.61%
Armenian	79,238	1.94%
Missing/Unknown	57,671	1.41%
Mandarin	49,447	1.21%
Cantonese	43,628	1.07%
Korean	35,007	0.86%
Vietnamese	30,350	0.74%
Farsi	15,074	0.37%
Russian	14,268	0.35%
Tagalog	9,861	0.24%
Cambodian	8,670	0.21%
Arabic	6,108	0.15%
Other Non-English	5,847	0.14%
Other Chinese	2,613	0.06%
Total	**4,091,603**	**100.00%**

Los Angeles Homeless Services Authority's 2020 Greater Los Angeles Homeless Counts

The following information is taken from the Quality Assessment and Performance Improvement Evaluation Report 2021 and Work Plan 2022:

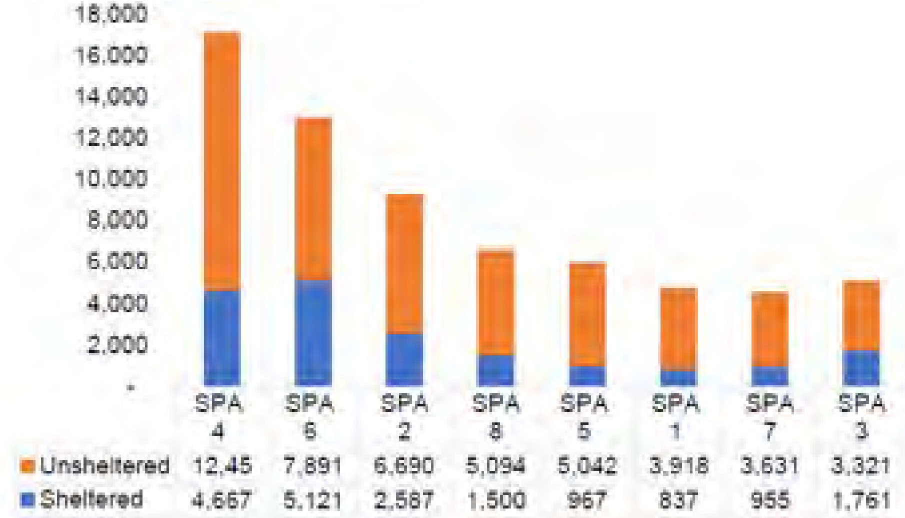
The Los Angeles Homeless Services Authority's (LAHSA) results of the 2020 Greater Los Angeles Homeless Count showed 66,436 individuals in Los Angeles County were experiencing homelessness. The city of Los Angeles saw a 16.1% rise to 41,290. The 2020 Homeless Counts were conducted in January 2020, before the impacts of the COVID-19 pandemic could be felt, measured, or responded to through efforts such as Project Roomkey, rent freezes, and eviction moratoriums.

Figure 6 . Three-year Trend for Sheltered versus Unsheltered Individuals Experiencing Homelessness

Note: Data reflects individuals ages 18 years and older and households with no adults over age18 years (unaccompanied minors).

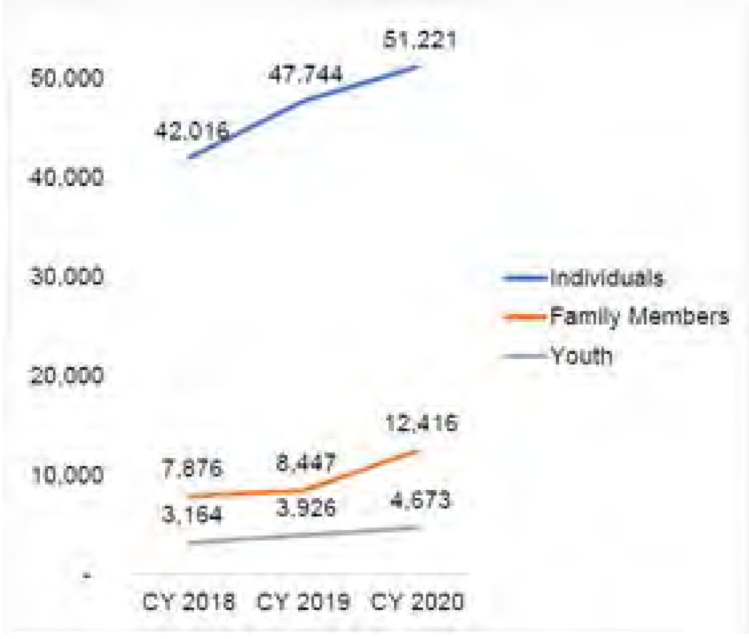
At the SPA level, percentage point (PP) changes ranged from 44% to -10% between CY 2019 and CY 2020. Homeless counts increased by 44% in SPA 1, 36% in SPA 2, 16% in SPA 3, and 14% in SPA 5. Homeless counts increased by five, four, and one PPs in SPAs 8, 4, and 3, respectively. Conversely, homeless counts declined by 10% in SPA 7 from CY 2019 to CY 2020. SPA 4 had the highest distribution of unsheltered individuals, whereas SPA 6 had the highest allocation of sheltered individuals. Across all eight SPAs, SPA 1 had the lowest allocation of homeless, and SPA 3 had the lowest distribution of unsheltered homeless.

Figure 7. Individuals Experiencing Homelessness by Shelter Status and Service Planning Area (SPA), Calendar Year 2020



Most SPAs had a higher proportion of unsheltered individuals experiencing homelessness, with those sheltered in the 4,000 to 800 range. In CY 2020, SPA 4 had greater than 17,000 individuals experiencing homelessness, the highest of all SPAs. SPA 6 had greater than 5,000 individuals experiencing homelessness who are sheltered.

Figure 8. Three-Year Trends for Individuals, Youth, and Families Experiencing Homelessness



The number of individuals, youth, and families experiencing homelessness trends upward. Over the past three years, the number of families experiencing homelessness showed the most significant increase between CY 2019 and CY 2020.

County's Capacity to Implement Mental Health Services

Practitioners speaking a non-English threshold language most commonly spoke Spanish (84.2%), followed by Korean (3.0%), Mandarin (2.1%), Armenian (1.9%), Tagalog (1.9%), and Farsi (1.4%). Spanish, Korean, Mandarin, Armenian, and Farsi were the primary languages most frequently spoken by clients in CY 2021 other than English.

Table 1. Practitioners Fluent and Certified in Non-English Threshold Languages, May 2022

Language	Number of Certified Practitioners	Number of Fluent Practitioners	Total	Percent
Arabic	9	26	35	**0.6%**
Armenian	29	89	118	1.9%
Cambodian	7	40	47	0.8%
Cantonese	8	62	70	1.1%
Farsi	10	75	85	1.4%
Korean	20	161	181	3.0%
Mandarin	17	109	126	2.1%
Other Chinese	**5**	55	60	1.0%
Russian	10	40	50	0.8%
Spanish	**544**	**4,594**	**5,138**	**84.2%**
Tagalog	18	96	114	1.9%
Vietnamese	8	50	58	1.0%

Note: Bolded numbers represent the highest and lowest values for that column.

Table 2. Percentages of diverse cultural, racial/ethnic, and linguistic groups represented among direct service providers, as compared to percentage of the total population needing services and the total population being served.

Language	Percent of Certified/Fluent Practitioners	Percent of Population Enrolled in Medi-Cal	Percent of Clients Served in Outpatient LACDMH Clinics
Arabic	0.6%	0.2%	0.07%
Armenian	1.9%	1.94%	0.59%
Cambodian	0.8%	0.21%	0.31%
Cantonese	1.1%	1.07%	0.25%
Farsi	1.4%	0.37%	0.31%
Korean	3.0%	0.86%	0.37%
Mandarin	2.1%	1.21%	0.25%
Other Chinese	1.0%	0.06%	0.31%
Russian	0.8%	0.35%	0.16%
Spanish	84.2%	33.61%	14.67%
Tagalog	1.9%	0.24%	0.12%
Vietnamese	1.0%	0.74%	0.25%

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

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

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

To ensure voice and advocacy for underserved communities, LACDMH a Cultural Competence Committee stakeholder group and seven Underserved Cultural Community (USCC) groups made up of stakeholders which include persons with lived experience and community members. The seven groups include: Latino, African/African Heritage, American Indian/Alaska Native, Eastern European/Middle Eastern, LGBTQIA2-S, and Access for All, and advocacy group for individuals with disabilities. The Department has also developed a Faith Based Leadership stakeholder group recognizing the role the many different faiths play in our local communities.

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

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

The largest barrier that impacts LACDMHs ability to meet the needs of racially and ethnically diverse populations and implement programs is workforce availability. Los Angeles County is impacted by the statewide shortage of service professionals. To meet our local needs, LACDMH has invested in workforce incentives, developed a workforce recruitment campaign "Do Worthwhile Work". Recruitment efforts target racially and ethnically diverse communities, and the Department is invested in programing for High School age youth to learn more about the field of Mental Health. LACDMH is offering training and supports for community members with lived experience interested in becoming Peer providers.

The geographical and population size of Los Angeles County also presents some challenges when working to assure access. LACDMH does work to ensure each Service Area has services available that is culturally reflective of the community. In some areas, LACDMH has worked to ensure Access through Telehealth. An example is with our Long Beach Asian Pacific Program, where service providers speak a variety of languages which may not be available Countywide. Long Beach API offers services via Telehealth to individuals in need of services, but do not live near the Long Beach Area.

Community Planning

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

The CPP used for developing the MHSA Three Year Program and Expenditure Plan for Fiscal Years 2024-25 and 2025-26 included two interlocking steps:

1. Forming a Community Planning Team (CPT) representing a diverse set of stakeholder groups, with particular attention to ensuring robust representation of people with lived experience as consumers, family members, caregivers, and peers.

2. Conducting a Community Planning Process offering meaningful engagement opportunities for stakeholder groups to provide input and generate recommendations, while offering equitable supports to ensure participation for all groups.

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

Community Planning (CPT)

The Community Planning Team (CPT) is the diverse, multi-stakeholder entity responsible for agreeing on recommendations for the MHSA Three-Year Plan. Consisting of 122 members, the CPT structure embodies three central commitments to a community-driven community planning process:

- A commitment to including a broad range of community and systems stakeholders. For this CPT, 92% (92 out of 100) of the members represent community voices, non-governmental organizations, and service provider networks.

- A commitment to robust representation of people with lived experience, by establishing a minimum threshold of 20%-to-30% of the total CPT being people with lived experience as consumers, clients, family members, caregivers, and peers. (This threshold is a floor, not a ceiling; the percentage can be higher.)

- A commitment to mirror as much as possible the demographic and cultural diversity of Los Angeles County.

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

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

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

Stakeholder Category 1

Community Leadership Team

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

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

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

Stakeholder Category 2

Community Stakeholders

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

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

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

Stakeholder Category 3

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

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

Stakeholder Category 4

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

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

Stakeholder Category 6

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

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

Community Planning Process

The Community Planning Process (CPP) was implemented in three phases and began in early July 2023 and ended in late February 2024.

- Phase 1 – Stakeholder Input (July, August, September)
- Phase 2 – Stakeholder Recommendations (October, November, December)
- Phase 3 – Consensus and Closing (January, February)

Phase 1 – Stakeholder Input (July – Sept. 2023)

The purpose of the stakeholder input phase during the months of July, August, and September, was to identify critical mental health issues (i.e., unmet mental health needs and/or mental health service gaps) impacting different populations from the perspective of community stakeholder groups.

DMH leveraged its extensive stakeholder engagement system—consisting of 30-plus distinct stakeholder groups that meet monthly—to identify critical mental health issues and to develop recommendations on how to best address the critical mental health issues for different populations and geographies. Community stakeholder groups that meet monthly includes Service Area Leadership Teams (8), SALT Leadership Team (1), Underserved Cultural Communities (7), UsCC Leadership Team (1), Health Neighborhoods (9), Peer Advisory Councils (2), Faith-Based Advocacy Council (1), to name a few.

Two Community Planning Team (CPT) meetings of three hours each were held each month to provide CPT members, MHSA stakeholders, and DMH staff an opportunity to engage each other on a sustained basis to develop communication expectations and a common understanding of MHSA, MHSA programs, services, interventions, and population and client data.

A. Foundation Setting: July

At the July 11th and 28th meetings, DMH consultants reviewed the CPP planning process and the following communication expectations to build positive and constructive relationships over the course of the planning process.

1. Be Present: Be on time and do your best to participate and engage each other in the spirit of conversation and learning.
2. Speak From Your Own Experience: Sharing your perspective based on your experiences helps us build community. It helps us find areas where we can relate and connect with each other. It also helps us in hearing and honoring the experiences of others.
3. Practice Confidentiality: The practice of respecting and protecting sensitive information that people share with you helps to builds trust.
4. Step Up, Step Back: To 'step up' means to being willing to share your thoughts and experiences with others so that your voice is part of the conversation. To 'step back' means being aware and mindful that others also need time to speak, and that some people take a little longer to compose their thoughts.
5. Seek To Understand and Then Be Understood: Ask questions to understand someone's view before expressing your view. This helps everyone feel heard and prevent misunderstandings.

In addition, CPT members were informed that if any felt uneasy with the content or process, they were encouraged to take care of themselves by reaching out to designated people who can help you process thoughts and feelings. In addition, participants were informed at the beginning of each meeting that DMH provides the following resources to ensure equitable access for everyone at all meetings:

1. American Sign Language interpreters in person and/or online.
2. Communication Access Real-Time Translation (CART) service in person and/or online:
    a. For in-person sessions, CART service transcription is projected onto a screen with simultaneous transcription; and spaces are reserved at the table(s) closest to the screen.
    b. For online sessions, CART service can be accessed by pressing a link in the Chat Box; if the person cannot access the Chat Box, the link can be obtained by emailing the moderator for the session.
3. Interpretation in Spanish and Korean.
    a. In person interpretation via a headset.
    b. Online interpretation via a telephone line.
4. Meeting materials used a minimum 12-font size in Arial or Times New Roman.
5. All materials in English and Spanish.
6. Chat Box:
    a. Generally available during the session to enable communication for access purposes: i.e., to add links to CART services, telephone lines for interpreters, and other links provided in real time.

b. When Chat Box not available, an email address is provided to enable participants to send questions to moderators in real time to participate in the meeting and/or request interpretation and/or CART services.

From a content perspective, the July sessions provided CPT members and MHSA stakeholders an overview of foundational MHSA information, such as:

1. Description of MHSA, MHSA Mission, Vision, Focus, and Core Principles.
2. How MHSA works.
3. MHSA Oversight and Reporting.
4. The California Code of Regulations' key definition of stakeholder engagement based on, which stipulates "meaningful stakeholder involvement…in mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocation" (Title 9 CCR 3300); and
5. MHSA components (CSS, PEI, INN, WET, CFTN):
   - Community Services and Supports (CSS): Direct mental health services and supports for children and youth, transition age youth, adults, and older adults. Permanent supportive housing for clients with serious mental health needs.
   - Prevention and Early Intervention (PEI): Services to engage individuals before the development of serious mental health need or at the earliest signs of mental health struggles. Statewide projects: Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction.
   - Innovations: Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system,
   - Capital Facilities and Technological Needs (CFTN): Building projects and improvements of mental health services delivery systems using the latest technology.

B. Reviewing Data and Defining Workgroups: August

The August 8th and 25th sessions focused on a review of planning data. In the first session, CPT members and MHSA stakeholder covered population-level and service-access data:

1. Total LA County population data, by race/ethnicity, by race/ethnicity and Service Area, and by age group and Service Area.
2. Population enrolled in Medi-Cal by Race/Ethnicity and Age Groups, Age Distribution, Primary Language, and Penetration Rate Changes for Medi-Cal Beneficiaries by Age and Race/Ethnicity.
3. DMH clients served by Service Area and specific racial/ethnic groups (FY 2022-23), number of MHSA clients served by Service Area and specific racial/ethnic groups (FY 2022-23), Foster Youth Placement and Foster Youth Removal Rate in Los Angeles County (2021), Total County of Adult/Youth Sheltered/Unsheltered Homeless and Justice Equity Need Rank in Los Angeles County (2022), and Justice Equity Need Rank in Los Angeles County (2022).
4. Number of MHSA Clients (2022-23) served by Race/Ethnicity; Services by Service Area and Racial/Ethnic Group; Distribution by Age; Served by Primary Language (2022-23); Served by Gender (2022-23); Served by Primary Language and Service Area (2022-23).

The August 25th session focused on data pertaining to the MHSA system of care (i.e., CSS, PEI, INN, WET, and CFTN), including:

1. Unique clients per program and Service Area
2. Cost per client
3. Unique clients by age group
4. Unique clients per Service Area

Lastly, CPT members and MHSA stakeholders were introduced to four Workgroups that would be the basis for developing recommendations for the MHSA Two-Year Plan. These were:

1. **Community Supports Continuum (CSC):** Promotes recovery, hope, and well-being for individuals experiencing serious mental health challenges through a continuum of community supports that includes the following: urgent/emergency services; intensive services; outpatient care services; and access points.
2. **Homeless Services and Housing Resources (HSHR):** Provides mental health services and housing resources for individuals experiencing serious mental health challenges through Homeless Services (i.e., outreach and treatment; and housing supports) and Housing Resources (i.e., short-term interim housing; and long-term permanent supportive housing).
3. **Prevention and Early Intervention (PEI):** Focuses on building protective factors, preventing trauma, eliminating mental health stigma, and intervening at the early onset of mental health challenges. Strategies include prevention, suicide prevention, early intervention, stigma and discrimination reduction, and outreach to increase recognition of early signs of mental illness.
4. **Workforce Education and Training (WET):** Focuses on recruiting and sustaining a highly qualified and talented workforce for the public mental health system in order to deliver culturally competent, congruent, and effective services for linguistically and culturally diverse mental health consumers who meet Specialty Mental Health service criteria.

C. Critical Issues and Categorization: September

During the September 5th and 22nd meetings, with information about the general population, access to services, and clients per MHSA program, CPT members and MHSA stakeholders began to generate a list of critical issues (i.e., unmet needs and service gaps) per Workgroup area.

In addition, some community stakeholder groups also submitted their lists of critical issues to DMH staff, which were integrated into a broader list. By the end of September and early October, 713 critical issues were identified and placed in each of the CPT Workgroups:

1. CSC: 133 critical issues
2. HSHR: 118 critical issues
3. PEI: 288 critical issues
4. WET: 174 critical issues

MHSA Meeting Date	In Person Attendees	Virtual Attendees	TOTAL
7/11/2023	10	24	34
7/28/2023	12	25	37

MHSA Meeting Date	In Person Attendees	Virtual Attendees	TOTAL
8/8/2023	35	32	67
8/25/2023	44	34	78
9/5/2023	59	36	95
9/22/2023	52	30	82

Survey Results

The following are results of surveys completed by attendees of the community planning meetings for Phase 1:

Questions	Aug-2023 (n=18)			Sep-2023 (n=48)		
	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion
Q1 - Meeting time was used efficiently	89%	11%	0%	73%	6%	21%
Q2 - Meeting provided opportunity to express views and ask questions	83%	6%	11%	65%	10%	25%
Q3 - Questions answered clearly and respectfully	47%	6%	47%	70%	6%	24%
Q4 - Safe environment for expressing views and asking questions	82%	0%	18%	81%	4%	15%
Q5 - Meeting had clear purpose and objectives	83%	6%	11%	90%	4%	6%
Q6 - Meeting materials relevant to purpose and objectives	78%	5%	17%	88%	2%	10%
Q7 - Presentations provided helpful information pertaining to the meeting objectives	83%	6%	11%	83%	6%	11%
Q8 - Logging in virtually on MS Teams was relatively easy	75%	6%	19%	61%	6%	33%
Q9 - ASL was clear and accurate	31%	0%	69%	45%	2%	53%
Q10 - Language interpretation was clear and accurate	31%	6%	63%	45%	2%	53%
Q11 - Accessing language interpretation was relatively easy	20%	0%	80%	43%	2%	55%
Q12 - CART services were clear and accurate	36%	0%	64%	45%	2%	53%
Q13 - Accessing CART services was relatively easy	36%	0%	64%	47%	2%	51%
Q14 - Meeting announcement and materials were provided in advance in a timely manner	72%	22%	6%	85%	9%	6%

Phase 2 – Stakeholder Recommendations (Oct. – Dec. 2023)

The purpose of the stakeholder recommendation phase during the months of October, November, and December was to provide facilitation support the CPT Workgroup members to review their list of critical issues, cluster their critical issues into specific sub-categories, create goal statements, and then combine critical issues into more specific their recommendations. Combining critical issues into specific recommendations was an important step because many critical issues were duplicates and/or very similar.

A. Organizing Critical Issues: October

On October 3rd and 27th, the CSC Workgroup organized its critical issues into the following sub-categories and corresponding goals:

Sub-categories	Goals
1. Emergency Response	*Improve Emergency Response*
2. Psychiatric Beds	*Expand and/or Improve Existing Program, Service, or Intervention*
3. Full-Service Partnerships	*Improve access to and efficacy of Full Service Partnerships (FSPs)*
4. Access to Quality Care	*Increase Access to Quality Care*

Accordingly, the CSC Workgroup refined its 133 critical issues into 52 distinct recommendations.

The HSHR Workgroup organized its critical issues into the following sub-categories and corresponding goals:

Sub-categories	Goals
1. Eviction Prevention	*Strengthen eviction prevention services and supports.*
2. Street Outreach	*Strengthen street outreach.*
3. Service Quality	*Improve service quality.*
4. Types of Housing Options	*Increase types of housing options.*
5. Specific Populations	*Provide targeted support to specific underserved populations.*

Accordingly, the HSHR Workgroup refined its 118 critical issues into 97 distinct recommendations.

The PEI Workgroup organized its critical issues into the following sub-categories and corresponding goals:

Sub-categories		Goals
1. Populations	A. Early Childhood/ Birth to 5	Strong and effective prevention and early intervention programs/services for various stages of childhood from prenatal and birth to five.
	B. Underserved Communities	Improve the cultural and linguistic capacity of prevention and early intervention programs/services to reach hard to reach underserved populations
2. Access	A. School-Based: K-12 Schools, Colleges, Universities, and Trade Schools	Increase Access for services to youth in School-Based: K-12 Schools, Colleges, Universities, and Trade Schools
	B. Community Engagement (Including TAY Advisory Group)	Increase Access for PEI services leveraging community platforms/partners.
3. Effective Practices	A. Suicide Prevention	Strengthen suicide prevention programs/services
	B. Evidence Based Practices/Treatment	Increase use of evidence-based practices and community defined evidence

Accordingly, the PEI Workgroup refined its 288 critical issues into 134 distinct recommendations.

The WET Workgroup organized its critical issues into the following sub-categories and corresponding goals:

Sub-categories	Goals
1. Mental Health Career Pathways	Strong partnerships and mental health career pathways with local colleges/universities to increase the availability and diversity of the potential workforce pool.
2. Residency and Internship	Increase the department's residency and internship opportunities.
3. Financial Incentives	Strengthen the available financial incentives for recruiting new and retaining current DMH staff.
4. Training and Technical Assistance	Highly trained DMH workforce with the skills and capacity to deliver quality services

Accordingly, the WET Workgroup refined its 174 critical issues into 52 distinct recommendations.

B. Organizing and the Recommendations: November and December

Between the October 27th and November 7th and 17th Workgroup meetings, DMH managers reviewed all the Workgroup recommendations and coded them into two types:

1. Program, Service, or Intervention (PSI) Recommendations:
   - Exist Already: Expand and/or Improve Existing PSI
   - Do Not Exist: Add New PSI
2. Policy, Practice, and/or Advocacy Recommendations

Each Workgroup spent time reviewing, refining, and validating that the recommendations indeed fell into these two types.

In preparation for the December meetings, DMH managers then color-coded each recommendation in the following manner:

Color	Description
Green	DMH or partner agency is already doing this work, ongoing funds are already appropriated, and/or additional funds can be appropriated.
Red	MHSA regulations prohibit funding this recommendation, or the program can not be implemented with one time limited funding, or the recommendation is outside of the DMH's authority, or the recommendation was not clear. CPT members can still advocate for these recommendations.
Yellow	DMH needs Workgroup members to provide additional feedback.

This color-coding exercise led to the following number of recommendations for each workgroup:

Statistics	Overall	CSC	HSHR	PEI	WET
Total CPT Recommendations	335	52	97	134	52
Total CPT Recommendations Not Possible	21	4	7	4	5
Total CPT Recommendations Possible	314	48	90	130	47

During the December 5th and 15th meetings, CPT members were asked to review and refine the yellow recommendations in order to rank them.

MHSA Meeting Date	In Person Attendees	Virtual Attendees	TOTAL
10/3/2023	69	41	110
10/27/2023	74	31	105
11/7/2023	119	38	157
11/17/2023	66	36	102
12/5/2023	81	34	115
12/15/2023	54	31	85

The following are results of surveys completed by attendees of the community planning meetings for Phase 2:

Questions	Oct-2023 (n=42)			Nov-2023 (n=16)		
	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion
Q1 - Meeting time was used efficiently	79%	12%	9%	94%	6%	0%
Q2 - Meeting provided opportunity to express views and ask questions	71%	17%	12%	75%	6%	19%
Q3 - Questions answered clearly and respectfully	74%	14%	12%	69%	6%	25%
Q4 - Safe environment for expressing views and asking questions	85%	10%	5%	75%	6%	19%
Q5 - Meeting had clear purpose and objectives	76%	12%	12%	88%	6%	6%
Q6 - Meeting materials relevant to purpose and objectives	75%	15%	10%	94%	6%	0%
Q7 - Presentations provided helpful information pertaining to the meeting objectives	79%	12%	9%	94%	6%	0%
Q8 - Logging in virtually on MS Teams was relatively easy	46%	23%	31%	53%	7%	40%
Q9 - ASL was clear and accurate	38%	5%	57%	33%	7%	60%
Q10 - Language interpretation was clear and accurate	33%	5%	62%	27%	7%	66%
Q11 - Accessing language interpretation was relatively easy	24%	6%	70%	33%	7%	60%
Q12 - CART services were clear and accurate	33%	16%	51%	53%	7%	40%
Q13 - Accessing CART services was relatively easy	37%	10%	53%	47%	7%	46%
Q14 - Meeting announcement and materials were provided in advance in a timely manner	55%	29%	16%	80%	13%	7%

Questions	Dec-2023 (n=39)		
	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion
Q1 - Meeting time was used efficiently	85%	10%	5%
Q2 - Meeting provided opportunity to express views and ask questions	74%	10%	16%
Q3 - Questions answered clearly and respectfully	72%	8%	20%
Q4 - Safe environment for expressing views and asking questions	76%	11%	13%
Q5 - Meeting had clear purpose and objectives	85%	13%	2%

Questions	Dec-2023 (n=39)		
	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion
Q6 - Meeting materials relevant to purpose and objectives	80%	10%	10%
Q7 - Presentations provided helpful information pertaining to the meeting objectives	80%	10%	10%
Q8 - Logging in virtually on MS Teams was relatively easy	36%	12%	52%
Q9 - ASL was clear and accurate	33%	6%	61%
Q10 - Language interpretation was clear and accurate	37%	9%	54%
Q11 - Accessing language interpretation was relatively easy	31%	9%	60%
Q12 - CART services were clear and accurate	39%	6%	55%
Q13 - Accessing CART services was relatively easy	41%	6%	53%
Q14 - Meeting announcement and materials were provided in advance in a timely manner	67%	14%	19%

Phase 3 – Community Planning Process Closing (Jan 2023 – Mar. 2024)

The purpose of the last phase was to generate consensus among CPT Workgroup members around a core set of programs, services, and interventions.

From December 22 to January 6, CPT members and MHSA stakeholders were sent a survey to score the yellow recommendations. The survey results were tallied and presented to the Workgroups on January 16th and members were asked to build consensus on their ranking order. The CSC, PEI, and WET Workgroups achieved consensus on January 16th and the HSHR Workgroup achieved consensus on its ranking at the January 26th meeting.

DMH managers then reviewed all the information from the Workgroups, including their ranking results, and produced a list of DMH recommendations for funding consideration that accounted for Board priorities, DMH obligations, and other key criteria (e.g., ensuring that recommendations for one-time funding can be implemented within a two-year period to avoid reverting back to the state coffers).

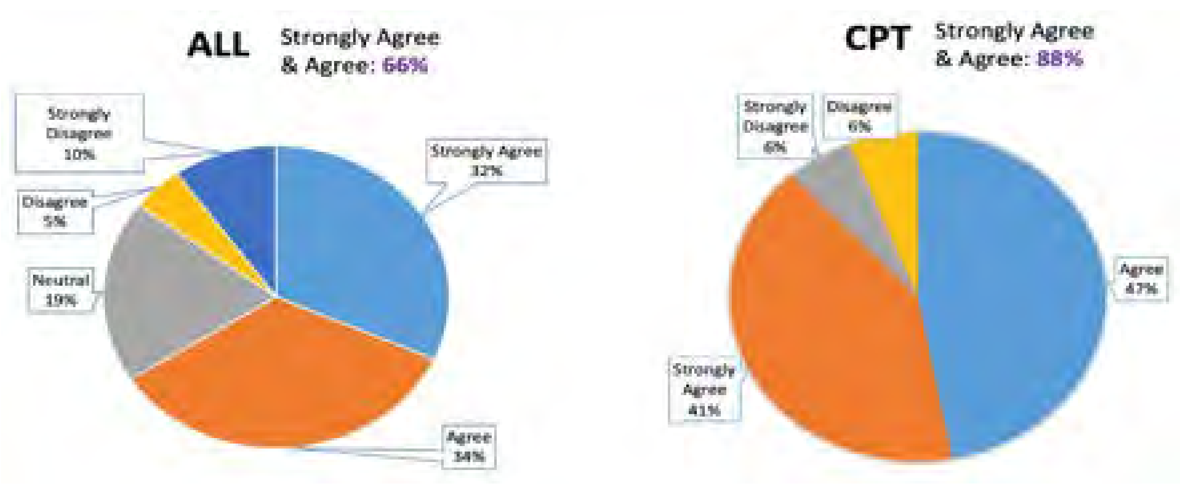
This list was presented to the CPT members and MHSA stakeholder of February 6th for feedback. Based on feedback, DMH provided additional materials to show how its recommendations aligned with stakeholder-generated recommendations. The following table show the percent of CPT recommendations that DMH is recommending for funding consideration:

Statistics	Overall	CSC	HSHR	PEI	WET
Total CPT Recommendations	335	52	97	134	52

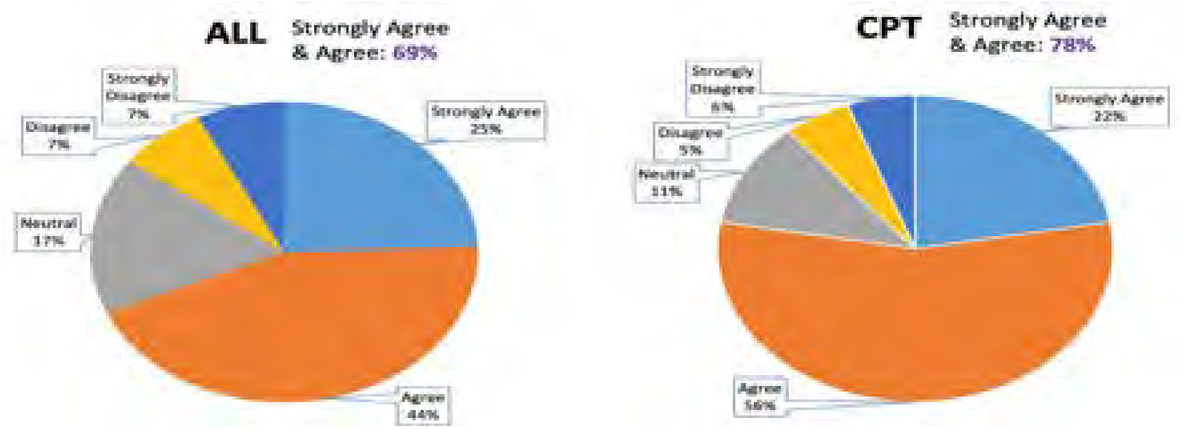
Statistics	Overall	CSC	HSHR	PEI	WET
Total CPT Recommendations Not Possible	21	4	7	5	5
Total CPT Recommendations Possible	314	48	90	129	47
Total DMH Recommendations for Implementation	247	37	72	102	36
Percent of Recommendations for Implementation	79%	77%	80%	79%	77%

CPT members and MHSA stakeholders were asked to indicate the extent to which they felt that the DMH's list of recommendations comprehensively addressed their Workgroup's recommendations and the CPT's overall recommendations (all four Workgroups). The results were as follows:

DMH's List of Recommendations comprehensively addresses the recommendations from the CPT Workgroup(s) I participated in.



DMH's List of Recommendations comprehensively addresses the <u>overall</u> set of CPT and stakeholder recommendations



MHSA Meeting Date	In Person Attendees	Virtual Attendees	TOTAL
1/6/2024	69	33	102
1/26/2024	67	39	106
2/6/2024	51	60	98

The following are results of surveys completed by attendees of the community planning meetings for Phase 3:

Questions	January 2024 (n=19)		
	Agreed / Strongly Agreed	**Disagreed/ Strongly Disagreed**	**No Opinion**
Q1 - Meeting time was used efficiently	63%	37%	0%
Q2 - Meeting provided opportunity to express views and ask questions	58%	37%	5%
Q3 - Questions answered clearly and respectfully	53%	31%	16%
Q4 - Safe environment for expressing views and asking questions	61%	28%	11%
Q5 - Meeting had clear purpose and objectives	69%	26%	5%
Q6 - Meeting materials relevant to purpose and objectives	74%	26%	0%
Q7 - Presentations provided helpful information pertaining to the meeting objectives	61%	33%	6%
Q8 - Logging in virtually on MS Teams was relatively easy	30%	31%	39%
Q9 - ASL was clear and accurate	21%	29%	50%

Questions	January 2024 (n=19)		
	Agreed / Strongly Agreed	Disagreed/ Strongly Disagreed	No Opinion
Q10 - Language interpretation was clear and accurate	33%	27%	40%
Q11 - Accessing language interpretation was relatively easy	33%	27%	40%
Q12 - CART services were clear and accurate	29%	28%	43%
Q13 - Accessing CART services was relatively easy	31%	31%	38%
Q14 - Meeting announcement and materials were provided in advance in a timely manner	40%	40%	20%

C. Public Hearing

LACDMH completed the 30-day public posting and comment period on March 28, 2024. The pubic hearing meeting occurred on March 28, 2024 with Spanish and Korean interpreters along with interpreters for those individuals with hearing impairments. The meeting was held at 510 S. Vermont, Los Angeles. The agenda, presentations and transcripts are included in Appendix E. The community and stakeholders were notified about the event via email, DMH MHSA Announcements Page and included as part of the Mental Health Commission calendar of events.

D. Stakeholder Feedback

During the public hearing, comments received included compliments for the hard work and improvements made to the plan. Other comments included identifying how services will be distributed equally and the explanation for why the organization Parents Anonymous was not included as a recommended project.

In addition to providing public comments in person, a survey was posted in conjunction with the MHSA Two Year Program and Expenditure Plan to collect feedback in both English and Spanish during the public posting and comment period. The results of the survey include:

1. Please identify strengths of the Plan (8 responses).

ID	Response
1	Positive
2	N/A
3	The magnitude in which the passion and the unwavering support these impactful programs, and initiatives have.
4	Plan written appears to address some concerns - but does not address the overarching issue for DMH - as internal DMH issues of not having staff that are subject matter experts on the ADA, disability and Deaf/Hard of hearing issues. Those appointed are not experts, and do not have the breadth of knowledge to bring DMH into ADA compliance. - Note that one of the chairs of the Access 4 All meeting indicated that the MHSA plan is not accessible to persons with disabilities.

ID	Response
5	The Plan contains all the mayor areas of mental health. It includes how the effectiveness can be evaluated during the implementation.
6	None
7	Key strengths of the CSS plan TBD
8	The plan does cover a whole lot of recommendations and did take the effort to bring community stakeholders in to work through them.

2. Please identify any weakness of the Plan (12 Responses)

ID	Response
1	Negative
2	I did not see any breakdown by ethnic disaggregated data on utilization rates of MHSA services. I'd like to see how many APIs, African Americans, etc. are using the MHSA services and if possible by service area. This is important to understand disparity issues and where outreach needs to be focused.
3	N/A
4	Develop service teams to provide direct mental health services to deaf, hard of hearing, deafblind, and deaf disabled individuals and families fully accessible in ASL. − CSC/Q15. Provide a one-stop mental health center across all Service Areas that provides direct mental health services to deaf, hard of hearing, deafblind, and deaf-disabled individuals and families fully accessible in American Sign Language (ASL). Services include mental health therapy, anger management counseling, substance abuse counseling, case management, and aftercare support, which are the areas historically lacking accessibility and support across all Service Areas in Los Angeles County. (not shouting - trying to separate out the section from my response) THIS ONE STOP CENTER NEEDS TO BE DEVELOPED AND OVERSEEN BY DMH - NOT "FUNDED" IN THE COMMUNITY. WE ARE TIRED OF PROGRAMS FOCUSED ON US SHUTTING DOWN DUE TO "GRANT ISSUES". THERE APPEARS TO HAVE BEEN SOME SHADY DEALS WITHIN DMH AND GLAD - THIS IS NOT AN AGENCY THAT SHOULD BE FUNDED FOR MENTAL HEALTH. WE DEMAND THAT GLAD NOT BE PROVIDED ANY FUNDING FOR MENTAL HEALTH SERVICES - THEY HAVE RARELY ATTENDED THE USCC MEETINGS AND ONLY APPEAR TO CARE IF THERE IS MONEY INVOLVED. THEIR SERVICE RECORD IN THE COMMUNITY IS NOT GREAT NOR DO THEY ADDRESS THOSE WHO DO NOT USE ASL. The recommendation is for LACDMH to create a Deaf/HH Division to develop and address the current issues facing the community and the ongoing barriers to treatment. Hire Deaf/Signing clinician to be director and the appropriate staff - there needs to be a great deal of education within all of DMH for staff and contractors to understand their ADA obligations. What you have implemented, and not hired an actual ADA Coordinator, but someone who has to be trained - leading to the MHSA report allegedly not being accessible - DMH was on notice about their website, documents and emails for more than 2 years and clearly still have not properly staffed and funded positions to address 508 and ADA compliance. ADDITIONALLY - JUST TO LET YOU KNOW - The 2 of the 3 projects supported by the Access 4 All USCC were ALL INACCESSIBLE to the DHH community - shamefully DMH does not have staff qualified to assess bidders competency and awarded grants to some agencies that did not work with, nor provide services to the disability/DHH community. Comments from A4All members about the false information and data expressed by the grantee, and the inaccessibility of the products fell on "deaf ears" as they are still posted and inaccessible!!! It also appears that the new "ASL interpreter"

ID	Response
	they hired does not have RID certification nor do they have Mental Health interpreter training.
5	"Explore potential trainings for ASL interpreters on working with individuals with mental health disabilities." DMH has failed for more than 8 years, but specifically the past 2 years by ignoring the USCC Access 4 All ongoing pleadings to get ASL interpretrers trained in mental health - finally they approve a project to establish a training in LA for ASL interpreters on mental health, yet DMH pulled it to assign internally - ignoring the dire need and placing the DHH community at risk. Subject matter experts have attempted to assist DMH - but they have ignored their offer, they refused to put it out for bid so that they could bid on it, instead are now going to depend on a new hire ASL interpreter who, from contacting the Registry of Interpreters for the Deaf, is not nationally certified, nor have they taken any mental health interpreter training themselves. One of the DHH co-chairs just resigned due to staff at DMH playing games for more than 2 years, taking all information from the members and then screwing it up because they dont understand it. The saying in the disability/DeafHH community is - NOTHING ABOUT US WITHOUT US - yet DMH fails as they don't have staffing that reflect our community and continue to put bad actors in place to silence us.
6	Some of the requirements are not specific. For example, in the case of the awareness campaigns mentioned, it is not specified what type of campaigns are required, may it be traditional media or social media or both.
7	Core services so the funding is just recycled back to the state I'm assuming medi-cal. Not all individuals diagnosed with a illness need residental settings besides the providers currently available are less than desired by a mental health patient. Investing more funding is a waste of money core services are not needed by the patient. Mental health stability comes with stability and self care. The ability to be able to take care of oneself like maintain a home maintain a bank account maintain a car payment, insurance and other personal finances provides self worth and self sustainable wellness. The structured facilities is just another reminder that the patient can't or doesn't deserve to take care of themselves. Therefore the stigma grows larger and digs deeper into the patients self identity. Funding needs to go towards housing and temporary housing not congregated shelters. Congregrated shelters are for stray animals. Housing is a human right. The basic needs, housing, temporary housing , motel vouchers airbnb gift cards grocery gift cards Walmart, Burlington Coat Factory all retailers that support self care. target, CVS, and Walgreens these retailers provide the everday necessities that support self care. Effective Advocacy and a system needs to be created to monitor the effectiveness of the entity's funded by the MHSA. The effectiveness reported by the patients served. Every patient receiving assistance that is logged with a organization and or funded program needs to complete a survey to receive help. A overall survey of effectiveness and be able to rate and or state any issues or concerns they may have had with the organizations process and services provided or lack there of. Abundance of uneccessary providers takes away actual funds that need to be utilized on the patient, not a multimillion dollar property for the core provider and or organization. There is zero need for so many organizations that claim they are part of the solution and that they are supporting mental health wellness. When in fact they provide only to those they choose . Its not a popularity contest or a raffle it needs to be segregated in levels of severity and or crisis, not by peoples origin. A brain is a brain trauma and pain is universal. to provide mental health wellness Inclusion needs to be able to reflect AMERICAN CITIZENS not just Latino and Latina, focused assistance. Mental

ID	Response
	Health is the Group, there should be no other segregated groups funded assistance because now those organizations are EXCLUDING everyone else. They are part of the problem and take away from effective ability and available solutions and financial resources that go directly to the actual patient. Terms and conditions to recieve assistance is again another way to disqualify to the providers discretion who gets help and who doesn't. If you are disgnosed by a mental health professional then tier one, tier two hospitalized, involuntary, tier three hospitalized voluntarily, outpatient tier four hospitalized voluntarily inpatient. Levels not origins and not all are in need of structured facilities just another way of degrading the patient and projecting the lack of trust or confidence that a patient needs to progress further with sustained mental health stability and wellness
8	The document is 373 pages long. With a significant burden of cost to print it and try have access to the information in it that is only in English and not accessible to people with disabilities. Not Americans with Disabilities Act (ADA) accessible pdf for people with disabilities. Requested accessible version, condensed summary, Spanish version to LACDMH staff numerous times during various MHSA stakeholder meetings. Deadline will now passed and access was not available because of our disabilities and language needs. None of these need for access are new but we did encounter LACDMH staff inform consumers and stakeholders that no disability or language interpeteation would be provided for these and other MHSA stakehoelder process.
9	Key struggles for the plan include the concerns over homelessness, funds to help capitalize and reinstate the Housing Trust Fund to support the development of supportive housing. Today, to keep pace with the crisis in our communities. We need immediate ready for occupancy dwellings, housing and investments. Not Two or Three year housing units down the road. The importance of re-establishing the Housing Trust Fund to support the development of Homelessness. Transitional housing, Permanent housing for the unhoused in Los Angeles County, The critical need to produce dwellings and restore buildings, immediately. We must Explore Long-term commitments and investments for housing, Building Hope... Sincerely, Osbee Sangster - Black Los Angeles County Client Coalition Inc.
10	REVERSE the REDLINE OF Parents Anonymous Proposal on page 356 3B which does not reflect the facts. Elimination of Parents Anonymous was based on "MHSA regulations prohibit funding this recommendation, the recommendation is outside of the DMH's authority, or the recommendation was not clear. CPT members can still advocate for these recommendations, but they cannot be funded by MHSA." INCORRECT. Parents Anonymous has a 3-year grant for MHSA PEI funding by DMH under Transforming LA totally $ 600,000 and furthermore, we have a seven year Master Agreement for Parents Anonymous services 2019-2026 for MHSA PEI. Please reverse this decision to GREEN based on the FACTS. We have served millions of LA county residents and many more are seeking our evidence-based services that are culturally responsive and produce positive results for all. According to the Federal Title IV-E Prevention Clearinghouse, Parents Anonymous® is the ONLY culturally responsive program that is proven to Effectively Improve Parenting, Enhance Mental Health and Reduce Substance Abuse while Ensuring Child Safety for parents and children and youth of all ages.
11	The CPP process, intended to guide the distribution of funds for mental health services, has fallen short in its methodology. Despite the significant financial

ID	Response
	stakes involved—billions of dollars earmarked for the betterment of our community—the decision-making process lacks the rigor and data-driven evaluation needed to ensure the most impactful allocation of resources. Rather than a thorough examination of the impact and effectiveness of proposed recommendations, decisions appear to have been made without the necessary research and analysis. The absence of comprehensive data on the outcomes and efficacy of proposed initiatives undermines the credibility and integrity of the decision-making process. Furthermore, the exclusion of organizations like Parents Anonymous, which have a proven track record of service and support for diverse communities, raises serious concerns about the transparency and inclusivity of the CPP process. It's disheartening to witness the elimination of organizations that have long been pillars of support for vulnerable populations, without due consideration of their contributions and effectiveness. As stewards of public resources and advocates for the well-being of our community, it's imperative that we demand accountability and transparency in the decision-making process. We owe it to the residents of Los Angeles to ensure that their needs are met with the utmost care and diligence.
12	As a CPT member, Consumer who is Native and Latino I am concerning about the elimination of Parents Anonymous from the MHSA PEI 2426 Plan even though a Proposal was submitted, and the PEI Committee added this to the list page 356 3B. False pretenses are being used to eliminate a nationally recognized Program that prevent, treats and has me and my family and millions of other diverse families throughout LA County since 1969. Parents Anonymous is APPROVED AND CURRENTLY RECEIVES MHSA PEI FUNDING under TLA for a total of $ 600,000. So if we meet all MHSA Guidelines and no one at DMH even met with Parents Anonymous to discuss their proposal what is the meaning of REDLINING IT OUT OF THE PLAN. With more than 1 billion in reserves and PEOPLE HURTING how can you deny needed services for the million like my family suffering? The Federal Government recognizes the value of Evidence-Based Parents Anonymous Programs since 1969 and LA County Agencies are contracting with us. Please include these lifesaving services for PEI NOW.

3. After reviewing the plan, please rate your understanding of the following (10 responses):

ID	Overall ease and clarity of the information presented	How MHSA programs are being implemented	How MHSA funding is being spent
1	Excellent	Excellent	Excellent
2	Good	Fair	Good
3	Very Good	Very Good	Very Good
4	Fair	Fair	Poor
5	Fair	Poor	Poor
6	Good	Good	Fair
7	Fair	Poor	Poor

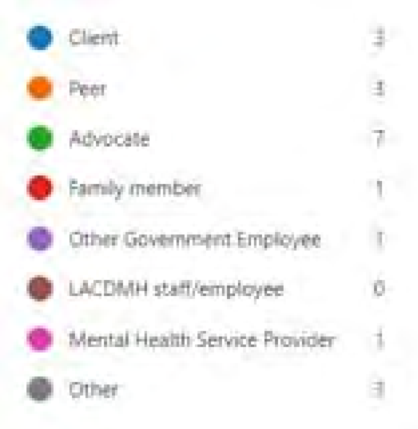
ID	Overall ease and clarity of the information presented	How MHSA programs are being implemented	How MHSA funding is being spent
8	Poor	Poor	Poor
9	Good	Good	-------------
10	Fair	Poor	Poor

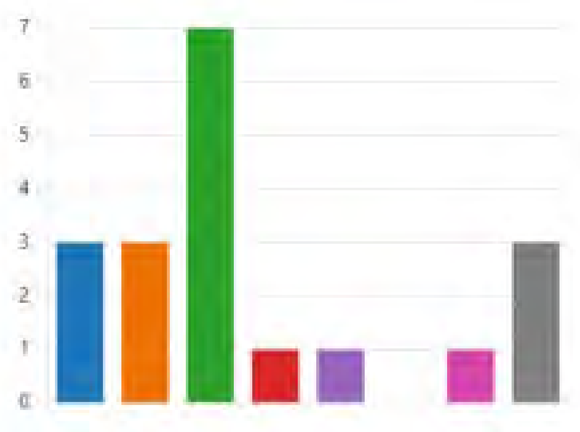
4. Do you have any ideas on how to improve the presentation and content of future MHSA reports and updates? (9 Responses)

ID	Response
1	Yes
2	See above – lack of disaggregated data on utilization by ethnicity and service area
3	The consideration of providing supplementary and supportive materials throughout the Los Angeles County Library District. The potential for community involvement, engagement and outreach support available from each of the 86 library branches throughout L.A. County. The Los Angeles County Library Foundation is invaluable in such areas.
4	Data isnt accurate - funding is being mismanaged and people with disabilities need to be represented in all programs, projects and divisions. and for crying out loud, make your documents accessible to screen readers and 508 compliant - its 2024, not 1990!!! Hire an actual ADA Compliance Officer to vet the document to address the other areas that need to be accessible
5	Some information is repeated which may confuse the reader.
6	A three rule needs to be implemented that if a government and or funded organization employee gets three valid complaints they need to be terminated. The discrimination. And poor attitudes and rude, cold, and short uncaring demeanor of some employees only drives the patient away and discourages them to ask for help.

ID	Response
7	Follow the law, and the new Proposition 1 mandates.
8	N/A
9	Begin with the amount on table and if there are any restrictions on allocations. Be clear, and don't just talk in percentages. Total the dollar amounts allocated. Be clear as to which recommendations are moving forward and which arent and PROVIDE RATIONALE as to why that has been decided or recommended.

5. What is your affiliation?





VI. DMH LIST of RECOMMENDATIONS FOR FUNDING CONSIDERATION FOR FISCAL YEAR 2024-25

Below is a list of recommendations for MHSA programming for FY 2024-25. These are the projects/concepts proposed by Stakeholders and other County Departments during the Stakeholder process from July 2023 through February 2024. LACDMH is committed to working with proposers to finalize project details, budget and the ability to implement the programs.

No.	Proposal
Community Supports Continuum (CSC)	
1.	Lower level FSP: Develop and implement a program to meet the varying levels of need for Field Service Partnership graduates who may still need field based and occasional field-based services and prevention for individuals who are at risk for need of higher level of care.
2.	WRAPAROUND Full Service Partnership (FSP)
3.	Lower level of FSP – provide funding for the Measure H funded mental health services for individuals housed in Measure H funded Permanent Supportive Housing.
4.	Expand Preventing Homelessness, Promoting Housing. (PH^2)
5.	Add Peer Support Across Programs (operationalize as add to Measure H Program).
6.	Lower level FSP – to expand and add services to current Veterans Peer Access Network (Develop or integrate mental health services into existing programming for women veterans who have experienced Trauma.)
7.	Establish a centralized source of information to access culturally and linguistically appropriate services in a timely manner.
8.	Invest in LA County efforts to track equity metrics, focusing on health, income, education and access disparities.
9.	Community and Stakeholder Capacity Building
Community Supports Continuum / Housing/Prevention	
10.	Expand Service Navigator teams across all age groups to assist families and individuals, and housing resources in each service area. Consider central team to track and communicate internal and community resources.
11.	Invest in media campaigns to raise awareness regarding available programming in CSC including Veterans, Prevention, Housing Resources, and Recruitment, improve website accessibility.
Capital Facilities Technological Needs	
12.	Children's Community Care Village
13.	Investment in capital facilities for services for individuals who are unhoused (Crocker).
14.	IT investment to improve data tracking and automation to improve reporting out outcomes, expenditure, and service usage data.
Housing	

No.	Proposal
15.	Increase MHSA funds for Flexible Housing Subsidy Pool which can be used for rent subsidies for individuals who do not meet homeless definition but do not have funds to move into other forms of housing (creating flow).
	Housing/ Community Supports Continuum
16.	Expand Peer Respite Programs to each Service Area with a priority on individuals who are at risk of losing or without housing.
	Prevention
17.	Contract with a third party intermediary to facilitate CBO funding for Prevention projects.
18.	Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family. Partner with DCFS to fund CBOs to provide this service.
19.	Explore how to increase awareness of existing services in the community through health promoters, awareness campaigns, increasing visibility through websites and social media through increasing support and oversight of Promoters program.
20.	Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities, health education on metal health and /or SUDs and wellness classes on meditation, fitness, healthy cooking, etc. Target individuals experiencing homelessness and justice involved. Prioritize high need communities, such as the Antelope Valley.
21.	Expand service to Transition Age Youth (TAY) who are not enrolling in colleges, universities, or trade schools. This includes youth struggling with transitioning into adulthood and outside of school systems through development of a TAY unit which leverages current work in partnership with local community colleges.
22.	Explore options to increase accessibility for training and services for individuals with disabilities so that service delivery staff have skills needed to ensure access and competent services.
	Workforce Education Training (WET)
23.	Explore developing strategies for DMH to partner with middle and high schools/school districts to increase the opportunities into mental health (outreach, fairs, afterschool programs, etc.)
24.	Explore developing a marketing campaign/program for mental health services and careers, include but don’t limit to a focus on high school age youth.
25.	Explore developing recruitment opportunities with Community colleges to create pathways for potential mental health employees.
26.	Increase financial incentives for specialty public mental health staff including but not limited to Mental Health Loan Repayment program and stipends for all direct service levels.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
DMH List of Recommendations
MHSA Programming FY 2024/25 to FY 2025/26

PURPOSE

The purpose of this document is to provide Community Planning Team (CPT) members and MHSA stakeholders information and instructions to fill out a survey to close the stakeholder input segment of the MHSA Community Planning Process.

- The first section describes how DMH responded to the key CPT and MHSA stakeholder questions that emerged on February 6, 2024, when DMH presented its List of Recommendations for Funding Consideration.
- The second section displays the percentage of CPT and MHSA stakeholder recommendations that DMH's List of Recommendations addresses. This includes the overall set of CPT Recommendations and the more specific CPT Workgroup consensus recommendations.
- The third section reviews the survey and gives specific instructions on how to fill it out.
- The fourth section contains three tables that respond to the CPT and MHSA stakeholder questions raised on February 6, 2024.

Lastly, as you fill out the survey, please review the document that contain the full list of recommendations from the various Workgroups. This document is attached separately.

SECTION 1: BACKGROUND

On February 6, 2024, after DMH managers presented their list of recommendations for MHSA funding consideration for FY 2024/25 and 2025/26, CPT members and MHSA stakeholders requested additional time to review the materials before completing a survey to close this segment of the MHSA community planning process.

More specifically, CPT members raised two general questions to help them respond to the survey:

1. How are DMH's recommendations for funding consideration aligned with the CPT Workgroup consensus recommendations?

2. What will happen to the CPT Workgroup consensus recommendations that do not appear on DMH's list of recommendations for funding consideration?

A request was made for a table that displays the concrete CPT Workgroup recommendations covered by DMH's list of recommendations.

Over the past week, DMH used these two questions to review the CPT Workgroup consensus recommendations (i.e., the yellow-colored ones) and developed three tables to respond to these questions.

1. Table 1 - Crosswalk Table: This table shows how DMH's recommendations align with the CPT Workgroup consensus recommendations for the Community Supports Continuum (CSC), Homeless Services and Housing Resources (HSHR), Prevention and Early Intervention (PEI), and Workforce Education and Training (WET). The right hand columns display the Workgroup's consensus recommendations. Importantly, DMH recommendations include the Workgroup's recommendation. In other words, the content of the Workgroup recommendation is part of DMH's recommendation.

DMH then analyzed the CPT Workgroup consensus recommendations that do not appear in the Crosswalk Table and distinguished between two types of recommendations:

2. Recommendations that DMH can move forward with because they do not entail funding consideration, or the resources can be obtained either through a partnership or by restructuring current work. See Table 2: Move Forward.

3. Recommendations that DMH does not recommend moving forward with at this time because they entail funding considerations and/or did not meet other evaluation criteria that were presented to the CPT members in January 2024 (e.g., implementable within a two-year period; meets Board priorities; etc.). See Table 3 - Future Funding Considerations.

In summary, DMH recommends that the list of programs, services, and interventions contained in Table 1 and Table 2 at the end of this document, along with all the green-colored recommendations in the attached Total CPT and Workgroup Recommendations document, should move forward into the implementation phase.

SECTION 2: SUMMARY

This final DMH List of Recommendations, compared to the one presented on February 6, 2024, increases the total number and percent of CPT recommendations and those of the CPT Workgroups that can be implemented over the course of the next two fiscal years.

STATISTICS	OVERALL	CSC	HSHR	PEI	WET
Total CPT Recommendations	335	52	97	134	52
Total CPT Recommendations Not Possible	21	4	7	5	5
Total CPT Recommendations Possible	314	48	90	129	47
Total DMH Recommendations for Implementation	247	37	72	102	36
Percent of Recommendations for Implementation	79%	77%	80%	79%	77%

SECTION 3: SURVEY INSTRUCTIONS

Please fill out this survey after reviewing the three tables below and the attached CPT Workgroup Recommendations.

Use this link to access the survey: https://forms.office.com/g/JwPvJmZ0Zp

Surveys are due by 5 PM on Tuesday, February 20, 2024.

If you have any questions about how to fill out this survey, please email us at communitystakeholder@dmh.lacounty.gov.

We will provide you a summary of the results on Friday, February 23, 2024.

This survey has three parts:

1. Participant Background
2. Your Views on the DMH List of Recommendations
3. Your Views on the Overall MHSA Community Planning Meetings

Each question also has a window where you can add your comments.

PART 1: Participant Background

I am a:

- ☐ Community Planning Team Member
- ☐ MHSA Stakeholder Participant
- ☐ Other [Please specify]

I participated in the following CPT Workgroup(s) [Check all that apply]

- ☐ Community Supports Continuum (CSC)
- ☐ Homeless Services and Housing Resources (HSHR)
- ☐ Prevention and Early Intervention (PEI)
- ☐ Workforce Education and Training (WET)
- ☐ I did not participate in a Workgroup

PART 2: DMH's List of Recommendations

How strongly do you agree or disagree with the following statements regarding DMH's List of Recommendations?

1. DMH's List of Recommendations comprehensively addresses the recommendations from the CPT Workgroup(s) I participated in.
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree

Comment:

2. DMH's List of Recommendations comprehensively addresses the overall set of CPT and stakeholder recommendations.
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree

Comment:

3. The DMH List of Recommendations is good enough to move forward onto implementation.
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree

Comment:

PART 3: Overall MHSA Community Planning Meetings

Please reflect on total set of meetings you participated in from July 2023 through February 2024 and let us know your overall view of the meetings.

How strongly do you agree or disagree with the following statements regarding your experience in the community planning meetings?

1 – The meeting time was used efficiently.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

2 – The meetings provided opportunity to express my views and ask questions.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

3 – My questions were answered clearly and respectfully.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

4 – The meetings provided a safe environment for expressing my views and asking questions.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

5 – The meetings had a clear purpose and objectives.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

6 – The meeting materials were relevant to the meeting purpose and objectives.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

7 - The presentations provided helpful information pertaining to the meeting objectives.

- ☐ Strongly Agree
- ☐ Agree

- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree

Comment:

8 - Logging in virtually on MS Teams was relatively easy.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need to participate virtually

Comment:

9 - ASL was clear and accurate.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

10 - Language interpretation was clear and accurate.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

11 - Accessing language interpretation was relatively easy.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

12 - CART services were clear and accurate.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

13 - Accessing CART services was relatively easy.

- ☐ Strongly Agree

- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

14 - Meeting announcements and materials were provided in advance in a timely manner.

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly Disagree
- ☐ I did not need this service

Comment:

SECTION 3: TABLES

TABLE 1 - CROSSWALK TABLE: DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION

This table shows how DMH's recommendations align with the CPT Workgroup consensus recommendations for the Community Supports Continuum (CSC), Homeless Services and Housing Resources (HSHR), Prevention and Early Intervention (PEI), and Workforce Education and Training (WET). The right hand columns display the Workgroup's consensus recommendations. Importantly, DMH recommendations include the Workgroup's recommendation. In other words, the content of the Workgroup recommendation is part of DMH's recommendation.

PROGRAM	DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION	CPT SCORE
CSC	1. Lower level FSP: Develop and implement a program to meet the varying levels of need for Field Service Partnership graduates who may still need field based and occasional field-based services and prevention for individuals who are at risk for need of higher level of care. – CSC/Q11. Develop and implement a program to meet the varying levels of needs of Full Service Partnership (FSP) graduates who may still need field-based and occasional intensive services.	85% (CSC)
CSC	2. Develop service teams to provide direct mental health services to deaf, hard of hearing, deafblind, and deaf disabled individuals and families fully accessible in ASL. – CSC/Q15. Provide a one-stop mental health center across all Service Areas that provides direct mental health services to deaf, hard of hearing, deafblind, and deaf-disabled individuals and families fully accessible in American Sign Language (ASL). Services include mental health therapy, anger management counseling, substance abuse counseling, case management, and aftercare support, which are the areas historically lacking accessibility and support across all Service Areas in Los Angeles County.	77% (CSC)
HSHR	3. Expand Preventing Homelessness, Promoting Housing. (PH2) (Field Based Eviction Prevention Program) – HSHR/Q1: Expand the Preventing Homelessness and Promoting Health (PH Square) collaborative program with Department of Health to provide psychiatric, medical, and other social service interventions to prevent imminent eviction.	92% (HSHR)
HSHR	4. Justice Involved Clients – Use MHSA to continue Care First Community Investment (CFCI) funding upon termination June 2024. – HSHR/Q16: Justice-Involved Clients: Continue the operation of Interim Housing beds for those with justice involvement funded with CFCI dollars when the funding source terminates on June 30, 2024.	85% (HSHR)
HSHR	5. Increase MHSA funds for the Flexible Housing Subsidy Pool which can be used for rent subsidies for individuals who do not meet homeless definition and do not have funds to move into other forms of housing (creating flow). – HSHR/Q21: Low-Income People Not Meeting the Definition of Homeless: Increase MHSA funds for the Flexible Housing Subsidy Pool which can be used for rent subsidies in a variety of housing types, such as licensed care facilities, for individuals who do not meet the definition of homeless but do not have the income to move to other forms of housing such as licensed residential facilities. This Flexible Housing Subsidy Pool can help create more flow for special populations across different housing types.	85% (HSHR)

PROGRAM	DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION	CPT SCORE
HSHR	6. Justice Involved Clients – Dedicated interim housing beds for formerly incarcerated clients served through the men's and women's re-entry program. – HSHR/Q17: Justice-involved Clients: Establish dedicated interim housing beds for formerly incarcerated clients served through the Men's and Women's Community Reentry Program.	77% (HSHR)
HSHR	7. Add Peer Support Across Programs (including as part of Measure H Housing Support Programs). Peers are already part of MHSA service programs. – HSHR/Q23: Add peer support across all programs.	77% (HSHR)
HSHR	8. Enhance staffing and supportive services (such as trauma informed training and employment support) in existing congregate interim housing sites. – HSHR/Q25: Enhance staffing and supportive services (such as, trauma informed training and job/employment support) in existing congregate interim housing sites.	69% (HSHR)
HSHR	9. Training landlords, housing developers, and security staff on de-escalation. – HSHR/Q24: Improve safety in housing units and ensure housing developers include 24-hour security when underwriting projects. People that are providing security Should be trained on de-escalation and trauma informed responses. – HSHR/Q10: Develop or integrate into an existing program training and support for landlords, property managers and housing developers on working with and addressing the needs of individuals with mental illness (e.g., implicit bias training, cultural awareness concepts and information on supportive programs).	77% (HSHR 24) 62% (HSHR 10)
HSHR	10. Housing Subsidy Pool program for rental assistance for unhoused who do not qualify for federal housing subsidies due to immigration status or type of felony offence. – HSHR/Q15: Justice-Involved and/or Undocumented Clients: Support the Legacy Flexible Housing Subsidy Pool (FHSP) Program that provides ongoing rental assistance to clients who are homeless and do not qualify for federal housing subsidies due to their documentation status or type of felony offense (e.g., Registered Sex Offenders).	54% (HSHR)
HSHR + CSC	11. Expand Peer Respite Programs to each Service Area with a priority on individuals who are at risk of losing or without housing. – HSHR/Q23: Add peer support across all programs. – CSC/Q2: DMH contracts for two peer-run residential homes offering short-term respite. Expand to at least two peer-run residential homes per Service Area, including oversight.	62% (CSC)
CSC + PEI	12. Expand Service Navigator teams across all age groups to assist families and individuals, and housing resources in each Service Area. Consider central team to track and communicate internal and community resources. – PEI/Q2: Implement a Parent Navigator program familiar with community- based resources, social service agency resources, and DMH Programming – CSC/Q3: Expand Service Area Navigator Teams work across age groups and 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 mental health system clients.	92% (CSC) 93% (PEI)
PEI	13. Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family. Partner with DCFS to fund CBOs to provide this service. – PEI/Q4: Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family.	86% (PEI)

PROGRAM	DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION	CPT SCORE
PEI	14. Explore how to increase awareness of existing services in the community through health promoters, awareness campaigns, increasing visibility through websites and social media through increasing support and oversight of Promoters program. – PEI/Q5: Explore how to increase awareness of existing services in the community through health promoters, awareness campaigns, increasing visibility through websites and social media.	86% (PEI)
PEI	15. Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities, health education on mental health and /or SUDs and wellness classes on meditation, fitness, healthy cooking, etc. Target individuals experiencing homelessness and justice involved. Prioritize high need communities, such as the Antelope Valley. – PEI/Q8: Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities (Talking Circles), health education on mental health and/or SUDs, and wellness classes on meditation, fitness, healthy cooking, relaxation strategies, caregiver support, cultural activities, workforce development, and community wellness events. Targets individuals below 200% of federal poverty level in the Antelope Valley, including individuals experiencing homelessness and justice involved.	71% (PEI)
PEI	16. Expand service to Transition Age Youth (TAY) who are not enrolling in colleges, universities, or trade schools. This includes youth struggling with transitioning into adulthood and outside of school systems through development of a TAY unit which leverages current work in partnership with local community colleges. – PEI/Q12: Expand service to Transitional Age Youth (TAY) who are not enrolling in colleges, universities, or trade schools. This includes youth struggling with transitioning into adulthood and outside of the school systems.	71% (PEI)
PEI	17. Explore options to increase accessibility for training and services for individuals with disabilities so that service delivery staff have skills needed to ensure access and competent services. – PEI/Q35: Explore options to increase accessibility for training and services for individuals with disabilities.	79% (PEI)
WET	18. Explore developing strategies for DMH to partner with middle and high schools/school districts to increase the opportunities into mental health (outreach, fairs, afterschool programs, etc.) – WET/Q2: Explore developing a pilot program for DMH to partner with middle and high schools/school districts to increase the opportunities into mental health (outreach, fairs, after school programs, etc.). – WET/Q7: Implement innovative efforts to recruit junior and high school students into employment/careers in the public mental health system. This would be a long-term project.	88% (WET)
WET	19. Explore developing a marketing campaign/program for mental health services and careers, include but do not limit to a focus on high school age youth. – WET/Q3: Explore developing a marketing campaign/program for mental health services and careers.	88% (WET)
WET	20. Explore developing recruitment opportunities with community colleges to create pathways for potential mental health employees. – WET/Q4: Explore developing recruitment opportunities with community colleges to create pathways for potential mental health employees.	88% (WET)

PROGRAM	DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION	CPT SCORE
WET	21. Increase financial incentives for specialty public mental health staff including but not limited to Mental Health Loan Repayment program and stipends which will require LA County MHSA WET funding. – WET/Q1: Increase financial incentives for specialty public mental health staff, such as Mental Health Loan Repayment Program, which will require LA County MHSA WET funding.	63% (WET)
Systems: CBO Contracting	22. Contract with a third party intermediary to facilitate Community-Based Organization (CBO)funding for projects. – PEI/Q34: For new and expanded programs, increase investment in community-based organization (CBO) service and expand the number of providers that work with underserved cultural communities. – PEI/Q36: Reduce the silos and barriers that keep CBOs and systems from working together to engage in cross-sector collaborations/solutions.	
Systems: Promotion/ Awareness & Services	23. Invest in media campaigns to raise awareness regarding available programming in Community Supports Continuum including Veterans, Prevention, Housing Resources, and Recruitment, improve website accessibility. – CSC/Q10. Develop a media campaign to raise awareness about available crisis services including urgent care and mental health crisis teams; and to integrate more CBOs, community leaders, faith-based organizations within DMH to serve their communities. This includes developing and implementing trainings and resource materials focused on increasing the communities' and stakeholders' knowledge of services provided by DMH. Ensure crisis services are in place before launching campaign.	92% (CSC)
Systems: Service Access	24. Establish a centralized source of information to access culturally and linguistically appropriate services in a timely manner. – CSC/Q6. Establish a centralized source of information to access culturally and linguistically appropriate services and supports in a timely manner. This includes a dashboard for service providers to know what is available in real time and specific referral pathways. This system entails entering data efficiently, using data to gauge evolving needs and provide services and supports, bringing stakeholders to the table, and developing a guide to navigate services. Improve customer service, a website (multiple languages, drop-down menus, chat box, etc.) that is easy to use with simple language targeting different age groups and audiences, including training and accountability.	85% (CSC)
Systems: Equity	25. Invest in LA County efforts to track equity metrics, focusing on health, income, education, and access disparities. – PEI/1.B.6: Maintain a racial equity lens in program implementation through use of tools such as the CEO equity explorer. – PEI/1.B.10: Continue to instill in all DMH programming and services to focus on diversity, equity and inclusion (DEI). – CSC/1.B.2: Use tools like the CEO Equity tool to identify specific geographic areas of need within each Service Area and to target specific underserved populations when implementing and/or expanding programs. – HSHR/2.B.17: Implement client satisfaction surveys across programs use that information to improve programs/services. – HSHR/2.B.19: Collect and analyze 911 usage for PEH issues. – HSHR/3.B.28: Implement customer satisfaction surveys.	

PROGRAM	DMH LIST OF RECOMMENDATIONS FOR FUNDING CONSIDERATION	CPT SCORE
Systems: Equity	26. Information Technology (IT) investment to improve data tracking and automation to improve reporting out outcomes, expenditure, and service usage data. – PEI/Q38: Increase investment in service promotion, such as updated booklets, resource guides and leverage technology to promote services. – CSC/1.1: Expand the call center and strengthen the triage process to improve the client experience, based on review key metrics and qualitative data. – HSHR/3.11: Improve infrastructure to support better data collection of homelessness and housing data that can be used to improve programs via Housing and Homelessness Incentive Program (HHIP).	
Department Obligations	27. Wraparound (WRAP) Aftercare Post Short-Term Residential Treatment Programs (STRTPs) expand WRAP Full Service Partnership capacity to serve children and youth leaving STRTPs.	
Department Obligations	28. Lower level of FSP – provide funding for the Measure H funded mental health services for individuals housed in Measure H funded Permanent Supportive Housing	
Department Obligations	29. Capital Facilities - Children's Community Care Village	
Department Obligations	30. Investment in capital facilities for services for individuals who are unhoused (Crocker)	
Department Obligations	31. Lower level FSP – to expand and add services to current Veterans Peer Access Network, focus training on services for women (Develop or integrate mental health services into existing programming for women veterans who have experienced Trauma.) – CSC/Q5: Develop or integrate mental services into existing programming for women veterans who have experienced trauma.	77% (CSC)

TABLE 2: MOVE FORWARD TO IMPLEMENTATION

DMH is committed to moving forward with the following CPT Workgroup recommendations that do not entail funding consideration or where the resources can be obtained either through a partnership or by restructuring current work. Importantly, these recommendations increase the number of total CPT Workgroup recommendations to be implemented over the course of FY 2024/25 and 2025/26.

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
CSC	Develop or integrate mental health services into existing programming for victims of domestic violence, and train direct service staff to respond to domestic violence when working with clients. [Partnership with Department of Public Health and Enhance Training for Clinicians]	85%
	Provide transportation to obtain services. [DMH can facilitate access via Managed Care Plans Benefits]	54%
	Improve customer service, including a website (multiple languages, drop-down menus, chat box, etc.) that is easy to use with simple language targeting different age groups and audiences, including training and accountability. [Explore with Quality Improvement, Patients Rights, MHSA, ARDI, etc.]	77%
	Develop quality improvement projects and processes to existing programs and services, e.g. Outpatient Care Services (OCS), drop-in/wellness	54%

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
	center, age specific services, etc. [DMH is already engaged in these annual projects via Quality Improvement Plan, which is publicly posted annually]	
HSHR	Veterans: Implement awareness campaign targeting veterans and their families to address and target barriers to improve access to housing resources. [Partnership with County Veteran's Affairs.]	77%
	Develop a countywide eviction prevention program that has a central phone number for support, provides training for law enforcement and landlords and property managers on working with mental health issues and available resources, helps individuals access eviction prevention funds available through county programs, and provides life skills trainings in the community. [This is part of PH Square. See HSHR/Q1]	77%
PEI	Identify programs that offer/have focus on older adults.	64%
	Complete development of a Transition Aged Youth Advisory Group.	71%
	DMH will explore effective non-traditional programs, services and forms of healing for those suffering from mental health issues.	71%
WET	Explore potential trainings for ASL interpreters on working with individuals with mental health disabilities.	75%

TABLE 3: DMH LIST OF RECOMMENDATIONS FOR FUTURE FUNDING CONSIDERATIONS

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
CSC	Increase peer support to adequate amount, highlighting the role and success stories of peers.	38%
	Develop and implement trainings and materials to improve coordination of care among DMH Programs and other County Departments and contract providers, e.g., individuals with developmental delays.	77%
	Provide comprehensive, culturally and linguistically competent, and person-centered services that aim to enhance the well-being of African immigrants, underserved communities, and other vulnerable immigrant adults facing significant mental health needs by (1) building a collaborative network to ensure connections to services that increase the accessibility of outpatient mental health and coordination of psychiatric rehabilitation supportive services, (2) utilizing several Evidence-based Practices (EBPs) to reduce behavioral health challenges for targeted populations, (3) providing opportunities for mentoring, clinical support, outpatient mental health care, and psychiatric support rehabilitation services, and substance use or abuse rehabilitation, and (4) tackling co-existing conditions such as substance abuse, homelessness, and involvement with judicial and/or child welfare services.	62%
	Provide quality early intervention services to children ages two to five years old in Foster and Post Adoptive Care who have experienced early childhood trauma to help them learn new skills and change behavior to help them be successful in home, public, and school settings. Program addresses the social, emotional, and behavioral issues of at-risk children in Foster and Post Adoptive Care under the guidance of therapeutic professionals and trained staff through a therapeutic learning center day treatment program. This should include coordination with other programs for effective use of resources beyond DMH.	69%
	A mobile health outreach intervention that partners with youth serving community-based organizations in South Los Angeles to provide mental health care for Transitional Aged Youth, ages 18-25 by focusing on primary, secondary and tertiary levels of prevention and appropriate interventions. Targets unstably housed or unsheltered youth and young adults (ages 18-25 years old) in the SPA6 community of South Los Angeles.	62%
	Address the mental health of veterans from a family perspective, as recognized by the US military and Department of Veterans Affairs. Innovations and extensions of couple and family interventions have the	62%

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
	potential to increase the reach and impact of treatments for service members and veterans, as well as to ultimately improve the quality of their family relationships (NIH, 2023). The proposed program fills in family-based treatment gaps and other barriers to veterans connecting with mental health support. Targets all ages seeking help, veterans, and family members, with a separate camp for teens.	
	A mental health summer camp for trans/gender-diverse youth and youth affected by HIV/AIDS (aged 6-17) that aims to provide an emotionally safe, supportive, and enriching environment for these vulnerable populations. Designed to address the unique mental health and wellness needs of trans/gender-diverse youth and those affected by HIV/AIDS, offering a holistic approach to support, combining therapeutic interventions, education, and recreational activities to create a well-rounded experience that improves each camper's mental health.	54%
	Provide aftercare program/services after encounter with law enforcement and fire and emergency medical services (EMS).	77%
	Ensure hospital discharge planners are aware of all housing and support options and other programs within DMH, including the availability and oversight of Peer Run respite homes and other services across all Service Areas.	69%
HSHR	Provide housing in a home setting for up to 6 young adult males diagnosed with serious mental illness that face housing insecurity and are unable to live independently, grouped by same age range and same diagnosis (schizophrenia) in a supportive home model with 24/7 trained staff in the LEAP method and in-house holistic program that stimulates motivation, engagement and provides improvement in behavioral and physical health through nutrition, music and nature outings, besides job coaching to create purpose in staying well. The supportive housing model creates a social community where they can grow in trust and confidence and forge friendships, and the model also provides a sense of belonging and community, reducing the isolation and stigma that people with serious mental illness face.	92%
	Expand on congregate housing (such as shared and permanent supportive housing) with on-site peer supportive services. Develop glossary of key terms, such as shared housing; permanent supportive housing; congregate housing;	85%
	Implement independent living centers and supports to increase the ability to live independently.	85%
	Establish funding for African American (AA) population to own/lead interventions related to their communities outside of faith-based groups.	54%
	Develop and implement programs that assign mental health treatment and peer services staff to places where Person Experiencing Homelessness (PEH) are located including shopping centers and local libraries to treat and support library patrons experiencing homelessness.	69%
	Develop stationary hubs (centralized services) so there is a direct pipeline to DMH in the community including transportation with wheelchair access.	69%
	Develop a damage mitigation pool of funding to repair damage in interim and permanent housing to repair damage by DMH clients.	69%
	Use a community land trust model building upon innovative solutions presented in the Alameda County Supportive Housing Community Land Alliance Project Proposal to bring permanent affordability and community control to help ease Los Angeles County's housing crisis for SMI consumers whose income is 200% of the federal poverty level.	69%
	Develop public education about Senate Bill 43 which modernizes the definition of grave disability and probable cause for conservatorship. The bill broadens eligibility to people who are unable to provide for their personal safety or necessary medical care. In addition, Senate Bill 43 encompasses people with a severe substance use disorder, such as chronic alcoholism. Incorporate the new definition in HOME services in Los Angeles County if permissible. This should be done as an anti-stigma campaign to ensure we do not further stigmatize people.	62%

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
	Implement or partner with services providing supports to adult children with SMI to improve access to support groups such as NAMI, and respite care options.	62%
	LGBTQIA: Invest in housing specific to LGBTQ community.	62%
	Utilize a comprehensive, community-based approach, leveraging existing strengths to provide housing, a coordinated continuum of culturally and linguistic competent health services, employment support and other recovery support services tailored to the needs of, but not limited to, African heritage populations, indigenous immigrants, refugees and other underserved populations experiencing homelessness in Los Angeles County, California.	62%
	Eliminate site control to expand types of housing.	31%
	Contain costs per bed at less than $100K.	38%
	TAY, LGBTQ, Transgender, Domestic Violence, and Older Adults: Develop or expand existing housing resource guides to identify housing available to specific populations.	69%
	Develop PMRT Team dedicated to the skid row area and other areas where PEH are concentrated to improve mental health crisis response time.	77%
	Develop safe sleep programs.	62%
PEI	A peer support program for birthing people in Los Angeles County affected by perinatal mental health disorders to reduce stigma, relieve symptoms, and navigate the perinatal mental health care system so that they can care for themselves as well as their children. Objectives include: (1) hire and train a team of individuals with firsthand experience with perinatal mental health disorders to be certified perinatal peer supporters; (2) provide peer support and systems navigation services to 900 prenatal and postpartum people across Los Angeles County per year; (3) facilitate weekly peer support groups for 1,050 pregnant and postpartum persons across Los Angeles County per year.	79%
PEI	With over five years of rigorous longitudinal evaluation, this community defined evidence-based program reduces violence, PTSD symptoms, recidivism, trauma symptoms, and depression, and increasing resilience. The program consists of 80 hours of intensive intervention activities (5 workshops, 8 two-hour sessions over an 8-week period) that focus on developing and enhancing protective factors, healing trauma, financial literacy, and emotional intelligence. This program focuses on youth (18 and under), adults (18 and older), and African American male youth (ages 15 – 29) who are on probation, parole, foster and former foster care, and lack a support system.	79%
	This prevention program offers several in-person and virtual training academies for youth throughout Los Angeles County, focusing on understanding their position within the social determinants of health and how to reduce the stigmas related to gaining access to resources to support their development in each of these areas and as a means of preventing unhealthy behaviors and life trajectories. Workshops are trauma and culturally informed, focusing on social-emotional resilience, mentoring, peer support, education, and behavioral health career preparation. The target population for outreach and engagement is youth from 16-25, serving approximately 6,000 youth annually. Broaden focus to all youth in LA County, not just Latinx.	79%
	• Q20: Increase programming for older adults. • Q25: Identify and increase available programs that are focused on older adults. Q30: Develop and launch a documentary as an educational storytelling tool to promote mental and physical health among Latino immigrant elderly women (60+ years) and emphasize the importance of maintaining friendships and strong support systems. The documentary aims to improve health in California by spotlighting the mental resilience and inspirational stories of elderly immigrant women who have faced adversity in California.	79%

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
PEI	Provide camping trips and retreats with activities for children experiencing foster care/children ages 7 through 17, to help create a sense of belonging, connectivity, and promotes youth participation in recreational and extracurricular activities as an intervention in fostering positive behaviors, relationships, and teamwork.	71%
	Organize a community concert event targeting young adults/college students in Inglewood, Hawthorne, and South Los Angeles to provide mental health education, resources, and support through a culturally relevant and engaging event. Conducted in collaboration with mental health professionals, local organizations, and artists to promote early intervention, increase mental health awareness, reduce stigma, and provide resources to access mental health services. Serves as a platform to promote the importance of community support for mental health and encourage peers and family members to support individuals struggling with mental health.	27%
	Augment the reach of Reading & Rhythm and Life Skills Drumming to more children, TAY, adults and older adults in Los Angeles County.	57%
	Increase awareness and access to Birth to Five services through: Health Promoters, awareness campaigns, increasing visibility of resources through websites and social media, targeting strategies to reach underserved communities	79%
	Provide a coordinated, eight-tier Prevention and Early Intervention program to engage and instill Adverse Childhood Experiences (ACE) buffers in young children (zero to eight years of age), their families, neighborhoods, support systems, caregivers, schools, and communities in Los Angeles County.	79%
PEI	Provide a 6-week program in the Antelope Valley to provide small group equine-based therapy sessions for foster TAY that integrates experiential learning, mindfulness instruction, and collaboration with identified community resources available for foster care TAY (ages 16 to 24). Program provides small group Equine-Assisted Psychotherapy (EAP) sessions focused on understanding personal choices and implications of them through experiences with therapy herd to identify potential risk factors. Participating youth with learn how to utilize appropriate resources as they build their support network and be provided tools to develop a sense of self, identifying and fostering protective factors with healthy independent living skills.	71%
	MakerMobile (MākMō) vehicles are a mobile delivery system to support makerspaces and promote Science, Technology, Engineering, Arts, and Math (STEAM) programs for children and teens. MakMo programs develop social and emotional skills including teamwork, problem solving, working with others, dealing with conflict, resilience, and creativity. MakMo vehicles, staffed by MakMo Librarians and Library Assistants, travel throughout LA County bringing creative programming to libraries, parks, and local community and outreach events. MakMo staff use high- and low-tech equipment to spark an interest in STEAM while building skills necessary to thrive in a 21st Century workforce. Technology includes circuits, 3D modeling and printing, robotics, microscopes, and tools, and with participants of all ages working in diverse teams.	71%
	Biofeedback therapies are a non-invasive treatment that encourages the brain to develop healthier activity patterns to assist children and Transition Age Youth (TAY) with improved self-regulation to address trauma and stressors with the ultimate treatment goal of achieving optimal functioning. Biofeedback can be used as a complement to talk therapy or without talk therapy. Project aims to increase community access to biofeedback therapy, using state-of-the-art technology tools for sensory treatment through a current site in Santa Monica, CA, Service Planning Area 5, while also implementing field-based services and partnering with other community-based organizations, community colleges, juvenile halls, and directly operated programs throughout Los Angeles County to increase access to this preventive service. Biofeedback therapies have been	71%

PROGRAM	RECOMMENDATIONS	% STRONG VERY STRONG
	available for many decades, but those who can pay out-of-pocket or have top-of-the-line insurance pay for these interventions, making it out of reach for individuals receiving mental health services within the public sector. The program will impact access across ethnic, racial, and other diverse communities that have traditionally been under- or un-served.	
	Facilitate the Two-Spirit Storytelling as Medicine Project for American Indian/Alaska Native Transition Age Youth (TAY), Adults, and Elders through different forms of storytelling (oral storytelling, folk stories, film) along with art therapy, painting, poetry, and a final showcase to highlight the work throughout the project.	64%
	This program focuses on four mechanisms of support intended to change perceptions, decrease stigma, and improve community mental health for families in the Boyle Heights community. The four mechanisms are (1) substance abuse prevention, (2) physical wellness and nutrition, (3) self-esteem and mindfulness, and (4) digital mental health and safety.	64%
	New and expanded program to focus on underserved communities, API, BAH, American Indian, LGBTQIAS+, Individuals with Disabilities, and Middle Eastern Communities.	64%
	An interactive theatrical performance in Spanish to engage intergenerational Latino families to teach them to identify eight emotions (anger, happiness, love, fear, sadness, etc.), based on scientific evidence that supports how the use of culture and laugh therapy can heal depressive and anxiety-like symptoms. Theater is used as a tool to stay entertained and learn faster, while using family-friendly activities that unite generations with people you love.	57%
	Develop and launch a documentary as an educational storytelling tool to promote mental and physical health among Latino immigrant elderly women (60+ years) and emphasize the importance of maintaining friendships and strong support systems. The documentary aims to improve health in California by spotlighting the mental resilience and inspirational stories of elderly immigrant women who have faced adversity in California.	57%
	Explore possibility of utilizing Eye movement desensitization and reprocessing (EMDR) therapy.	29%
	Explore expanding Safe Passages program.	57%
	Explore new programs and services focused on the Deaf and Hard of Hearing community.	71%
	Explore programs to educate CBOs regarding LGBTQIA-S+ community needs and creating welcoming environments. Focus on schools and religious institutions.	71%
	Explore conducting an annual youth summit with DMH and medical doctors.	64%
	Explore partnerships to expand the suicide support groups available within DMH, including but not limited to general loss and grief; LGBTQIA2-S support groups; culturally responsive support groups; and faith/spiritual support groups.	64%
	Explore suicide prevention programs that address and provide services for young black males (ages 18-25).	64%
	Explore programs that provide evidence-based practices for the LGBTQIA2-S population related to suicide prevention.	50%
WET	Develop pilot project/mentorship program to mentor individuals from diverse backgrounds interested in future leadership positions.	63%
	Funding opportunities post high school (i.e., certification, AA, and BA) for people from under-served populations who desire a career in public specialty mental health.	75%
	Increase partnerships with universities to find staff who have similar culturally relevant backgrounds to clients served	75%
	Explore developing a program to build capacity among DMH staff to utilize American Sign Language (ASL).	
	Explore offering retention bonuses to current DMH staff, to be determined later which staff category(ies) specifically.	

VII. ACTIONS SINCE THE LAST MHSA ANNUAL UPDATE, FISCAL YEAR 2023-24

MID-YEAR ADJUSTMENTS

The Los Angeles County Board of Supervisors (Board) approved the MHSA Annual Update for FY 2023-24. A mid-year adjustment is required to reflect changes to the approved plan.

A. The first mid-year adjustment to the Annual Update was presented to the Community Planning Team on October 3, 2023 in-person from 9 a.m. – 12 p.m. The meeting was held at LACDMH Headquarters, located at 510 N. Vermont Ave., Los Angeles, CA, 90020. The session was also made available virtually. Meeting agenda, presentation and location were made available on the DMH website: [MHSA Announcements - Department of Mental Health (lacounty.gov)](). See Appendix D for presentation materials. Presentation materials were made available in both English and Spanish. The mid-year adjustment to the Annual Update was posted on the Department's website for review and comment, from October 4, 2023 through November 2, 2023. No comments were received via email or the public comment portal. The Board approved the mid-year adjustment on December 5, 2023.

DEPARTMENT OF MENTAL HEALTH

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LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

The Los Angeles County Department of Mental Health, as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA – Mid-Year Adjustment, Fiscal Year (FY) 2023-24, regarding changes made to the Los Angeles County Board adopted MHSA Annual Update, FY 2023-24.

#	MHSA Component	Program Name	Actions
1.	Innovation	Interim Housing Multidisciplinary Assessment & Treatment Teams	Proposed Action: The Oversight and Accountability Commission (OAC) approved the Innovation project on March 7, 2023. Propose to add $155,927,580 to the MHSA budget to cover program costs for 5 years. Fiscal Action: Add ongoing Innovation funding in the amount of $155,927,580 to be spent during FYs 2023-24 through 2027-28. Fiscal Year 2023-24 amount is $41,619,730.
2.	Community Services and Supports - Housing	Community Care Expansion	Proposed Action: Stakeholders approved the use of $11,200,00 million in one-time MHSA funding designated for licensed residential facility capital improvements. Fiscal Action: Transfer one time Community Services and Supports Housing funding to Capital Facilities and Technological Needs in the amount of $11,200,000.
3.	Community Services and Supports – Outpatient Care Services	Wellness Centers	Proposed Action: In FY 2017-208, LACDMH renamed its funding plans. All outpatient services, including Wellness is now under the Outpatient Care Services (OCS) LACDMH believes that wellness, recovery, and peer services are essential to the entire continuum of care. LACDMH is integrating its Wellness teams into outpatient service sites. Peer Run Centers and Peer Resource Centers remain as standalone services. Peer Run and Peer Resource Centers include peer support (individual and group), advocacy, linkage, social connections and supports. Fiscal Action: No fiscal impact

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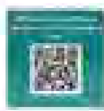
#	MHSA Component	Program Name	Actions
4.	Prevention and Early Intervention - Prevention	Stakeholder Engagement, Community Activities and Media & Outreach	Proposed Action: LACDMH finalized budgeting plans for Stakeholder, Media, and Community Activities, including May is Mental Health Month activities in May 2023. To continue vital stakeholder, community outreach, and media anti-stigma activities, LACMDMH is adding $8.65M to the ongoing allocation of $17M for FY 23-24 only. The California Mental Health Services Authority (CalMHSA) is the identified statewide fiscal intermediary to facilitate thee these activities, approved by the LA County Board of Supervisors on June 19th, 2023. Fiscal Action: Add Prevention and Early Intervention funding in the amount of $8,655,000 for Fiscal Year 2023-24.
5.	Community Services and Supports – Alternative Crisis Services	Children and Youth Crisis Stabilization Unit (CSU)[1]	Proposed Action: Add children and youth crisis stabilization service component to the Alternative Crisis Services plan. The CSUs will serve as valuable resources for children and youth in crisis in providing alternatives to hospitalization and justice involvement. The CSUs will partner with psychiatric hospitals that serve children, short-term residential treatment programs (STRTPs), residential group homes for youth, the County's Department of Children and Family Services, Juvenile Halls/Detention Centers, School Districts, and other community programs that serve children and youth. Fiscal Action: Add Community Services and Supports – Alternative Crisis Services on going funding in the amount of $15,775,906 for Fiscal Year 2023-24 and an annualized amount of $31,638,291 for Fiscal Years 2024-25 and 2025-26.
6.	N/A	Plan of Correction	Proposed Action: Department of Health Care Services provides the county with a written Performance Contract Review Report which includes a description of each finding, suggested improvements, a description of any corrective action(s) needed, and timeframes required for the county to come into compliance. LACDMH will incorporate items as requested into the MHSA Annual Update, FY 2023-24. Items include the MHSA 101 Training and the MHSA Issue Resolution process. Fiscal Action: No fiscal impact
7.	Prevention and Early Intervention - Prevention	Biofeedback Therapy for Children and Youth[2]	Proposed Action: Add Biofeedback Therapy for Children and Youth services to Prevention and Early Intervention services. Biofeedback therapy is a type of complementary and alternative medicine (CAM) that uses electronic devices to help people with self-regulation and self-

MHSA Mid-Year Adjustment
Page 3

#	MHSA Component	Program Name	Actions
			control. Biofeedback is often used to treat Attention Deficit Hyperactivity Disorder (ADHD), anxiety, depression, and pain. It can also help people with trauma recover from their experiences. The target population for this proposal includes children and Transition Age Youth (TAY) birth to 24 years of age and their families who are: • Enrolled in services at a Los Angeles County Child Directly Operated Mental Health Clinic, or • Receiving services through the Specialized Foster Care programs. Fiscal Action: Add Prevention and Early Intervention funding in the amount of $18,150,800.
8.	Community Services and Supports – Alternative Crisis Services	Psychiatric Mobile Response Teams (PMRT)	Proposed Action: PMRT is a stakeholder approved Alternative Crisis Service providing non-law enforcement-based mobile crisis response for clients experiencing a psychiatric emergency in the community. PMRT consists of LACDMH clinicians designated to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others, or who are unable to provide food, clothing, or shelter for themselves. Clarification: This service includes coordination and the dispatch of PMRT services. Fiscal Action: No fiscal impact

30-Day Public Comment Period: October 4, 2023 – November 2, 2023
Use this link to submit your comments during the public comment period
https://forms.office.com/g/[illegible] or scan the QR code:



[1] Children and Youth Crisis Stabilization Unit

Overview

The Los Angeles County Department of Mental Health (LACDMH) is the largest and most diverse public mental health care provider in the nation serving over 100,000 children and youth annually. Often, children in emotional or behavioral distress have experienced trauma that has not been treated accordingly. Most of the children and youth served by the LACDMH report experiencing years of trauma that has gone untreated or undertreated. Children are resilient and often benefit from early and appropriate mental health intervention. The children and youth in Los Angeles County would benefit from crisis stabilization programs that would meet the urgent mental health needs of children and youth, as this is currently a void in our system.

The three CSUs located in Willowbrook/South LA, Sylmar and Lancaster will provide 24/7/365 community-based crisis stabilization services to children and youth in Los Angeles County. Any child or youth who is experiencing a mental health crisis could be assessed for mental health needs, stabilized, and linked to ongoing treatment. The CSUs will serve as valuable resources for children and youth in crisis in providing alternatives to hospitalization and justice involvement. The CSUs will partner with psychiatric hospitals that serve children, short-term residential treatment programs (STRTPs), residential group homes for youth, the County's Department of Children and Family Services, Juvenile Halls/Detention Centers, School Districts, and other community programs that serve children and youth. The service providers for the CSUs will hire staff who can provide the cultural and specialized needs of children and youth in the community. The focus will be on ensuring services culturally and linguistically appropriate, trauma focused, providing the least restrictive environment with the goal to return the child or youth back to their community setting. The three CSUs will provide 24/7/365 community-based crisis stabilization services to children and youth in Los Angeles County.

Any child or youth who is experiencing a mental health crisis could be assessed for mental health needs, stabilized, and linked to ongoing treatment. The CSUs will serve as valuable resources for children and youth in crisis in providing alternatives to hospitalization and justice involvement. The CSUs will partner with psychiatric hospitals that serve children, short-term residential treatment programs (STRTPs), residential group homes for youth, the County's Department of Children and Family Services, Juvenile Halls/Detention Centers, School Districts, and other community programs that serve children and youth. The service providers for the CSUs will hire staff who can provide the cultural and specialized needs of children and youth in the community. The focus will be on ensuring services culturally and linguistically appropriate, trauma focused, providing the least restrictive environment with the goal to return the child or youth back to their community setting.

Services will include:

- 24/7 mental health assessment and crisis stabilization
- Therapeutic and mental health services
- Case management
- Family/caregiver support and education
- Referrals to community-based services for ongoing needs

Site	Address	Service Area	Construction Start Date	Estimated Completion/ Occupancy	Estimated Service Date
Olive View	14659 Olive View Dr, Sylmar, CA 91342	2	8/21/2023	4/30/2024	6/30/2204
MLK/Jacqueline Avant	1741 E. 120th Street, Los Angeles, CA 90059	6	8/28/2023	3/15/2024	5/31/2024
High Desert	Located on the High Desert Restorative Care Village Campus: 415 E. Avenue I, Lancaster, CA 93535	1	4/16/2024	4/28/2025	6/30/2025

Capacity

The Olive View, MLK/Jacqueline Avant and High Desert CSUs will each have nine beds, for a total of 27 beds for children and youth. At the very minimum, each of the three CSUs will be able to serve 3,285 clients ages 3 to 12 annually (i.e., a minimum of 9,855 total clients annually for all three locations), based on each site seeing nine clients per day on an annual basis.

Treatment Space

The treatment space at each facility will be separated into three areas by age group: 3-5, 6-9 and 10-12.

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[2] Biofeedback Therapy for Children and Youth

Overview

Biofeedback therapy is a type of complementary and alternative medicine (CAM) that uses electronic devices to help people with self-regulation and self-control. Biofeedback is often used to treat Attention Deficit Hyperactivity Disorder (ADHD), anxiety, depression, and pain. It can also help people with trauma recover from their experiences. The history of biofeedback can be traced back to the early 1900s when researchers began to study the relationship between the mind and the body. In the 1960s, researchers developed devices that could measure physiological responses, such as heart rate and blood pressure. These devices were used to help people learn to control their bodily functions. In the 1970s, biofeedback began to treat various conditions, including stress, anxiety, and pain.

In Los Angeles County, Biofeedback is available in the private sector and at a high cost. Two types of biofeedback include Infra- Low Frequency (ILF) neurofeedback and sensory therapy; both use technology to offer immediate feedback to the user. Biofeedback therapy is typically a short-term treatment lasting 12-20 sessions. During each session, the client will work with a therapist using a biofeedback device to monitor the client's progress and provide feedback.

Trauma Treatments

Biofeedback therapy has been identified as an effective trauma treatment. In a study published in the Journal of Traumatic Stress, researchers found that biofeedback therapy was effective in reducing symptoms of Post-Traumatic Stress Disorder (PTSD) in veterans[3]. The study found that biofeedback therapy was more effective than a control group that received traditional therapy.

Bessel Van Der Kolk (2014) studied the effects of neurofeedback in children and adults in his book The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma. Van Der Kolk found that "20 sessions of neurofeedback resulted in a 40% decrease in PTSD symptoms in a group of participants with chronic histories of trauma who had not significantly responded to talking or drug therapy" (p. 335)[4]

In her book, Neurofeedback in the Treatment of Developmental Trauma: Calming the Fear-Driven Brain, Sebern Fisher, Ph.D., provides a comprehensive overview of neurofeedback and its use in treating developmental trauma. Fisher discusses the underlying brain mechanisms of developmental trauma, the benefits of neurofeedback, and the different types of neurofeedback that can be used to treat developmental trauma. Fisher also provides case studies of patients who have benefited from neurofeedback treatment. These case studies illustrate the power of neurofeedback to help people with developmental trauma heal and recover[5].

The sensory therapy proposed in this project uses positive psychology and technology to help people who have experienced trauma. The approach helps people to:

- Identify their strengths and resources. Trauma can make people feel like they have lost their sense of self. Positive psychology can help people to identify their strengths and resources, which can give them a sense of hope and resilience.
- Focus on positive experiences. Trauma can make it difficult for people to focus on positive experiences. Positive psychology can help people to focus on the good things in their lives, which can help them to feel more connected to others and the world around them.
- Develop healthy coping mechanisms. Trauma can cause people to develop unhealthy coping mechanisms, such as substance abuse or self-harm. Positive psychology can help people to develop healthier coping mechanisms, such as exercise, relaxation techniques, or journaling.

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Sensory therapy uses various techniques, including:

- Guided imagery: This technique uses visualization to help people relax and focus on positive experiences.
- Biofeedback: This technique uses sensors to measure physiological responses, such as heart rate and breathing, and provides feedback to help people learn to control these responses.
- Mindfulness meditation: This technique helps people to focus on the present moment and to become more aware of their thoughts and feelings.

Sensory therapy is designed to be a safe and supportive environment for people to explore their experiences and learn new coping mechanisms. The therapy is also intended to be flexible and can be adapted to meet the individual needs of each participant.

Primary Problem

The children, youth, and families served by the Los Angeles County Department of Mental Health (LACDMH) are exposed to chronic and prolonged trauma and stressors resulting in symptoms associated with several mental health disorders including, but not limited to, anxiety, depression, attention deficits, sleep and appetite disorders, behavior disorders, psychotic symptoms, and emotional disturbances impacting their brain's ability to self-regulate and function to its full capacity. This increased after the Covid 19 pandemic. In 2021, the United States Surgeon General released an advisory highlighting the urgent need to address the nation's youth mental health crisis. It is essential to support our children and youth in their pursuit of optimal self-regulation, increasing their capacity to appropriately adapt their thoughts, feelings, and behaviors in various situations to achieve optimal well-being and reduce or prevent the more harmful symptoms associated with chronic and severe mental illnesses.

Biofeedback therapies can assist children and youth with improved self-regulation to address trauma and stressors. LACDMH proposes implementing biofeedback therapies, a new practice in the public mental health system which will increase access to underserved groups. To achieve optimal well-being and reduce or prevent the more harmful symptoms associated with chronic and severe mental illnesses[6].

Supporting children and youth's mental health requires a sustained workforce. The mental health workforce shortage is a serious problem in the United States. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), by 2025, the U.S. will be short about 31,000 full-time equivalent mental health practitioners[7]. This shortage is due to several factors, including:

- Increased demand for mental health services: The number of people seeking mental health services has been increasing in recent years due largely to the rising rates of chronic mental illness, the increasing awareness of mental health issues, and the decreasing stigma associated with seeking help.
- Decreasing supply of mental health professionals: The number of professionals graduating from training programs has not kept pace with the increasing demand for services. High rates of burnout have been identified as another contributor to the decrease in the supply of mental health professionals.

The proposal to use biofeedback with children and families in the LACDMH system is intended to support the mental health workforce by improving mental health outcomes for clients, which in turn can lead to increased job satisfaction for mental health professionals.

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Infra-Low Frequency Neurofeedback

ILF Neurofeedback is a function-focused intervention that builds and strengthens brain functioning by giving the brain feedback to itself to promote self-regulation and self-control. The specific application involves placing sensors on the head to read brainwave activity, processing the signal by computer, and showing the activity back to the brain using visual, tactile, or sensory feedback. Staff will be trained to use ILF neurofeedback therapy.

Sensory Therapy

This proposed intervention is designed to provide clients with a simple and effective way to manage their mental health. This proposal outlines a web-based voice analysis program that measures emotional states and provides users with instant binaural beats and biofeedback. This program aims to improve mental health outcomes for youth by providing easy-to-use tools.

Implementation of the proposed intervention requires the following:

- Software Subscription
  - Voice analysis technology: The program uses voice analysis technology to measure the energy and frequencies in a person's voice to determine their emotional state. The voice analysis will give the user a real-time understanding of their emotions and help them regulate their mood. Clinical staff will be trained to assist youth in using the web-based voice analysis technology to create positive goals and set positive intentions. The frequencies in the voice are analyzed in the web-based software to determine the vibration of that specific thought and recommend a sensory therapy that amplifies those frequencies. Next, a guided breathing exercise helps to regulate the nervous system. Finally, using the breath and mindset as the guide, the sensory process begins and can be followed independently.
  - Instant binaural beats: Binaural beats are a form of auditory therapy that involves listening to different frequencies in each ear. The program provides users instant binaural beats tailored to their emotional state and the desired goal. These beats will help the user to achieve a relaxed state and reduce stress. Clients may use this outside session as a coping skill to reduce stress.
  - Self – administered mood evaluation: The program includes a mood journal feature that will allow users to monitor and improve their mood over time. The mood journal will help users identify triggers and patterns affecting their mental health. Clients may also use these outside sessions as a daily coping skill to assist with self-control and self-regulation.
- Hardware
  - Wavetable: This device synchronizes sound frequencies, light pulses, tactile vibrations, color, and music into a timed session to take the user's nervous system out of fight or flight mode and allow for the reduction of stress and anxiety. This biofeedback therapy would be available to parents while their children receive services at the directly operated clinics and available in a portable table for field-based services.

These biofeedback therapies were chosen because they can reduce symptoms in weeks or months, which is needed for an overwhelmed public mental health system. A project by the Pritzker Family Foundation, which offered training to Los Angeles County community mental health agency providers, found that providers trained in biofeedback reported improved outcomes for their clients and increased satisfaction with their work.

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Target Population

The target population for this proposal includes children and Transition Age Youth (TAY) birth to 24 years of age and their families who are:

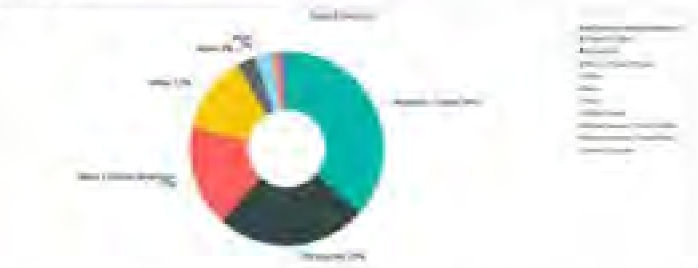
- Enrolled in services at a Los Angeles County Child Directly Operated Mental Health Clinic, or
- Receiving services through the Specialized Foster Care programs.

There are approximately 4,300 children and youth receiving services from the 14 the Directly Operated children's mental health clinics in Los Angeles County.

Specialized Foster Care (SFC) programs cover all 8 Service Planning Areas (SPAs). There are approximately 21,000 receiving services from SFC. Clients SFC are involved in the Department of Children and Family Services (DCFS) system and are delivered services in the field. Neurofeedback will be a field-based service for SFC clients. TAY aged 16 to 24 will be served via a mobile van.

Community Disparities

This project will reduce disparities in the underserved population in Los Angeles County, who are predominantly people of color, living below the poverty line, lack awareness of alternative mental health treatment modalities, and may be limited in the services they access due to transportation challenges[4].



[illegible]

This project will provide access to biofeedback therapy, generally available to Los Angeles County residents who can afford to pay out of pocket.[5] By making biofeedback therapy available in the field, we can reduce transportation issues and make it more accessible to people who need it. Additionally, training the public mental health workforce will help to educate more people about biofeedback therapy and its benefits.

Intended Outcomes

This prevention project will help LACDMH learn the following about the impact of biofeedback therapies on a large public mental health system:

- The best strategies for introducing interventions that rely heavily on technology to support healing interventions.
- The impact on complex trauma, chronic and severe mental illness, and other symptoms.
- The impact across ethnic, racial, and other diverse communities who have traditionally been under or un-served.
- The impact on mental health workforce retention of large-scale biofeedback training
- The budgetary impact of reduced hospitalization, reduced treatment length, or improved functioning of communities.

Positive outcomes of this project will support the expansion of biofeedback therapies to all mental health programs and the expansion of a training program available to all clinicians.

Community Leadership Team (CLT)

The CLT brings together leadership from important networks of stakeholders (e.g., Service Area Leadership Teams, Underserved Cultural Communities, Cultural Competency Committee) among others, to gather input about experiences with programs in the current mental health system; to gauge the overall impact and effectiveness of programs; to drive recommendations for improvement of programs and processes; and to acknowledge and provide feedback regarding.

The program proposal was presented and approved by the CLT on January 31, 2023.

Panisch LS, Hai AH. The Effectiveness of Using Neurofeedback in the Treatment of Post-Traumatic Stress Disorder: A Systematic Review. Trauma Violence Abuse. 2020 Jul;21(3):541-550. doi: 10.1177/1524838018781103. Epub 2018 Jun 11. PMID: 29890906.

Van der Kolk, B. A. (2015). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY: Penguin Books.

Fisher, S. F. (2014). Neurofeedback in the treatment of developmental trauma: Calming the fear-driven brain. New York, NY: W. W. Norton & Company.

Office of the Surgeon General (OSG). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory [Internet]. Washington (DC): US Department of Health and Human Services; 2021. PMID: 34982518.

Delphin-Rittmon, M. (2023, March 8). How SAMHSA is Tackling the Mental Health Workforce Shortage. MedCity News. Retrieved June 16, 2023, from [illegible]

Rhee TG, Evans RL, McAlpine DD, Johnson PJ. Racial/Ethnic Differences in the Use of Complementary and Alternative Medicine in US Adults With Moderate Mental Distress. J Prim Care Community Health. 2017 Apr;8(2):43-54. doi: 10.1177/2150131916671229. Epub 2016 Sep 27. PMID: 27670432; PMCID: PMC5932659.

Duke University. (2022, March 8). The color of wealth in Los Angeles. Samuel DuBois Cook Center on Social Equity. Retrieved June 1, 2023, from https://socialequity.duke.edu/portfolio-item/the-color-of-wealth-in-los-angeles/

B. The second mid-year adjustment to the Annual Update was presented to the Community Planning Team on February 6, 2024 in-person. The meeting was held at St. Anne's Conference and Event Center, 155 N. Occidental Blvd., Los Angeles, 90026. Meeting agenda, presentation and location were made available on the DMH website: MHSA Announcements - Department of Mental Health (lacounty.gov). See Appendix D for presentation materials. The mid-year adjustment to the Annual Update was posted on the Department's website for review and comment, from February 1 through March 1, 2024.

Mid-year Adjustment was reposted on March 4, 2024 to reflect a change in the budget amounts. During the public comment period, it was determined the budget allocations transferred from CSS to CFTN, WET and the Prudent Reserve necessitated changes to ensure the budget remains accurate and achievable:

- CFTN increased from $49 million to $64 million.
- WET decreased from $42 million to $25 million.
- Prudent Reserve decreased from $40 million to $31 million.

1. Posted on February 1, 2024

DEPARTMENT OF MENTAL HEALTH

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[illegible], Ph.D.
Director

[illegible], M.D.
Chief Medical Officer

[illegible]
Acting Chief Deputy Director

The Los Angeles County Department of Mental Health, as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA – Mid-Year Adjustment, Fiscal Year (FY) 2023-24, regarding changes made to the MHSA Annual Update, FY 2023-24 adopted by the Los Angeles County Board on December 5, 2023.

#	MHSA Component	MHSA Component/Program Name	Actions
1.	Capital Facilities and Technological Needs (CFTN)	—	Proposed Action: Include documentation to indicate the transfer of Community Services and Supports (CSS) funding to fund the following CFTN projects: Technological projects: Integrated Behavioral Health Information System (IBHIS) – Netsmart, IBHIS – Microsoft Agreement; Data Warehouse restructuring; purchasing of hardware; hiring application developers; redesigning the Department's website and new technology projects. Capital Facilities projects: [illegible] Urgent Care Center. Support the award received from the Behavioral Health Continuum Infrastructure Program award to build a Children & Youth Crisis Stabilization Unit (CSU), Mental Health Hub for Department of Children and Family Services involved children and youth, as well as an Adult Crisis Residential Treatment Program on the High Desert Restorative Care Village campus, the designing of a fence for the Los Angeles and Olive View Restorative Care Village to help keep the campus from trespassers entering and causing destruction to property and potential harm those on the campus, and the purchasing of furniture for the [illegible] and hubs at the Martin Luther King [illegible] Center and

[illegible] | [illegible] | [illegible]

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Page 2

#	MHSA Component	MHSA Component/Program Name	Actions
			the Olive View Children and Youth Center. In addition, the amount will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. Fiscal Action: [illegible] for FY 2023-24
2.	Workforce Education and Training (WET)	• Training and Technical Assistance • Residency and Internship • Financial Incentives • Mental Health Career Pathway	Proposed Action: Include documentation to indicate the transfer of CSS funds to fund new WET projects and the existing WET projects: Training and Technical Assistance, Residency and Internship, Financial Incentives, and Mental Health Career Pathway. In addition, the amount will be used to purchase certification training and associated fees related to the new State Mental Health Peer Specialist Certification [illegible]. Once certified, [illegible] will be reimbursable by Medi-Cal. [illegible] has been designated by the State as the sole entity to implement these certification efforts. Fiscal Action: [illegible] for FY 2023-24
3.	Community Services and Supports (CSS)	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Homeless Outreach and Mobile Engagement (HOME) program. This action will 1) to increase bed availability in [illegible] where there are few interim housing beds available, 2) to support clients with needs that are higher [illegible] and who, as a result, have not been able to successfully remain at traditional [illegible] interim housing sites, and 3) to ensure there are interim housing options without [illegible] criteria for those that cannot access the current interim housing beds. In addition, HOME staff are already meeting [illegible] on a daily basis, so being able to [illegible] HOME-specific sites allows HOME to set up programming for clients that meets their specialized needs. Fiscal Action: [illegible] for FY 2023-24
4.	CSS	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Women's Community Reintegration Program (WCRP). The WCRP is seeking hotel/motel rooms with no [illegible] criteria for clients served by WCRP that have specific needs related to their treatment and

MHSA Mid-Year Adjustment
Page 2

#	MHSA Component	MHSA Component/Program Name	Actions
			housing that impact their ability to successfully remain at traditional DMH interim housing sites. Having clients housed together slows service delivery, which impacts the ability of the program to serve more individuals. Fiscal Action: [illegible] in FY 2023-24
7.	CSS	Prudent Reserve	Proposed Action: Transfer funds from CSS into Prudent Reserve (PR). Per WIC 5847(b)(7), counties are required to establish and maintain a prudent reserve to ensure children, adults, and seniors can continue receiving services at current levels in the event of an economic downturn. The Prudent Reserve is funded with monies allocated to the Community Services and Supports component and cannot exceed 33% of a county's average distribution for the previous five years. Fiscal Action: $40,000,000 for FY 2023-24
8.	Prevention and Early Intervention	• Prevention • Stigma and Discrimination Reduction	Proposed Action: Include documentation to reflect previously approved programming in the MHSA Annual Update, FY 2023-24: Anti-Racism, Diversity and Inclusion (ARDI) training, Power of the Pack Program: CBA Wolf Connection, Take Action, Peer, Family and Community Supports Towards Stigma and Discrimination Reduction; NAMI Urban LA and NAMI Greater LA and iPrevail. Fiscal Action: No fiscal impact. Amount for programming is currently included in the Prevention budget in the MHSA Annual Update, FY 2023-24.

30-Day Public Comment Period: February 1, 2024 through March 1, 2024
Use this link to submit your comments during the public comment period: [illegible] or scan the QR code:

2. Re-posted on March 4, 2024

MHSA Mid-Year Adjustment
Page 2

#	MHSA Component	MHSA Component/Program Name	Actions
			potential harm those on the campus, and the purchasing of furniture for the CSUs and Hubs at the Martin Luther King, Jacqueline Avant Center and the Olive View Children and Youth Center. In addition, the amount will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. Fiscal Action: $64,000,000 for FY 2023-24
2.	Workforce Education and Training (WET)	• Training and Technical Assistance • Residency and Internship • Financial Incentive • Mental Health Career Pathway	Proposed Action: Include documentation to indicate the transfer of CSS funds to fund new WET projects and the existing WET projects: Training and Technical Assistance, Residency and Internship, Financial Incentive, and Mental Health Career Pathway. In addition, the amount will be used to purchase certification training and associated fees related to the new State Mental Health Peer Specialist Certification (SB 803). Once certified, select peer delivered services will be reimbursable by Medi-Cal. CalMHSA has been designated by the State as the sole entity to implement these certification efforts. Fiscal Action: $25,000,000 for FY 2023-24
5.	Community Services and Supports (CSS)	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Homeless Outreach and Mobile Engagement (HOME) program. This action will 1) to increase bed availability in some areas where there are few interim housing beds available; 2) to support clients with needs that are higher acuity and who, as a result, have not been able to successfully remain at traditional DMH interim housing sites; and 3) to ensure there are interim housing options without exclusionary criteria for those that cannot access the current interim housing beds. In addition, HOME staff are already needing to see clients on a daily basis, so being able to have HOME-specific sites allows HOME to set up programming for clients that meets their specialized needs. Fiscal Action: $3,106,099 for FY 2023-24
6.	CSS	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Women's Community Re-Entry Program (WCRP). The

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

Reposted March 4, 2024

The Los Angeles County Department of Mental Health, as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA – Mid-Year Adjustment, Fiscal Year (FY) 2023-24, regarding changes made to the MHSA Annual Update, FY 2023-24 adopted by the Los Angeles County Board on December 5, 2023.

#	MHSA Component	MHSA Component/Program Name	Actions
1.	Capital Facilities and Technological Needs (CFTN)	________	Proposed Action: Include documentation to indicate the transfer of Community Services and Supports (CSS) funding to fund the following CFTN projects: Technological projects: Integrated Behavioral Health Information System (IBHIS) – Netsmart, IBHIS – Microsoft Agreement, Data Warehouse restructuring, purchasing of hardware, hiring application developers, redesigning the Department's website and new technology projects. Capital Facilities projects: Tenant Improvement/New Facilities, Exodus Eastside Urgent Care Center, Support the award received from the Behavioral Health Continuum Infrastructure Program award to build a Children & Youth Crisis Stabilization Unit (CSUs), Mental Health Hub for Department of Children and Family Service involved children and youth, as well as an Adult Crisis Residential Treatment Program on the High Desert Restorative Care Village campus, the designing of a fence for the Los Angeles and Olive View Restorative Care Village to help keep the campus from trespassers entering and causing destruction to property and

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#	MHSA Component	MHSA Component/Program Name	Actions
			potential harm those on the campus, and the purchasing of furniture for the CSUs and Hubs at the Martin Luther King, Jacqueline Avant Center and the Olive View Children and Youth Center. In addition, the amount will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs. Fiscal Action: $64,000,000 for FY 2023-24
2.	Workforce Education and Training (WET)	• Training and Technical Assistance • Residency and Internship • Financial Incentive • Mental Health Career Pathway	Proposed Action: Include documentation to indicate the transfer of CSS funds to fund new WET projects and the existing WET projects: Training and Technical Assistance, Residency and Internship, Financial Incentive, and Mental Health Career Pathway. In addition, the amount will be used to purchase certification training and associated fees related to the new State Mental Health Peer Specialist Certification (SB 803). Once certified, select peer delivered services will be reimbursable by Medi-Cal. CalMHSA has been designated by the State as the sole entity to implement these certification efforts. Fiscal Action: $25,000,000 for FY 2023-24
5.	Community Services and Supports (CSS)	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Homeless Outreach and Mobile Engagement (HOME) program. This action will 1) to increase bed availability in some areas where there are few interim housing beds available; 2) to support clients with needs that are higher acuity and who, as a result, have not been able to successfully remain at traditional DMH interim housing sites; and 3) to ensure there are interim housing options without exclusionary criteria for those that cannot access the current interim housing beds. In addition, HOME staff are already needing to see clients on a daily basis, so being able to have HOME-specific sites allows HOME to set up programming for clients that meets their specialized needs. Fiscal Action: $3,106,099 for FY 2023-24
6.	CSS	Housing	Proposed Action: Increasing interim housing funding for participants enrolled in the Women's Community Re-Entry Program (WCRP). The

MHSA Mid-Year Adjustment
Page 3

#	MHSA Component	MHSA Component/Program Name	Actions
			IWCRP is seeking hotel/motel rooms with no exclusionary criteria for clients served by IWCRP that have specific needs related to their treatment and housing that impact their ability to successfully remain at traditional DMH interim housing sites. Having clients housed together eases service delivery, which impacts the ability of the program to serve more individuals. Fiscal Action: $[illegible] for FY 2023-24
7.	CSS	Prudent Reserve	Proposed Action: Transfer funds from CSS into Prudent Reserve (PR). Per WIC 5847(b)(7), counties are required to establish and maintain a prudent reserve to ensure children, adults, and seniors can continue receiving services at current levels in the event of an economic downturn. The Prudent Reserve is funded with monies allocated to the Community Services and Supports component and cannot exceed 33% of a county's average distribution for the previous five years. Fiscal Action: $[illegible] for FY 2023-24
8.	Prevention and Early Intervention	• Prevention • Stigma and Discrimination Reduction	Proposed Action: Include documentation to reflect previously approved programming in the MHSA Annual Update, FY 2023-24: Anti-Racism, Diversity and Inclusion (ARDI) training, Power of the Pack Program: DBA Wolf Connection, Take Action, and Peer, Family and Community Supports Towards Stigma and Discrimination Reduction: NAMI Urban LA and NAMI [illegible] LA and iPrevail. Fiscal Action: No fiscal impact. Amount for programming is currently included in the Prevention budget in the MHSA Annual Update, FY 2023-24.

VIII. PROGRAMS AND SERVICES BY COMPONENT

This section provides FY 2022-23 outcome data for existing MHSA programs and is organized by component: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities and Technological Needs and Innovation.

Community Services and Supports (CSS)

As the largest component with 76% of the total MHSA allocation, CSS was designed with service categories that shape the integrated system of care for clients diagnosed with SMI. In FY 2022-23, approximately 178,083 unique clients received a direct mental health service through CSS. The two tables below provide additional detail.

The CSS component of the Plan includes the following programs:

- Full Service Partnership (FSP)
- Outpatient Care Services (OCS)
- Alternative Crisis Services (ACS)
- Housing Services
- Linkage to County-Operated Functions/Programs (Linkage)
- Planning, Outreach, and Engagement Services (POE).

Table 7. Clients served through CSS in FY 2022-23

Clients Served	New Clients Served*
178,083 clients received a direct mental health service: - 38% of the clients are Hispanic - 17% of the clients are African American - 15% of the clients are White - 5% of the clients are Asian - 1% of the clients are Native American - 80% have a primary language of English - 13% have a primary language of Spanish	50,764 new clients receiving CSS services countywide with no previous MHSA service - 37% of the new clients are Hispanic - 15% of the new clients are African American - 15% of the new clients are White - 3% of the clients are Asian - 0.42% of the clients are Native American - 77% have a primary language of English - 12% have a primary language of Spanish

*Number of clients served also includes number of new clients served.

Table 8. CSS clients served by Service Area

Service Area	Number of Clients Served*	Number of New Clients
SA 1 – Antelope Valley	13,718	3,380
SA 2 – San Fernando Valley	28,536	7,712
SA 3 – San Gabriel Valley	27,516	8,162
SA 4 – Metro Los Angeles	35,058	9,675
SA 5 – West Los Angeles	10,122	2,563
SA 6 – South Los Angeles	26,453	6,741
SA 7 – East Los Angeles County	19,353	4,132
SA 8 – South Bay	33,097	8,399

*Number of clients served also includes number of new clients served.

The next few pages provide a summary of information for each CSS program. The summary will include a follow-up on the last approved Three-Year Plan (FYs 2021-24), as well as outcome data for the specific program.

A. Full Service Partnership (FSP)

Status	☒ New	☒ Continuing	☒ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

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

Intended Outcomes

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

Key Activities

- Clinical services (24/7 crisis response services; counseling and psychotherapy; field-based services; integrated treatment for co-occurring mental health and substance abuse disorder; case management to provide linkages to services to employment, education, housing and physical health care)
- Nonclinical services (peer and parent support services; self-help and family support groups; wellness centers; respite care)

FY 2022-23 ■ FULL SERVICE PARTNERSHIP Update

During FY 2022-23, FSP prepared for the impact of CalAIM Behavioral Health Payment Reform which became effective as of July 1, 2023. The initiative changed the way counties were reimbursed for Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS) services. As FSP is a field-based program, FSP providers had concerns relating to cost reimbursement not including travel and documentation time. DMH was able to address this concern with all our field-based programs including FSP.

On October 1, 2023, Homeless FSP and the Integrated Mobile Health Team (IMHT) specialized FSP programs were merged with our general Adult FSP program. Previously, both specialized FSP programs were overseen by the DMH Housing and Job Development Division (HJDD). The transfer included a total of 1,622 FSP slots between both programs and throughout the county.

In addition, due to new initiatives and projects being implemented in the Fall/Winter of 2023, LACDMH will expand the adult FSP program to account for the number of additional referrals anticipated specific service areas. The following are three (3) projects that are in the works that would require FSP expansion:

I. Department of Health Services (DHS) – Office of Diversion and Reentry (ODR) Housing Program: The ODR Housing program is a permanent supportive housing program serving individuals who are homeless, who have a serious mental health disorder, and who are incarcerated in the Los Angeles County Jail. Created in 2015, the program is offered to pretrial individuals who are charged with felony offenses through a partnership with the Los Angeles County Superior Court. The program works to resolve cases early and bring clients out of jail and into ODR Housing with either a grant of PC 1001.36 diversion or a grant of probation. Expansion of this

program in 2023 is anticipated increase the number of referrals to FSP by approximately 500 individuals to be served in Service Area's (SA) 2, 4, 6, and 8.

II. The Community Assistance, Recovery, and Empowerment (CARE) Court is a new state law meant to address and treat those with severe mental health disorders, such as schizophrenia or other psychotic disorders, by allowing a court to order behavioral health treatment in community-based settings. By focusing on a holistic, person-centered approach, CARE Court aims to break the cycle of homelessness and incarceration for individuals and promote long-term recovery through a civil court process. This holistic approach seeks to create a safe, supportive, and healthier community for all residents. CARE Court is intended to be a path towards recovery for a very specific population of adults. The goal of the program is to divert individuals with schizophrenia or other psychotic disorders from more restrictive settings (such as conservatorships or incarceration) into the community with a supportive Care Agreement or plan to meet their individual needs. CARE Court is scheduled to roll out by December 1, 2023. Implementation of this program is anticipated to generate new adult FSP referrals.

III. Institutions for Mental Diseases (IMD)/FSP Pilot Project: In collaboration with the Intensive Care Division (ICD) and Countywide FSP Administration, we are working to improve the linkage to mental health services for those individuals preparing for release from IMD's and who are ready to be stepped down to a lower level of care. LACDMH has identified two IMD's, one in SA 3 and another in SA 8, and will be working with LE contractors to facilitate linkage to FSP services. The pilot project will begin in SA 8, with Telecare's IMD (La CASA). We'll need to increase FSP slots, specifically with Telecare in that SA, to ensure capacity for this project. Subsequently, we'll need to do the same in SA 3.

FY 2024-25 and FY 2025-26■ FULL SERVICE PARTNERSHIP

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+.

In FY 2024-25, Legal Entity (LE) contracts will be amended to extend contracts through the end of FY 2024-25. In addition, we will start an FSP re-solicitation process to execute new three-year contracts starting on July 1, 2025. The Child Wraparound FSP will increase slots.

FY 2022-23 ■ FULL SERVICE PARTNERSHIP Data and Outcomes

As of June 30, 2023, LACDMH had 13,039 FSP slots as shown in the next table.

Table 9. FSP Slots summary: age group, slots, average cost per client, and unique clients served

Age Group	Number of Slots
Children (includes Wraparound and Intensive Field Capable Clinical Services)	3,673
Adult (includes Integrated Mobile Health Team, Assisted Outpatient Treatment, and Homeless)	9,366

Table 10. FSP summary: age group, average cost per client, unique clients served and total number to be served

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2024-25[2]
Children	$28,716	2,807	3,037
TAY	$20,160	2,273	2,389
Adult	$18,427	6,563	6,618
Older Adult	$16,481	1,692	1,737

[1]Cost is based on Mode 15 services, not inclusive of community outreach ser-vices or client supportive services expenditures.
[2]FY 2023-24 Total Number to be served: Reflects average of two prior fiscal years.

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.

Comparing a client's life before and after, FSP enrollment shows that the program

- Reduces homelessness;
- Reduces justice involvement;
- Reduces psychiatric hospitalization; and
- Increases independent living.

Table 11. Impact of FSP on post-partnership residential outcomes
Children and Young Adult (n=5,704), Adult (n=8,815)

Adult FSP Program	Percentage by Clients	Percentage by Days
Homeless		
Adult	39% reduction	49% reduction
Justice Involvement		
Adult	66% reduction	65% reduction
Psychiatric Hospitalization		
Adult	51% reduction	50% reduction
Independent Living		
Child and Young Adult	5% increase	33% increase
Adult	15% increase	55% increase

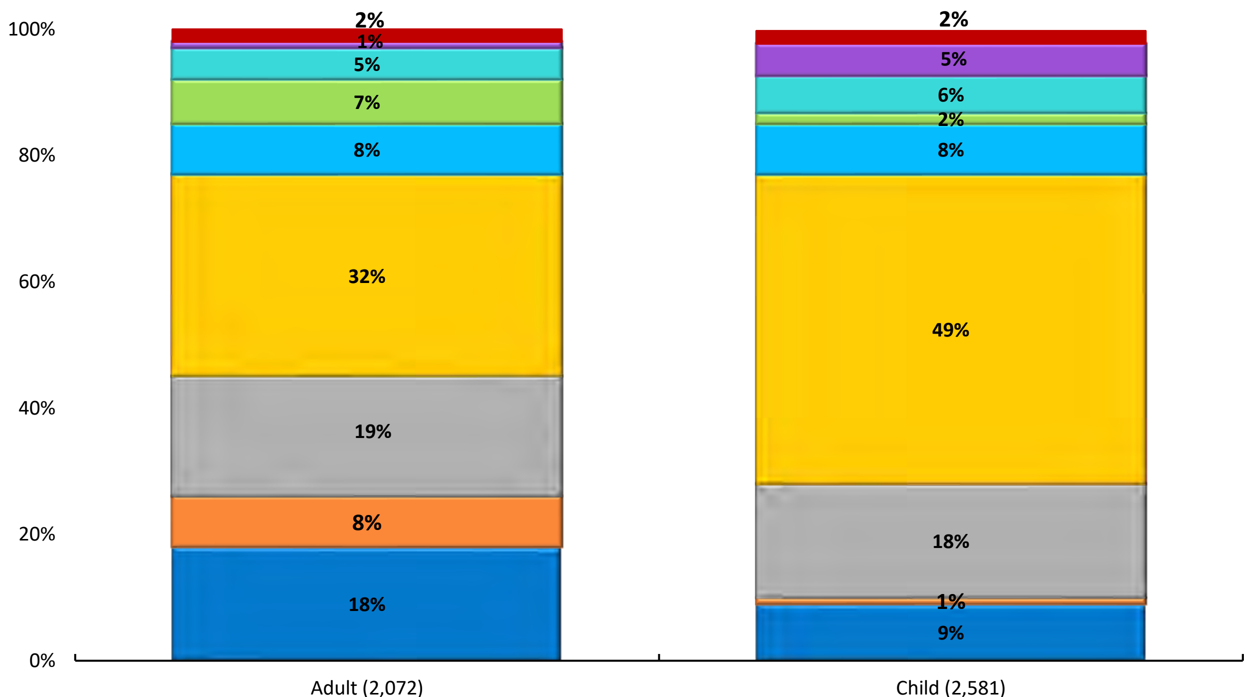
Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2023. Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program. Data must meet data quality standards to be included in the analysis.

Outcome data for clients with open outcomes in FY 2022-23 with a data cut off of 6/30/2023. Clients had a baseline sometime before 6/30/2023 and no disenrollment Key Event Change before 7/1/22 unless they also had a reestablishment that was active during FY 2022-23. Figures represents cumulative changes, inclusive of all clients through June 30, 2023

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

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

Figure 9. Reasons for Disenrollment, FY 2022-23



Target population criteria not met
No Discontinuation Reason Given
Community services/program interrupted - client is in a residential/institutional facility
Community services/program interrupted - client is detained
Client moved to another county/service area
Client has successfully met his/her goals such that discontinuation of FSP is appropriate
Client decided to discontinue FSP participation after partnership was established
Client is deceased
Client cannot be located after attempts to contact client

B. Outpatient Care Services

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

All outpatient services, including Wellness is now under the OCS. LACDMH believes that wellness, recovery, and peer services are essential to the entire continuum of care. In addition, the LACDMH is integrating its Wellness teams into outpatient service sites. Peer Run Centers and Peer Resource Centers remain as standalone services. Peer Run and Peer Resource Centers include peer support (individual and group), advocacy, linkage, social connections and supports.

The aim is for clients to move toward and achieve self-determined meaningful goals that promote connectedness, mental and physical wellbeing, and meaningful use of time. All age groups will have access to core components of mental health services such as assessments, individual and/or group therapy, crisis intervention, case management, housing, employment support, peer support, co-occurring disorders treatment, medication support services (MSS) and Medication Assisted Treatment (MAT). The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each client and will likely change over time. While most clients generally move from more intensive to less intensive services, some clients may need more intensive services for periods of time due to a variety of factors. These factors include, but are not limited to, the emergence or exacerbation of a severe mental illness; non-adherence to treatment recommendations; a substance use disorder; and exposure to trauma, violence, or external psychosocial stressors such as housing, employment, relationship, or legal problems. These services meet the needs of all age ranges from child to TAY to adults and older adults.

Examples of specialized services include but are not limited to the following:

- Child: Comprehensive services, specifically ages 0-5
- TAY: Enhanced Emergency Shelter Program, Supported Employment Individual Placement and Support (SEIPS) and Drop-in Centers
- Adult: Comprehensive Medication Assisted Treatment program
- Older Adult: Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) program
- Peer Run Respite Care Homes and Peer Run Centers

Intended Outcomes:
Our mission is to optimize the hope, wellbeing, and life trajectory of Los Angeles County's most vulnerable, through access to care and resources that promote not only independence and personal recovery, but also connectedness and community reintegration.

Key Activities:

- Clinical services (individual, group, and family therapy; crisis resolution/intervention; evidence-based treatments; MSS, including MAT; outreach and engagement screenings and assessments to determine level of functioning and impairment; case management)
- Non-clinical services (peer support; family education and support; co-occurring disorder services; linkage to primary care; housing services; vocational and pre-vocational services

FY 2022-23 ■ OUTPATIENT CARE SERVICES

One of the largest barriers experienced during FY 2022-23 was recruitment and retention of multidisciplinary mental health staff. This included a high volume of vacancies for mental health practitioners such as social workers, psychologists, nurses, psychiatric technicians, and psychiatrists. In order to address these challenges, the Department implemented multiple strategies, which included hiring fairs at local universities and a public relations campaign to increase community awareness of employment opportunities in public mental health. In addition, the Department invested in several incentive programs. Lastly, DMH has worked to streamline the hiring process and reduce the amount of time needed to onboard new staff. All of these strategies have assisted OCS in addressing its staffing needs.

FY 2022-23 ■ OUTPATIENT CARE SERVICES Clients Served

Table 12. FY 2022-23 Data for clients by Age Group served through various outpatient programs

Age Group	Average Cost per Client	Number of Unique Clients Served[1]	Total Number to be served in FY 2024-25[2]
Children, Ages 0-15	$6,950	20,534	20,534
TAY, Ages 16-25	$4,984	20,415	20,512
Adult, Ages 26-59	$4,026	65,286	65,474
Older Adult, Ages 60+	$4,350	18,288	18,071

[1]Cost is based on Mode 15 services, not inclusive of community outreach ser-vices or client supportive services expenditures.
[2]FY 2024-25 Total Number to be served: Reflects average of two prior fiscal years

FY 2024-25 and FY 2025-26 ■ OUTPATIENT CARE SERVICES Continued Work

Due to best practices, OCS is encouraging and promoting in person services to establish mental and physical health baselines. The Department has continued to provide telework as both a retention and access to care strategy and staff morale booster.

As the Department continues to pivot to meet the needs of special populations, including people experiencing homelessness and/or justice involvement, field-based services may expand along with the training to successfully engage and work with clients effectively in the field.

OCS will continue to focus on eating disorders, perinatal mental health, and services geared toward diverse populations.

C. Alternative Crisis Services

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

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

LACDMH MHSA ACS programs:

- Residential and Bridging Care (RBC) Program
- Psychiatric Urgent Care Centers
- Enriched Residential Services (ERS)
- Crisis Residential Treatment Programs (CRTP)
- Law Enforcement Teams (LET)
- Restorative Care Villages
- Psychiatric Mobile Response Teams (PMRT)

Intended Outcomes

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

Key Activities

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

FY 2022-23 ■ ALTERNATIVE CRISIS SERVICES

During FY 2022-23, the Department added 144 Crisis Residential Treatment Program beds, including two programs out in the community with 16 beds each and seven (7) programs at Restorative Care Villages on County Hospital campuses. The Department also added twelve (12) Enriched Residential Services beds which include specialty mental health services and treatment on site of the board and care.

In addition to adding treatment beds to the DMH network, the Department focused on expanding mobile crisis response with the ultimate goal of providing 24/7 services by December 2023. To that end, it has held hiring fairs and recruited staff for its psychiatric mobile response teams as well as contracted with three (3) providers to assist in covering the service areas during evenings and weekends.

In April 2023, Vista del Mar began providing Field Intervention Teams (FIT) services under their Mobile Crisis Outreach Teams (MCOT) contract in Service Planning Area 5. In June 2023, DMH

executed the final MCOT contract with Brain Health to cover Service Planning Areas 7 and 8. In July 2023, Sycamores MCOT had its first overnight team in operation from 11:00pm to 6:00am, Monday through Friday and Vista del Mar plans to have an overnight team in place in late October.

DMH has been working to fill vacancies on the Psychiatric Mobile Crisis Response (PMRT) teams as well as other crisis response teams: Law Enforcement Co-response teams (LET), Therapeutic Transportation Teams (TTT) and School Threat Assessment Response Team (START). A Community Health Worker (CHW) hiring fair was held in June 2023. In July 2023, DMH implemented a "strike team" to address the high number of vacancies across ACR's directly operated programs. The strike team includes key staff from ACR including the Equitable Outcomes Teams, Human Resources, the Emergency Outreach and Triage Division, and the Quality, Outcomes, and Training Division.

The strike team coordinated the attendance of ACR programs at the Emergency Appointment hiring fair on September 12, 2023 and held a virtual ACR "meet and greet" on September 14, 2023 for potential hires to hear about ACR programs. Over 100 potential hires attended. On September 21, 2023, an ACR hiring fair was held that capitalized on the following key ACR bonuses recently approved by the Board and described in the DMH Board Response on hiring incentives:

1. $10,000 in sign on and retention bonuses for all field-based practitioners within ACR programs (PMRT, TTT, LET inclusive of Systemwide Mental Assessment Response Teams (SMART) and the Mental Evaluation Team (MET), and START) over the course of 18 months;
2. An increase in the Field Assignment Bonus from $180 per month to $280 month; and
3. An increase in the existing weekend, evening and night Shift Differentials by 100%.

Through these efforts, DMH has hired and/or offered conditional offers of employment to fifty (50) practitioners including CHWs, Registered Nurses, Medical Case Workers, and Psychiatric Social Workers across ACR programs since September. The breakout of these positions across ACR programs is eighteen (18) at ACCESS, fourteen (14) at PMRT, ten (10) at TTT, four (4) at LET, and four (4) at START.

With the expansion of MCOT teams and PMRT teams, and other ACR programs, DMH plans to be 24/7 by November. DMH will continue to utilize overtime PMRT staff to fill gaps in coverage.

During FY 2022-23, LACDMH continued its investment in the development of PSH for homeless or chronically homeless individuals and families who are living with SMI or serious emotional disturbances (SED).

A1. Residential and Bridging Program (RBC)

RBC 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, FSP, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in subacute settings, Enriched Residential Services (ERS) facilities, and intensive residential programs to successfully transition to community living.

The County Hospital Adult Linkage Program is part of the RBC program. Its mission is to assist in the coordination of psychiatric services for LACDMH clients at County hospitals

operated by DHS to ensure clients are discharged to the appropriate level of care and that they are provided relevant mental health, residential, substance abuse, or other specialized programs. This program promotes the expectation that clients are successfully reintegrated into their communities upon discharge and that all care providers participate in client transitions.

A2. Psychiatric Urgent Care Centers (UCC)

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

Table 13. Location of the current UCCs

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

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

The following graphs provide an overview of FY 2022-23 outcomes of the UCCs. Olive View UCC has two components: Crisis Stabilization Unit (CSU) - 7913 and Outpatient UCC - 7591 that does not operate 24/7.

Figure 10. FY 2022-23 UCC New admissions by age group

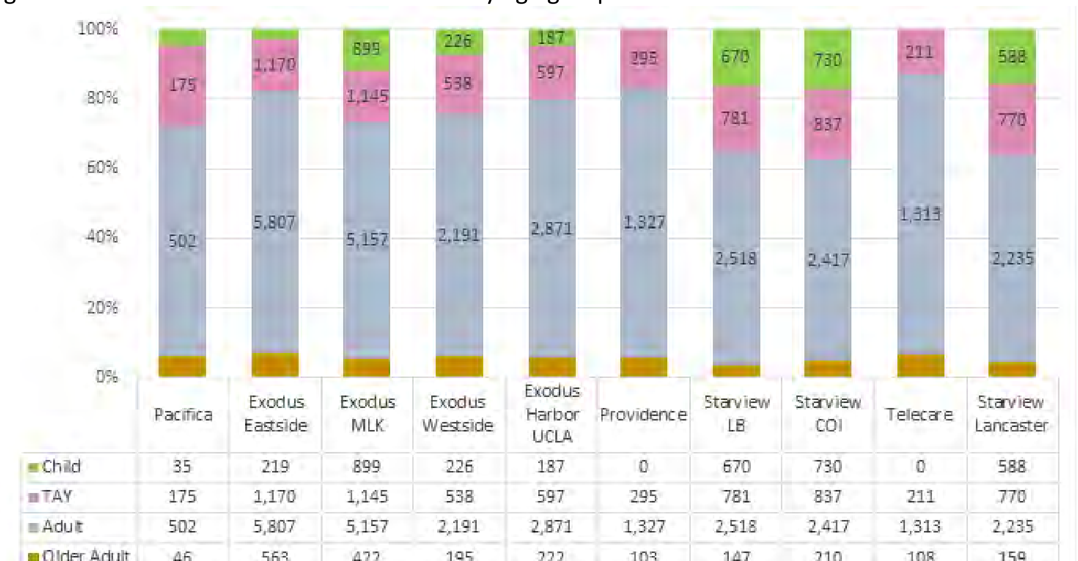


Figure 11. Clients with a psychiatric emergency assessment within 30 days of an UCC assessment

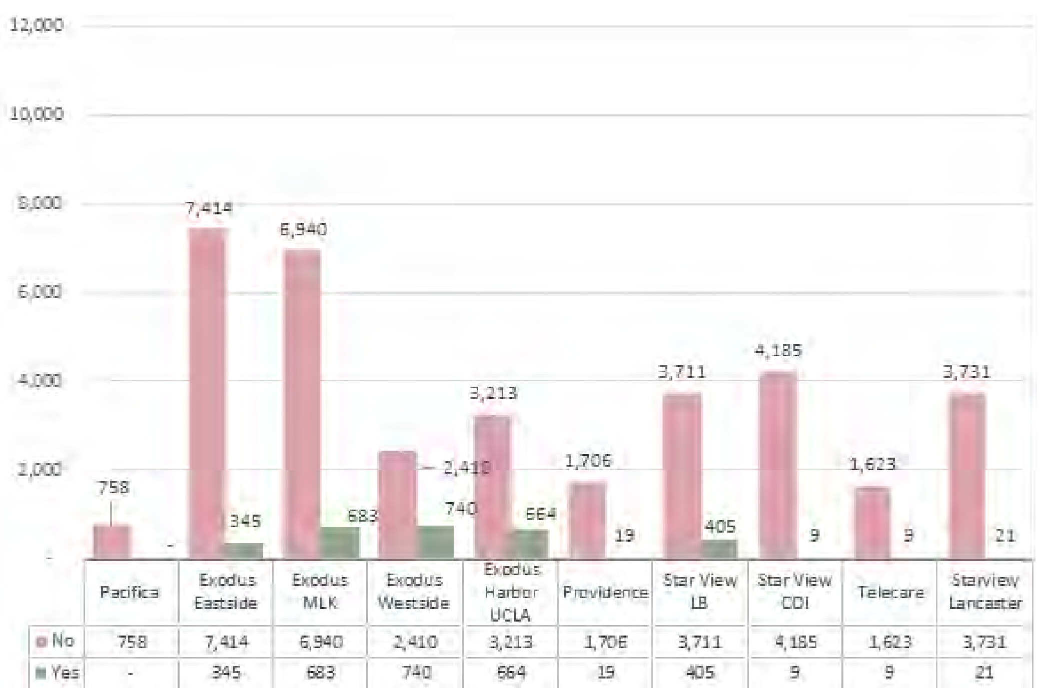
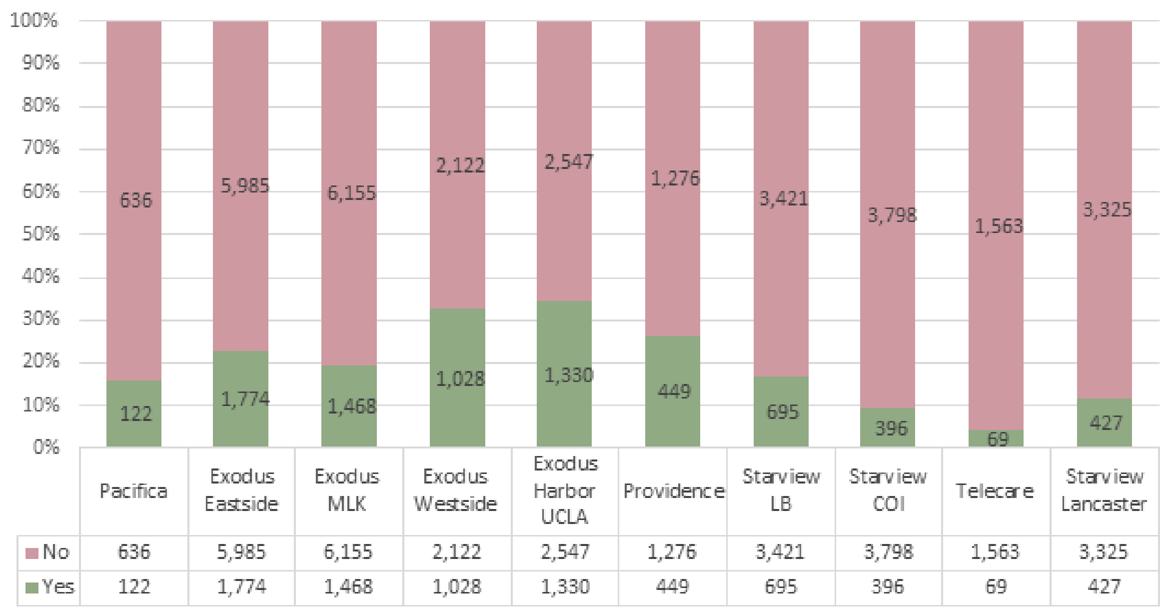


Figure 12. Clients returning to UCC within 30 days of prior UCC visit

Figure 13. Clients who were homeless upon admission to UCCs



C3. Enriched Residential Services (ERS)

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

Table 14. Enriched Residential Services Facilities

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

A4. Crisis Residential Treatment Programs (CRTP)

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

Table 15. List of current CRTPs

Hillview Crisis Residential 12408 Van Nuys Blvd., Bldg. C Pacoima, CA 91331 Ph: (818) 896-1161 x 401	Didi Hirsch Excelsior House DiDi Hirsch Comm. MH 1007 Myrtle Ave. Inglewood, CA 90301 Ph: (310) 412-4191	Didi Hirsch Jump Street CRTP DiDi Hirsch Comm. MH 1233 S. La Cienega Blvd. Los Angeles, CA 90035 Ph: (310) 895-2343
Exodus CRTP 3754-3756 Overland Avenue Los Angeles, CA 90034 Ph: (424) 384-6130	Freehab (Teen Project) CRTP 8142 Sunland Blvd., Sun Valley, CA 91352 Phone: (818) 582-8832	Gateways CRTP 423 N. Hoover Street Los Angeles, CA 90004 Ph: (323) 300-1830
Safe Haven CRTP 12580 Lakeland Rd. Santa Fe Springs, CA 90670 Phone: (562) 210-5751	SSG Florence House CRTP 8627 Juniper Street Los Angeles, CA 90002 Phone: (323) 537-8979	Valley Star MLK CRTP 12021 Wilmington Ave. Los Angeles, CA 90059 Phone: (213) 222-1681
Telecare Olive House CRTP 14149 Bucher Ave. Sylmar, CA 91342 Phone: (747) 999-4232	Telecare Citrus House CRTP 7725 Leeds Street Bldg. D Downey, CA 90242 Phone: (562) 445-3001	Telecare Magnolia House CRTP 1774 Zonal Ave RTP, Bldg. D Los Angeles, CA 90033 Phone: (323) 992-4323
Central Star Rancho Los Amigos 7745 Leeds St. Downey, Ca 90242 Phone: (562) 719-2866		

A5. Law Enforcement Teams (LET)

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

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

LET co-response teams consist of a law enforcement officer and a LACDMH mental health clinician who respond to 911 calls involving mental health crises. These teams ensure that the individuals in crisis receive appropriate, specialized care and safe transportation to the treatment facilities. LET and LACDMH's Psychiatric Mobile Response Teams (PMRT) support one another as resources permit. Mental health clinicians have already been assigned to work with 40 of the 46 police departments throughout the County.

During FY 2022-23, there were 11,312 incidents, of which 25.7% involved homeless individuals; 6% resulted in arrests; and 56.3% required hospitalizations.

A6. Psychiatric Mobile Response Teams (PMRT)

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

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

■ ALTERNATIVE CRISIS SERVICES FY 2024-25 and FY 2025-26

Another five CRTPs are set to come on-board over the next months. In addition, DMH continues to be in the very early stages of adding CSUs. This includes construction on two youth CSUs and scoping on a third youth CSU as well as the anticipated addition of two (2) adult CSUs in service areas where they are severely under-resourced currently (SA 4 and SA 7).

The following programs will continue in FY 2024-25 and FY 2025-26: Residential and Bridging Care (RBC) Program, Psychiatric Urgent Care Centers, Enriched Residential Services (ERS), Crisis Residential Treatment Programs (CRTP), Law Enforcement Teams (LET), Restorative Care Villages and Psychiatric Mobile Response Teams (PMRT).

Housing

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

The Department of Mental Health (DMH) provides a wide variety of housing resources and services for individuals who have a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) and are homeless or at risk of homelessness. In FY 2022-23, the Housing Resources and Services budget for the DMH Housing and Job Development Division (HJDD) and related programs totaled $77.3 million, of which $46.3 million was funded with Mental Health Services Act (MHSA) dollars. Data and outcomes are provided on the housing programs funded with MHSA support, with budget details specific for each program included in the chart below.

DMH HOUSING SERVICES BUDGET, FY 2022-23

Program Name	Budgeted Amount	MHSA Budgeted Amount	MHSA %
Housing Supportive Services Program	$ 25,201,137	$ 3,725,009	15%
Intensive Case Management Services Program	$ 6,200,000	$ 6,200,000	100%
Housing for Mental Health	$ 10,000,000	$ 10,000,000	100%
Housing Assistance Program	$ 2,408,566	$ 1,169,115	49%
Enriched Residential Care Program	$ 17,080,255	$ 9,122,067	53%
Interim Housing Program - Adults	$ 13,824,179	$ 13,824,179	100%
Enhanced Emergency Shelter Program - TAY*	$ 2,638,853	$ 2,328,853	88%
Total	**$ 77,352,990**	**$ 46,369,223**	**60%**

Intended Outcomes

- Assist LACDMH clients who are homeless to obtain interim housing and permanent housing
- Assist LACDMH clients living in permanent housing to retain housing
- Increase the overall number of interim and permanent supportive housing (PSH) units and rental subsidies targeting LACDMH clients

Key Activities

- Provide immediate interim housing and supportive services to LACDMH clients who are homeless to transition them from the streets into temporary shelter
- Provide financial assistance to help LACDMH clients transition from homelessness to permanent housing such as assistance with rental subsidies, security deposits, utility deposits, furniture and household goods
- Provide mental health, case management and housing retention services to LACDMH clients who are formerly homeless and living in permanent housing
- Help preserve the stock of Adult Residential Facilities and Residential Care Facilities for the Elderly in Los Angeles County by providing facilities with enhanced rates for DMH clients with complex needs
- Invest in the capital development of new PSH for individuals who are homeless and have a SMI/SED in partnership with the Los Angeles County Development Authority (LACDA) and through the use of No Place Like Home funding
- Manage the current portfolio of PSH that DMH has invested in to ensure the intended population is targeted.

D1. Capital Investments Program

Since 2008, the Los Angeles County Department of Mental Health (DMH) has invested over $1 billion in Mental Health Services Act (MHSA) funding toward the development of project-based Permanent Supportive Housing (PSH) in Los Angeles County for individuals and families who are homeless and living with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED). The below chart details these one-time capital investments and the corresponding amounts.

Table 16. One-Time Capital Investments

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

To date, $778.2 million of this $1.003 billion in MHSA funding has been committed toward the implementation and administration of capital efforts including providing capital funding for 152 PSH developments and 3,992 PSH units as well as providing capitalized operating subsidies for 13 of these developments to help make the units affordable for individuals with limited income. These PSH developments and units are intended to serve a wide range of DMH clients. Their target populations are further detailed in the chart below.

Table 17. MHSA Project-Based Permanent Supportive Housing Developments

TARGET POPULATION	NUMBER OF MHSA PROJECT-BASED PSH UNITS
Adults	2,538
Families	294
Older Adults	665
Transition Age You (TAY)	245
Veterans	250
TOTAL	**3,992**

By the end of FY 2022-23, 75 of the 152 PSH developments had finished construction, resulting in 1,680 units available for occupancy. PSH units ranged in size from studio to four-bedroom apartments and, throughout the fiscal year, provided housing for a total of 1,764 adult clients and adult family members along with 160 minor children. Specifically, during FY 2022-23, 18 PSH developments comprising 469 units began leasing up and 278 of those units were occupied by June 30, 2023.

Overall, the housing retention rate for the Capital Investments Program was 90%. DMH's initial Capital Investments Program, the MHSA Housing Program, funded 37 PSH

developments beginning in 2008 through 2015. Of those individuals housed through the MHSA Housing Program, 22% have remained in their housing for at least 10 years.

As reported last fiscal year, DMH's $744 million No Place Like Home capital investment includes $100 million that has been set aside to develop PSH on each of the County's five medical center campuses as part of the Restorative Care Villages initiative. Construction on the first Restorative Care Village site, which will be located at LAC+USC, is now projected to start in late 2025. The proposed 300-unit project includes 150 units that have been set aside to provide housing to individuals who are homeless and have a serious mental illness. Century Housing, who was selected as the developer for the LAC+USC site, plans to submit entitlements to Los Angeles County Planning by the third quarter of 2023 as they continue to secure all of the capital funding for the project, which also includes 150 units of affordable housing. DMH and the Los Angeles County Development Authority have also initiated planning discussions for the next Restorative Care Village site at Rancho Los Amigos – North Campus. It is anticipated that the Request for Proposals for this site, totaling $20 million, will be released in FY 2023-24.

D2. Federal Housing Subsidies Unit

In addition to supporting project-based PSH, DMH maintained its 17 contracts with the City and County of Los Angeles Housing Authorities, which provide DMH clients who are homeless with access to federal tenant-based PSH subsidies through such programs as Continuum of Care, Tenant Based Supportive Housing and Section 8. These subsidies make units affordable by allowing clients to pay 30% of their income as rent, with the balance paid to the property owner by the Housing Authority. DMH leverages MHSA-funded specialty mental health services, which are provided to DMH clients who access these tenant-based subsidies, to meet the match requirement for the Continuum of Care program. Leveraged services include the full range of specialty mental health services provided by DMH clinicians and case managers including housing supports such as assisting clients with the application, interview and housing location process as well as supporting clients in maintaining their housing once they move in.

During FY 2022-23, DMH Housing Authority contracts supported 2,753 tenant-based PSH units. These units helped to provide housing to 3,018 individuals, which included 2,361 adults and 657 minor children. New units that were leased up during the fiscal year totaled 219. The housing retention rate for DMH clients residing in these tenant-based PSH units was 96%, with the average length of stay totaling 5 years. Notably, the longest length of stay in tenant-based PSH though DMH Housing Authority contracts currently stands at over 24 years while 330 other DMH clients have been in this type of housing for 10 years or more.

D3. Supportive Services for Individuals in PSH

During FY 2022-23, Los Angeles County continued to use an integrated multi-Department service model to provide individuals living in PSH with the supportive services needed to promote housing stability and retention and to meet their recovery goals. Through this model, PSH residents were able to access specialty mental health services through the DMH Housing Supportive Services Program (HSSP), case management services through the Department of Health Services (DHS) Intensive Case Management Services (ICMS) program and substance use services through the Department of Public Health (DPH)

Substance Abuse Prevention and Control (SAPC) Client Engagement and Navigation Services (CENS) program.

MHSA and County Measure H funding were used to provide 2,223 individuals with HSSP services throughout the course of the fiscal year including such services as individual and group therapy, crisis intervention and medication management. MHSA dollars were also used to fund ICMS for 1,232 individuals living in MHSA-funded PSH units and other PSH units targeting individuals with mental illness. Many of those in PSH received both HSSP and ICMS services.

The following client success story helps to demonstrate the effectiveness of HSSP services in our clients' lives:

Client "A" is a female in her 50s who became homeless as a result of domestic violence. In 2018, she was able to get away from her aggressor; however, doing so resulted in her having little to no support as her abuser alienated her from her family and children. She found herself couch surfing, staying in a car and staying in shelters. In May 2020, she finally moved into PSH and was referred to an HSSP provider for mental health services shortly thereafter.

She has reported: "The services from the program impacted me as it allows me to be a human being and feel worthy again. Due to the support of services, it has allowed me to function, feel worthy and to thoroughly pick up the pieces in my life… it gave me the opportunity and confidence to be able to stand tall again, seek employment and live a purposeful life. I am grateful for [the HSSP provider] because they supported me through two major medical conditions in 2022. To me, having a home is almost a miracle as I feel empowered, confident and dignified. I am looking forward to living my best life, climbing the ladder and surpassing all odds, being the best of me to fully support myself and never relying on another person to do so."

She has also stated: "The support at [the HSSP provider] is immeasurable. It has been overwhelmingly amazing. Considering my situation, I am very blessed to have the support of my team at [the HSSP provider agency]. The sky is the limit. It is not only about being homeless or finding a home, it is a full circle. It is about finding what is your next goal, identifying strengths and creativity to be self-sufficient and independent."

D4. Housing for Mental Health

The Housing for Mental Health (HFMH) program uses MHSA funds to provide ongoing rental subsidies, as well as funding for security deposits, utility assistance and household goods, for highly vulnerable individuals with a serious mental illness who are homeless and enrolled in a Full Service Partnership (FSP) Program. Twenty percent of HFMH rental subsidies were for individuals who were referred to FSP by the DHS Office of Diversion and Reentry (ODR) and have criminal justice involvement. The HFMH program also collaborates closely with DHS ICMS teams who work alongside FSP staff to assist clients with obtaining and retaining housing.

A total of 424 DMH clients were in permanent housing supported by the HFMH program at some point during FY 2022-23. Of those clients, 335 were referred by DMH contracted providers and 89 were referred by ODR. Throughout the fiscal year, 77 individuals were newly referred to the program and 41 individuals newly moved into housing. Recognizing that the housing needs of referred clients vary, HFMH rental subsides can be used for

various types of permanent housing including tenant-based PSH, project-based PSH at one of eight partnering housing developments and licensed residential facilities. The chart below details the types of permanent housing to which clients were referred as well as where they moved in. The housing retention rate for the HFMH clients referred by DMH contracted providers was 93%.

Table 18. Housing for Mental Health Program Client Referrals

HFMH HOUSING TYPE	TOTAL IN HOUSING	NEW REFERRALS	NEW MOVE-INS
Tenant-Based PSH	254	49	19
Project-Based PSH	157	22	16
Licensed Residential Facility	13	6	6
TOTAL	**424**	**77**	**41***

* Clients included in this total may have been referred to HFMH in FY 2021-22.

D5. Housing Assistance Program

The Housing Assistance Program (HAP) uses MHSA and other funding to assist DMH clients in directly-operated and contracted programs who are homeless or at-risk of homelessness and who have limited or no income for security deposits, utility deposits, household goods and/or rent. There is also a specific set aside of Client Supportive Services funds for clients served by DMH directly-operated FSP programs. During FY 2022-23, HAP supported 1,054 financial assistance requests for households experiencing homelessness. The chart below provides additional details on the types of services rendered.

Table 19. Housing Assistance Program Households Served

HAP SERVICE TYPE	NUMBER OF HOUSEHOLDS SERVED
Security Deposits	328
Utility Deposits	31
Household Goods	417
Rental Assistance	260
Eviction Prevention	18
TOTAL	**1,054**

D6. Enriched Residential Care Program

The Enriched Residential Care (ERC) program assists DMH clients to obtain and maintain housing at an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) when the additional supports provided by these facilities is needed to live successfully in the community. ARFs and RCFEs are unlocked residential facilities that are licensed by the State and provide residents with 24-hour care and supervision, medication management, three meals per day and assistance with activities of daily living. MHSA and other funds are used to pay for client rent at the ARFs and RCFEs as well as Personal and Incidental (P&I) expenses should the client not have Supplemental Security Income (SSI) or other adequate income to pay for these items. DMH has partnered with DHS' Countywide Benefits Entitlement Services Team (CBEST) program to assist ERC clients without income

to apply for benefits for which they are eligible such as SSI. MHSA and other funds are also used to provide ARFs and RCFEs with an enhanced rate for the DMH clients they serve to help cover the costs of enhanced services that clients may require due to their higher acuity and complex needs.

As of June 30, 2023, the ERC program was serving a total of 1,238 clients. Throughout the fiscal year, 361 clients were referred to the program and 358 clients moved into an ARF or RCFE with ERC financial support. See chart below for further details on the types of financial support that was received by those served. Overall, the ERC program housing retention rate was 81%.

Table 20. ERC Program Housing Served

ERC FINANCIAL SUPPORT RECEIVED	NUMBER OF CLIENTS
Rent	308
P&I	290
Enhanced Rate	1,226

D7. Interim Housing

Interim Housing Program – Adults

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

In FY 2022-23, MHSA funds enabled DMH to contract for 618 IHP beds across 21 sites. This included 555 beds for individuals and 63 family units, although the capacity at some IHP sites was reduced to allow for safer occupancy in accordance with DPH COVID-19 guidelines. Using available resources, IHP served a total of 1,419 individuals and 75 families throughout the fiscal year.

Enhanced Emergency Shelter Program – TAY

The Enhanced Emergency Shelter Program (EESP) uses MHSA and other funds to serve the urgent housing needs of the TAY population, ages 18-25, who are unhoused or at immediate risk of becoming unhoused and have no alternative place to stay and no significant resources or income to pay for shelter; who are experiencing mental health concerns; and who are willing to accept the treatment offered. The EESP offers a warm, clean and safe place to sleep, hygiene facilities, hot meals (breakfast, lunch, dinner) and case management services. TAY have generally been provided shelter in the EESP for up to 60 nights while working with the TAY Navigation Team to identify longer-term and more permanent housing resources to help ensure stability as well as linkage to needed mental health and other supportive services. However, with the increase in the unhoused TAY population and the difficulties experienced in securing housing resources, many EESP clients stay longer than 60 nights until a longer-term housing option can be identified.
During FY 2022-23, two additional shelters were opened, expanding the total EESP capacity to 110 beds. This included a male shelter comprised of 14 beds in Service Area 2, which is

the first EESP shelter to be located in North County. The second new shelter is comprised of 12 beds for females in Service Area 6. The total number of TAY served in the EESP during the fiscal year was 592. Shelter restrictions and closures due to COVID-19 continued to impact the number of clients served overall and have also contributed to clients staying in beds longer than the designated 60 nights.

FY 2024-25 and FY 2025-26 ■ HOUSING

The Los Angeles County Department of Mental Health (DMH) Housing and Job Development Division continues to look for opportunities to grow and enhance its housing and employment services and resources for DMH clients who are homeless or at risk of homelessness. Recent activities and future plans are noted below:

- In June 2023, DMH and the Los Angeles County Department of Public Health – Substance Abuse Prevention and Control were conditionally awarded $321,189,238 in funding from the State Department of Health Care Services for the Behavioral Health Bridge Housing (BHBH) program to support bridge housing initiatives that will connect people experiencing homelessness who have serious behavioral health conditions, including serious mental illness and/or substance use disorders, to long-term housing stability. BHBH funded resources will prioritize Community Assistance, Recovery and Empowerment (CARE) Court program participants. Of the BHBH award amount, DMH will receive $259,280,749 between FYs 2023-24 and 2026-27 to establish new bridge housing beds and rental assistance resources as well as enhance staffing and services for interim housing beds in non-congregate settings currently funded with Mental Health Services Act (MHSA) dollars. To ensure that DMH interim housing beds in congregate settings have access to the same opportunities for enhanced staffing and services, MHSA funding has been requested beginning FY 2024-25 to support these sites and make certain there is equity across the DMH interim housing portfolio.

- DMH is continuing to move forward with implementation of its Community Care Expansion (CCE) Preservation program, which is intended to support the rehabilitation and preservation of Adult Residential Facilities and Residential Care Facilities for the Elderly in Los Angeles County through the funding of capital improvement projects and operating subsidy payments. Following the approval of its CCE Preservation Implementation Plan in June 2023, DMH is now working to finalize its CCE Contract with the State's third-party administrator as well as its Memorandum of Understanding with the Los Angeles County Development Authority, who will administer the capital improvement projects funding. It is currently anticipated the program will begin operations by early 2024. CCE will be funded with $97.5 million of State CCE Preservation Funds and $11.2 million of MHSA funds. A shift of the $11.2 million in MHSA funds from Community Services and Supports to Capital Facilities and Technological Needs was completed in FY 2023-24.

- In FY 2023-24, DMH committed $25 million in MHSA funds to the Department of Health Services (DHS) Office of Diversion and Reentry (ODR) to increase housing and services for individuals who are homeless, have a Serious Mental Illness and are incarcerated in the Los Angeles County Jail. This new program, known as the Diversion, Reentry and Mental Health (DREAM) program, began implementation in October 2023 and mirrors the existing ODR model, working to resolve cases early and divert clients out of jail and into interim housing. Funding will provide DREAM program clients with Intensive Case

Management Services (ICMS), Interim Housing, Enriched Residential Care (ERC) and Permanent Supportive Housing (PSH) as well as support the ODR staffing needed to administer the program. DMH specialty mental health services will also be leveraged to ensure the mental health needs of DREAM program clients are met. Additionally, $2 million in MHSA funding that had been previously dedicated through the Housing for Mental Health Program for permanent housing subsidies for ODR clients will now also be administered through the DREAM program, and the clients will be transitioned to this program as well.

- Beginning FY 2023-24, $2,050,0000 of MHSA funds will be used to enhance the program capacity of the Enhanced Emergency Shelter Program's existing 110 beds for Transition Age Youth (TAY).

- In FY 2023-24, DMH completed its capital commitment of $300,000 in MHSA funds to support Jovenes, Inc. with pre-development costs related to the development of a new PSH site for individuals who are homeless including TAY.

- In FY 2023-24, DMH increased MHSA funding for its Interim Housing, ERC and ICMS programs to support program growth and costs needed to administer the program.

- DMH worked with the Chief Executive Office (CEO) Jail Closure Implementation Team, DHS Care Transitions Team and the DMH Mental Health Court Linkage Team in FY 2022-23 to develop and implement an interim housing program for individuals with SMI being released from Los Angeles County jail. Through this new program funded with a two-year Care First Community Investment (CFCI) grant from the Los Angeles County Justice, Care and Opportunities Department, two new interim housing sites were opened totaling 45 beds. Due to the full utilization of these beds and the continued need for interim housing that meets the unique needs of this population, MHSA funding is being used to open two additional interim housing sites for justice-involved clients in FY 2023-24 totaling 55 beds. Beginning FY 2024-25, MHSA funding will also be used to continue operation of the initial 45 beds once the CFCI grant terminates.

- Los Angeles County has engaged Abt Associates to conduct a cost study looking at the reimbursement rates for interim housing and ICMS providers following research findings and stakeholder feedback that current rates are inadequate given increased costs due to inflation and the need to increase wages. DMH is looking forward to reviewing the cost study results in FY 23-24 and will respond accordingly.

- The DMH Interim Housing Program plans to expand funding beginning FY 2024-25 to establish dedicated interim housing beds, including motel beds, for clients of the Women's Community Reentry Program, Men's Community Reentry Program and Homeless Outreach and Mobile Engagement (HOME) Program.

- In FY 2024-25, DMH plans to expand its Flexible Housing Subsidy Pool Program, which provides ongoing rental assistance for DMH clients who are homeless and do not qualify for federal housing subsidies due to their documentation status or type of felony offense. This increased funding will be used to both right size the program budget for existing clients as rents have increased significantly since the program first started and serve additional clients annually.

- At the request of the Los Angeles County CEO – Homeless Initiative, DMH MHSA funds will be used to support all HSSP contractor services in FY 2024-25. This shift was made to help ensure that there remains sufficient Measure H funding for other homeless services programs in the County and prevent possible curtailments. DMH will also be assessing the ability to add peer staffing to the HSSP service model.

E. Linkage

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

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

Intended Outcomes

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

Key Activities

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

FY 2022-23 ■ LINKAGE Data and Outcomes

E1. Jail Transition and Linkage Services

Client Contacts: 2,401

This program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal is to successfully link individuals to community-based services upon discharge to prevent releasing them to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

E2. Mental Health Court Linkage Program

Client Contacts: 5,010

This program has two sub-programs funded by MHSA:

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

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

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

E3. Service Area Navigation

Client Contacts: 17,620

Service Area Navigator Teams assist individuals and families in accessing mental health and other supportive services and network with community-based organizations 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 long-standing goal of "no wrong door" achievable.

The following charts reflect FY 2022-23 data reported by the Service Area Navigators.

Figure 14. Number of phone contacts and outreach activities

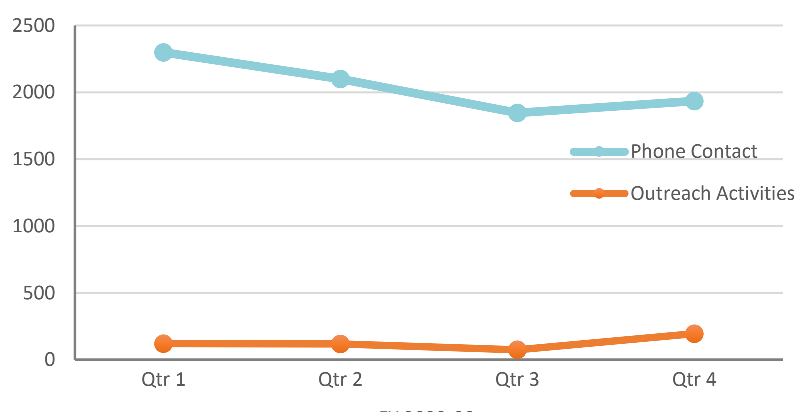
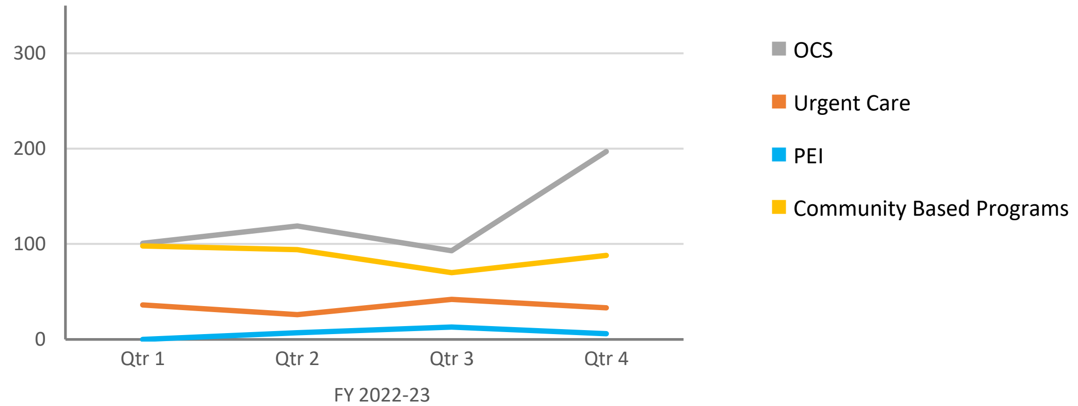


Figure 15. Number of clients referred to FSP services

2000
1000
1461
1483
1550
1727
Qtr 1
Qtr 2
Qtr 3
Qtr 4
FY 2022-23

Figure 16. Number of clients referred to Non-FSP services



E4. Homeless Outreach and Mobile Engagement (HOME)

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

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

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

The HOME Program expanded their service capacity by increasing the number of teams over a two fiscal year period beginning in FY 2022-23. This expansion is part of an effort to address the homelessness crisis as part of a lawsuit settlement between Los Angeles County and Los Angeles Alliance. Los Angeles County has committed to funding increased services, outreach, and interim housing for the most vulnerable people experiencing homelessness; in particular, the terms of agreement include expanding the number of HOME teams. DMH's HOME teams provide psychiatric support, outreach, and intensive case management to people experiencing homelessness with serious mental illnesses. In fiscal year 2022-23, the HOME program increased their capacity by adding 67 new positions.

- Rightsized existing teams to align the team staffing pattern across service areas;
- Expanded the number of HOME teams from 10 to 16 teams;
- Expanded the administrative infrastructure to support the program expansion;
- Expanded psychiatry services by adding Nurse Practitioners and Psychiatrists in each service area
- Created a HOME Operations and Navigation Team
- Involved in Inside Safe and Pathway Home

FY 2024-25 and FY 2025-26 ■ LINKAGE Continued Work
LACDMH will continue the indicated Key Activities by the following: • Continue to expand rapid diversion programs to additional courthouses to better service the significant needs of the County • Continue to expand and enhance videoconferencing capabilities and capacity in courthouse, lock-up, and jail facilities to more efficiently and rapidly provide diversion and linkage services to a greater number of clients, including leveraging flexible resource pools and economies of scale factors • Continue to enhance direct communication and coordination channels/pathways between the judicial system and diversion and linkage referral resources, including LACDMH directly-operated and contracted service programs

F. Planning, Outreach and Engagement

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☐ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

POE programs:

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

Intended Outcomes

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

Key Activities

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

FY 2022-23 ■ PLANNING, OUTREACH AND ENGAGEMNT Data and Outcomes

F1. Service Area Liaisons

In FY 2022-23, Service Area outreach staff attended multiple events with over 20,000 participants. The population consisted of the community at large from UsCCs. Staff disseminated mental health information at job fairs, Veteran events, colleges, libraries, community events and activities at local senior centers.

Significant milestones achieved by the Service Areas this year included greater social media presence, a podcast launch and hosting post covid hybrid virtual/in-person meetings. Successes included increased partnership with community organizations and increased attendance rates due to these partnerships. Unexpected challenges/barriers included event parking and transportation, community bias towards certain groups, e.g. LGBTQIA, procurement limits and restrictions and vendor payment delays.

F2. Underserved Cultural Communities

One of the cornerstones of MHSA is to empower underrepresented ethnic populations. In June 2007, LACDMH established the Underrepresented Ethnic Populations (UREP) to develop a stakeholder platform for historically underserved ethnic and cultural communities in LA County. Subcommittees were established to work closely with the various underrepresented/ underserved ethnic and cultural populations to address their specific

needs. In 2017, the UREP became the Underserved Cultural Communities (UsCC) after the incorporation of two (2) additional subcommittees implemented by the Cultural Competency Unit (CCU) in collaboration with the Cultural Competency Committee (CCC).

UsCC Subcommittees:

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

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

Intended Outcomes:

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

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

An overview of each UsCC subcommittee's projects for FY 2022-23 is provided in the following table.

A. ACCESS FOR ALL (DEAF, HARD OF HEARING, BLIND, AND PHYSICAL DISABILITIES) UsCC SUBCOMMITTEE

Project
Domestic Violence Task Force Workshops The goal of this project is to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community as well as their family members and caretakers into advocacy and activism around mental health. It aims to educate the participants on how to identify the signs of people who are victims of domestic violence and be able to provide the resources and access to appropriate help. The Facilitator is a clinician who specializes in domestic violence and providing

Project
mental health services to the Deaf, Hard of Hearing, Blind, and Physically Disabled populations. This project is designed to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. It will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well.
Disability Mental Wellness Round Table for the Deaf, Hard of Hearing, Blind, and Physically Disabled Community The goal of this project is to reduce mental health access barriers for this community by engaging the population into conversations about mental health where they can freely share their experiences with peers. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. Peers will be individuals aged 18+ who are members of the Deaf, Hard of Hearing, Blind, and Physically Disabled community with some experience with LACDMH mental health services, either directly or indirectly. This project will also include the testimony of at least three (3) Deaf/Hard of Hearing, three (3) Blind, and three (3) Physically Disabled community members with lived experience.
Podcast and YouTube Series Project The goal of this project is to provide better accommodation and accessibility to the targeted communities. This Consultant will deliver a total of 12 Podcast and YouTube sessions with different topics related to mental health and disabilities. Additionally, the Consultant will be responsible for recruiting panelists for each session including host/s, guests/participants, speakers, and presenters as well as the production and airing of all the shows. The objective of the project is to outreach and engage people from the deaf, hard of hearing, blind, and physically disabled populations into a virtual discussion regarding the mental health needs of these communities in a culturally appropriate and non-intrusive way as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services and create a safe space with mental health resources available to those that utilize American Sign Language (ASL).

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

Project
American Indian/Alaska Native Mending the Hoop Project The goal of this project is to promote mental health services for AI/AN community members, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. The objectives of this project will include engaging this population into conversations about mental health and creating healing spaces for community members to come together to improve overall health outcomes.
American Indian/Alaska Native Mental Health Community Engagement Campaign The goal of this project is to reinforce that LACDMH is here to support AI/AN community members. The project should be tailored to resonate with the AI/AN community, reaching members using video-based content with culturally appropriate messages, distributed in the places where they already seek information and using visuals/design that complement LACDMH's current public outreach efforts. The Campaign includes production and distribution of five videos that will serve as the centerpiece of the engagement efforts. The selected Consultant is expected to have experience reaching the intended audiences and expertise in the specific outreach strategies being

Project
used to reach them. An initial project proposal must be approved by LACDMH before beginning work.
American Indian/Alaska Native Traditional Wellness Gathering Project The goal of the project to reduce mental health access barriers for AI/AN community members by engaging this population into conversations about the role of cultural traditions and language in mental health and healing. This will enable this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. Additionally, this project aims to utilize traditional methods of healing such as language, prayer, spirituality, history, songs, and food to build connections and reclaim these traditions to improve overall health outcomes.
American Indian/Alaska Native Youth Academy Project The goal of the project is to identify mental health access barriers for AI/AN Transition Age Youth (TAY) (aged 16-24) by engaging this population in advocacy and activism around mental health all while building capacity using traditional forms of healing. This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. The Facilitator will recruit twenty (20) AI/AN Transition Age Youth (TAY) (aged 16-24) to participate in the Youth Academy. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. The Youth Academy should include a mental health stigma reduction program, art breakouts focused on traditional forms of healing, and athletic workshops. At the end of the Youth Academy, the youth and Facilitator will host a Community Forum to showcase their work.

C. ASIAN PACIFIC ISLANDER (API) UsCC SUBCOMMITTEE

Project
1000 Cranes - Healing Through Arts and Culture Project This project will target the API community County-wide, with a specific emphasis on the Japanese community throughout Los Angeles County by having API community members unite to fold 1000 origami cranes as symbol for wishing someone's emotional healing. The Japanese, red-crowned crane is an iconic bird that symbolizes many contexts such as resilience, recovery, and longevity giving the 1000 origami cranes a spiritual approach to encourage wellness in mental health. API communities continue to experience systemic inequities in mental health services and resources. In addition, over 30% of API Americans are not fluent in English. There is a significant gap in accessing treatment due to the lack of bilingual and bicultural mental health care providers. Cultural stigma and lack of understanding mental illness can lead to neglect and denial of mental health treatment particularly among the 1st generation API communities. In API's country of origin, often stigma, shame, and "losing face" will affect the whole family and result in being shunned by society. Families will go to great lengths to protect their reputation including isolation or suicide. This project aims to address the stigma, lack of knowledge, and cultural barriers that prevent many API community members from accessing quality mental health services in a timely manner.
Cambodian Americans Oral History Project A Consultant will be hired for the purpose of implementing a project to develop oral histories on the mental health impact of trauma on Cambodian American adults living in Los Angeles County

Project
who were children during the Khmer genocide. It would yield information on their mental health status and help reduce stigma in first generation Cambodian Americans. The goal is to fill a gap in knowledge and understanding as to the mental health impact of the historical trauma as a result of genocide of a Cambodian Americans who arrived as children. The culturally unresponsive mental health services and deeply embedded stigma prevents them from seeking or receiving mental health services resulting in mental health disparities that continue to persist. Culturally unresponsive services have also resulted in misunderstandings between therapist and patient, and barriers to successful access and engagement in treatment.
Promoting MH Wellness in South Asian Americans This project proposes to enhance mental health and wellness of South Asian immigrant families. According to literature, South Asian families are collectivistic and hence engagement efforts are most effective if these efforts take a multi-generational and holistic approach rather than individual-focused. A bilingual (Hindi or Punjabi)/English consultant with extensive experience working with the South Asian community in Los Angeles County will be hired for the purpose of developing and implementing Promoting Mental Health Wellness in South Asian Americans Project. South Asian immigrants often want to protect and preserve their culture and pass cultural practices and traditions to their children. For South Asian families, this may create tension and stress as they struggle to adjust to changes in their cultural identity as a result of acculturation. Cultural identity represents a person's cultural practices, values, and identification. South Asian families may experience difficulties between preservation and adaptation of two very different cultures. A first-generation South Asian person may experience a range of emotions while they learn to adjust to the new culture, many times with minimal or no family support. First and Second-generation family members living in the same household may experience the acculturation process very differently, resulting in different degrees of acculturation. This may cause conflicts as children may not be comfortable confiding about their socio-emotional struggles or difficulties with their parents. This may put them at risk of developing mental health issues such as depression and anxiety and in some cases may even put them at risk of suicidal ideation or developing personality disorders.

D. LATINO UsCC SUBCOMMITTEE

Project
Empowering Latino Youth Mental Health Advocates Project The goal of this project is to reduce barriers to accessing mental health services for underserved members of the Latino community by providing education to empower young people to be mental health advocates for their communities throughout Los Angeles County. Youth will incorporate the media arts utilizing age and culturally appropriate practices to provide outreach, engagement, and education to reduce stigma in their communities. The primary objectives of this project are to empower Latino youth as the experts in developing innovative strategies using media arts to reach other Latino youth throughout Los Angeles County, provide education about the importance of mental health care, destigmatize mental health issues amongst Latino youth, develop culturally sensitive resources/tools, and to increase Latino youth engagement in the LACDMH stakeholder process.
La Cultura Cura: Engaging the Traditional Arts in Healing Project The goal of the project is to provide engagement and mental health education through a partnership with the Mental Health Promotors and/or people with community outreach experience. The Consultant will integrate the traditional arts and cultural/ancestral knowledge into community education about mental health in the Latino community. The Consultant will partner

Project
with Mental Health Promotors from three different Service Areas of Los Angeles County to present a mental health workshop series that integrates cultural knowledge and healthy coping when facing emotional and mental distress. This project will target the Latino community County-wide focused on individual adults and youth. As documented by a Surgeon General report, only about 20% of the Latino community with mental health challenges speak to their doctor about their mental health. Negative cultural attitudes contribute to Latino communities living in the U.S. perceiving a lower need for mental health care despite common mental health conditions increasing among the Latino population. Stigma, language barriers, and inequities in mental health care continue to be key barriers to the Latino community receiving culturally responsive mental health services. Research has shown that engagement in cultural practices enhances physical and mental health, positive self-perception, desire to grow and learn, self-actualization, community involvement, and increased clarity of future goals. In addition, studies also indicate that engagement with art activities outside of traditional health care settings can help community members voice their mental health needs and explore the multiple facets of their wellbeing issues, including seeking mental health services when needed.
Healing Grief and Loss Through Community Project The goal of this project is to outreach, educate, and increase knowledge pertaining to grief/loss and trauma as well as mental health services by utilizing a non-stigmatizing and empowering approach to help the community begin the healing process. A consultant will be hired for the purpose of developing and implementing the Healing Grief and Loss Through Community Project. This project will target the Latino community at-large. Latinos are over-represented in occupations that require wage earners to leave their homes and interact with co-workers and clients, such as farm workers and grocery store clerks. Many of these workers are predominantly first-generation Latino immigrants. Since March of 2020, Latinos have held many of the essential jobs that have kept Los Angeles County and California well-fed and functioning. Unfortunately, this has resulted in Latinos having the highest rate of infections and deaths in California and 2.3x more times compared to White, non-Latinos/Hispanics. The disproportionally high number of deaths and infections resulting from COVID-19 has resulted in many Latinos experiencing unprocessed grief and loss while mental health education and service utilization remains significantly low. This project aims to address the stigma, lack of knowledge, and language barriers that have prevented many Latinos from accessing quality mental health services.

E. LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, QUESTIONING, INTERSEX, ASEXUAL, TWO-SPIRIT (LGBTQIA2-S) UsCC SUBCOMMITTEE

Project
Black LGBTQ+ Community Engagement Initiative Project The goal of the project is to accomplish four specific goals relative to meeting the mental health needs of Black LGBTQ+ people living in Los Angeles County. The first is to increase the level of buy-in from community stakeholders through community outreach and engagement. The second goal is to develop and implement a targeted needs assessment of the Black LGBTQ+ community living in Los Angeles County. The third is to develop and implement non-traditional and Black centered innovation support systems that address the specific needs of the Black LGBTQ+ community. The fourth goal is to develop a detailed and comprehensive report including recommendations for long-term systemic change within LACDMH to meet the needs of Black LGBTQ+ people living in Los Angeles County. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve four components. The first will include multi-stakeholder engagement that involves leading and managing a collaboration with multiple Black LGBTQ+ stakeholders that jointly addresses Black LGBTQ+ community priorities. The second

Project
component involves Black LGBTQ+ community education and empowerment involving closed biweekly meetings with community members that focus on specific issues of individual segments of the Black LGBTQ+ community. The third component involves Black LGBTQ+ community outreach and engagement. This will include planning a minimum of 2 community outreach events to hold discussions on Black LGBTQ+ community needs, share pertinent information with community stakeholders, and obtain input from community members. The fourth component consists of a community needs assessment and gap analysis.
LGBTQIA2-S Griot Project The goal of the project is to bring together an intergenerational group of Black and African-American LGBTQIA2-S community members to share and record stories of Black and African-American LGBTQIA2-S elders. The project will help to bridge the disconnect between Black elders and younger generations in order to improve mental health outcomes. It will provide an opportunity for younger generations to explore the past lives of Black elders from the LGBTQIA2-S community through active listening and dialoguing about elder experiences. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project looks to strengthen intergenerational ties in the Black and African American LGBTQIA2-S community. Through the exploration of Black LGBTQIA2-S cultural history, participants will gain a greater sense of self, build self-esteem and confidence, grow their ability for compassion, and embrace self-expression. Participants will bring newly minted skills and an improved sense of self to their communities and beyond. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black and African-American LGBTQIA2-S elders and youngers (elders aged 50 and older and youngers aged 25 and younger) into a cohort. Of those, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and will have some experience utilizing public mental health services. Cohort members will meet a minimum of eight (8) times to create a narrative videos/interviews of the elders' histories. The second component will involve conducting a community forum to present the finalized narrative videos/interviews.
LGBTQIA2-S Panthera Project The goal of the project is to provide an actionable and supportive environment for Black transmasculine community members navigating their mental health within the employment landscape. This project will provide insight and guidance on how strategy, education, and self-advocacy can be used to improve mental health outcomes for Black transmasculine community members. Tools will be developed to provide Black transmaculine community members the knowledge and capacity to secure their mental health while navigating employment with confidence and eliminate the stigma of coming out at work. Adverse experiences in workplace environments can lead to declining mental health and social standing as Black men, which can lead to other negative health outcomes. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first component will include outreach and engagement of 25 Black transmasculine community members into a Cohort. Cohort members will meet a minimum of 10 times. The purpose of the meetings will be to provide education on workplace rights as it relates to harassment in the workplace and accessing mental health during and after encounters with harmful workplace environments and educating community members on how to navigate toxic workplace environments while safeguarding their mental health. Additionally, the meetings will address the root causes of financial inequality that threaten self-sustainability amongst Black transmasculine community members. The meetings should also provide attendees with resources in the pursuit of affirming gainful employment and financial literacy in order to improve mental health outcomes. The second component will involve Facilitator and Cohort members designing a survey specific to

Project
Black transmasculine community members to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. This survey should also gather data relative to the employment needs amongst this community and the impact on mental health when facing toxic work environments. The goal will be for a minimum of 100 Black transmasculine community members in Los Angeles County to complete the survey.
LGBTQIA2-S What We Think Project The goal of the project is to identify the needs of Black Gay Male Elders, while educating and empowering this community about the importance of mental health care in an effort to build awareness and connection. This project aims to address the social isolation, trauma, and mental health issues experienced by Black Gay Male Elders by highlighting the diversity of the population and the need for culturally sensitive resources. Additionally, this project has a goal of increasing community member involvement in the LACDMH stakeholder process. This project will involve two components. The first will include outreach and engagement of a minimum of twenty-five (25) Black Gay Male Elders (aged 50+) into a cohort. Cohort members will meet a minimum of ten (10) times to support one another and to develop a survey to be disseminated to Black Gay Male Elder community members throughout Los Angeles County. The goal of the survey will be to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive and holistic way. The second component will involve conducting two (2) community town halls focused on the broader issues of aging, and in particular amongst the Black Gay Male Elder population.

FYs 2024-25 and 2025-26 ■ PLANNING, OUTREACH AND ENGAGEMENT Continued Work
LACDMH will continue outreach and engagement activities and expand its community planning efforts via a consultant to support stakeholder engagement and resource mapping. Engaging a diverse range of stakeholders is essential for effective community planning efforts.

Prevention and Early Intervention (PEI)

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

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

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

SB 1004 PEI PROGRAM PRIORITY AREAS

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

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

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

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

Table 21. PEI Priority Percentages by SB 1004 Priority Categories

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

A. EARLY INTERVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Total Number to be Served by Age Group for FY 2024-25*			
Child: 22,684	TAY: 7,967	Adult: 5,406	Older Adult: 1,094
Average Cost per Client by Age Group FY 2022-23			
Child: $5,033	TAY: $4,816	Adult: $2,968	Older Adult: $3,659

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

*FY 2024-25 total number to be served reflects average of two prior fiscal years.

FY 2022-23 ■ EARLY INTERVENTION Data and Outcomes

Table 21. FY 2022-23 Clients served

Clients Served	New Clients Served
36,206 clients received a direct PEI mental health service: - 61% of the clients are children - 21% of the clients are TAY - 14% of the clients are adult - 3% of the clients are older adult - 49% of the clients are Hispanic - 9% of the clients are African American - 10% of the clients are White - 3% of the clients are Asian/Pacific Islander - 0.25% of the clients are Native American - 3% of the clients are Multiple Races - 76% have a primary language of English - 21% have a primary language of Spanish	15,016 new clients receiving PEI services countywide: with no previous MHSA service - 44% of the new clients are Hispanic - 9% of the new clients are African American - 7% of the new clients are White - 3% of the new clients are Multiple Races - 1% of the new clients are Native American - 75% have a primary language of English - 21% have a primary language of Spanish

Table 22. FY 2022-23 Clients served through PEI by Service Area

Service Area	Number of Clients Served*	Number of New Clients
SA 1 – Antelope Valley	3,602	1,401
SA 2 – San Fernando Valley	5,284	2,128
SA 3 – San Gabriel Valley	6,236	2,710
SA 4 – Metro Los Angeles	5,169	2,164
SA 5 – West Los Angeles	1,439	596
SA 6 – South Los Angeles	3,436	1,772
SA 7 – East Los Angeles County	5,661	2,238
SA 8 – South Bay	5,818	2,142

*Number of clients served also includes number of new clients served.

The Department will continue to evaluate and review the usage of EBPs as needs are identified. The following are examples of EBPs that are implemented in Fiscal Year 2022-23, which will continue in future years.

Table 23. FY 2022-23 EBPs

Early Intervention EBP	Description
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17)	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT) Children (ages 4-15) TAY (ages 16-17)	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.
Brief Strategic Family Therapy (BFST) Children (ages 10-15) TAY (ages 16-18)	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.
Center for the Assessment and Prevention of Prodromal States (CAPPS) TAY	The focus of CAPPS is to conduct outreach and engagement specifically to those youths who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6)	CPP is a psychotherapy model that integrates psycho-dynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.

Early Intervention EBP	Description
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.
Depression Treatment Quality Improvement (DTQI) Children TAY Adults Older Adults	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.
Dialectical Behavioral Therapy (DBT) Children (ages 12-15) TAY (ages 16-20)	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.
Families Over Coming Under Stress (FOCUS) Children TAY Adults	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18)	FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults	Group CBT focuses on changing an individual's thoughts (cognitive patterns) to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.

Early Intervention EBP	Description
Incredible Years (IY) Young Children (ages 2-5) Children (ages 6-12)	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.
Individual Cognitive Behavioral Therapy (Ind. CBT) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics only	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psycho-education, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8)	An adaptation of Parent Project, LIFE is a 22- week skills-based curriculum implemented with parenting classes/ support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/ or school failure.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21)	MAP is designed to improve the quality, efficiency, and outcomes of children’s mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user- friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth’s characteristics. MAP as implemented in the County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.
Mental Health Integration Program (MHIP) **Formerly known as IMPACT** Adults	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time- limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.

Early Intervention EBP	Description
Multidimensional Family Therapy (MDFT) Children (ages 12-15) TAY (ages 16-18)	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.
Multisystemic Therapy (MST) Children (ages 12-15) TAY (ages 16-17)	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).
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.
Portland Identification and Early Referral (PIER) Children (ages 12-15) TAY (ages 16-25)	PIER provides early treatment for youth who pose a clinical-high-risk of developing severe mental illness, such as schizophrenia and psychosis. By detecting and treating patients at the onset of psychosis, the negative impact of psychosis may be mitigated. The PIER program assists youth and families to increase performance in all areas of life by building coping skills, reducing stress, and implementing problem-solving techniques.
Problem Solving Therapy (PST) Older Adults	PST has been a primary strategy in IMPACT/ MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults	PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.

Early Intervention EBP	Description
Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.
Reflective Parenting Program (RPP) Young Children (ages 2-5) Children (ages 6-12)	RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents/ caregivers enhance their reflective functioning and build strong, healthy bonds with their children.
Seeking Safety (SS) Children (13-15) TAY Adults Older Adults	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.
Stepped Care (SC) Children TAY Adults Older Adults	This service delivery option intends to improve access to services for clients and families who are experiencing early signs and symptoms of mental illness, require engagement into the mental health system, and are not ready to participate in evidence-based early intervention services. Client level of care received is determined by the initial and ongoing assessment.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18)	SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle Children (ages 3-8)	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational well-being. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.

Early Intervention EBP	Description
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community- based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by LACDMH directly operated and contract agencies.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12)	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho- educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption- specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

Table 24. EBP Outcomes since 2009 through June 2023

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,433	43%	- 21% Improvement in disruptive behaviors (as reported by parents and children) - 10% Reduction in the severity of problem behaviors (as reported by parents and children) - 14% Improvement in disruptive behaviors (as reported by teachers) - 6% Reduction in the severity of problem behaviors (as reported by teachers)
ART Skillstreaming	328	54%	- 21% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
AF-CBT	1,745	53%	- 62% Reduction in trauma related symptoms
BFST	203	63%	- 50% Reduction in behavioral problems - 66% Reduction in anxiety symptoms - 60% Reduction in attention problems - 100% Reduction in psychotic behaviors - 50% Reduction in aggressive behaviors
CFOF	733	67%	- 30% Improvement in disruptive behaviors - 20% Reduction in the severity of problem behaviors
CAPPS	213	42%	- 60% Reduction in prodromal symptoms
CPP	7,918	47%	- 17% Improvement in mental health functioning following a traumatic event
CBITS	132	71%	- No Data to Report (n=12)
CORS	4,187	60%	- 19% Improvement in mental health functioning
DBT	329	55%	- 10% Improvement in emotional regulation
DTQI	1,372	65%	- 55% Reduction in symptoms related to depression
FOCUS	803	72%	- 50% Improvement in direct communication
FC	24	44%	- No Data to Report (n=1)
FFT	1,727	66%	- 31% Improvement in mental health functioning
Group CBT	1,149	42%	- 42% Reduction in symptoms related to depression
IY	2,869	64%	- 35% Reduction in disruptive behaviors - 18% Reduction in the severity of problem behaviors
Ind. CBT	Anxiety 4,195	Anxiety 47% Depression 45% Trauma 48%	- 63% Reduction in symptoms related to anxiety - 58% Reduction in symptoms related to depression - 60% Reduction in trauma related symptoms

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
	Depression 8,232 Trauma 1,240		
IPT	8,815	50%	- 50% Reduction in symptoms related to depression
LIFE	433	65%	- 50% Reduction in disruptive behaviors - 23% Reduction in the severity of problem behaviors
MAP	71,063	49%	- 43% Reduction in disruptive behaviors - 25% Reduction in the severity of problem behaviors - 55% Reduction in symptoms related to depression - 44% Reduction in symptoms related to anxiety - 48% Reduction in trauma related symptoms
MHIP	Anxiety 3,211 Depression 7,288 Trauma 302	Anxiety 39% Depression 34% Trauma 30%	- 54% Reduction in symptoms related to anxiety - 57% Reduction in symptoms related to depression - 24% Reduction in trauma related symptoms
MPG	16	86%	- No Data to Report (n=1)
MDFT	77	89%	- No Data to Report (n=6)
MST	126	72%	- No Data to Report (n=0)
NPP	3	33%	- No Data to Report (n=0)
PCIT	5,009	40%	- 61% Reduction in disruptive behaviors - 36% Reduction in the severity of problem behaviors
PIER	93	17%	- No Data to Report (n=2)
PST	413	63%	- 45% Reduction in symptoms related to depression
PEARLS	176	49%	- 45% Reduction in symptoms related to depression
PE-PTSD	99	57%	- No Data to Report (n=15)
PATHS	747	33%	- 33% Reduction in disruptive behaviors - 19% Reduction in the severity of problem behaviors
RPP	256	71%	- 15% Reduction in disruptive behaviors - 6% Reduction in the severity of problem behaviors
SS	21,508	40%	- 51% Reduction in trauma related symptoms (Adults) - 44% Reduction in trauma related symptoms (Children)
SC	12,410	100%	- 24% Improvement in mental health functioning
SF	237	89%	- No Data to Report (n=15)
TF-CBT	27,691	54%	- 51% Reduction in trauma related symptoms
Triple P	6,652	60%	- 50% Reduction in disruptive behaviors - 27% Reduction in the severity of problem behaviors
UCLA TTM	197	50%	- No Data to Report (n=11)

B. Prevention

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

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

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

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

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

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

Programming listed below will continue unless otherwise indicated.

FY 2022-23 ■ PREVENTION PROGRAMMING Data and Outcomes

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

- Anti-Racism Diversity and Inclusion (ARDI) Training

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

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

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

This programming is currently ongoing.

- iPrevail

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

  This programming is currently ongoing.

- Media Campaign: Take Action LA

  In 2023, the Los Angeles County Department of Mental Health (LACDMH) undertook a social marketing campaign as part of prevention and early intervention for mental health: Take Action for Mental Health LA County (“Take Action for Mental Health”). Take Action for Mental Health involved community events funded through grants to community-based organizations and marketing promoting the events, as well as advertising promoting community connection and awareness of mental health resources.

  This programming is currently ongoing.

Evaluation Report

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Evaluation of Los Angeles County's 2023 Mental Health Campaigns

Identifying the Reach and Impact of the Take Action for Mental Health Los Angeles County and Do Worthwhile Work Campaigns

Mental health challenges are a common and growing problem in the United States (see, e.g., Eberhart et al., 2018; and Walker et al., 2015), especially in the aftermath of the coronavirus disease 2019 (COVID-19) pandemic and protests of racial injustice (Kessler et al., 2022; De France et al., 2022). Many people do not receive the mental health treatment they need, due, in part, to stigma of mental health problems (Arnaez et al., 2020) and a shortage of mental health treatment providers and services (McBain et al., 2022a; McBain et al., 2022b). Around the world (Gaebel, Rössler, and Sartorius, 2016), in the state of California (Collins et al., 2015), and in Los Angeles County, social marketing campaigns have been effective in shifting stigmatizing attitudes related to mental health and promoting awareness and use of mental health services (Collins et al., 2018; Collins et al., 2019; Collins et al., 2021; Collins, Eberhart, and Roth, 2022; Collins, Eberhart, et al., 2022a; Collins, Eberhart, et al., 2022b; Collins, Eberhart, et al., 2022c). The Los Angeles County Department of Mental Health (LACDMH) continued this work in 2023 with two campaigns: Take Action for Mental Health Los Angeles County (hereafter referred to as "Take Action for Mental Health") and Do Worthwhile Work.

To finance the events and campaigns, LACDMH used funds from Proposition 63, which was signed into law as the Mental Health Services Act (MHSA). This law levied a 1-percent tax on all California personal incomes over $1 million, resulting in a substantial investment in mental health in the state. The law made resources available to counties to support treatment for individuals with mental illness; it also provided prevention and early intervention services for mental health. Prevention and early intervention efforts generally can include mental health services; wellness support;

KEY FINDINGS

- The Take Action for Mental Health LA County campaign reached a substantial proportion of Los Angeles County residents.
- Take Action for Mental Health's youth campaign reached diverse communities with wide-ranging demographic backgrounds, especially those who reported a history of mental health challenges.
- Among adults, the Take Action for Mental Health reach was greater among Hispanic residents and county residents who had lower education and income levels.
- Perceptions of Take Action for Mental Health events and other social marketing efforts were overwhelmingly positive, and those exposed to the campaign had attitudes around mental health that were more positive.
- Residents exposed to Take Action for Mental Health were more likely than unexposed peers to report that they knew about mental health resources in their communities and that they felt more connected to their communities.
- Those exposed to Take Action for Mental Health also reported greater mobilization to promote mental health awareness in their own communities and reported fewer stigmatizing beliefs about mental health than did their unexposed peers.
- More than one in five county youth (22 percent) and nearly one in ten county adults (9 percent) reported exposure to Do Worthwhile Work.
- The reach of Do Worthwhile Work was greater among Hispanic adults. The campaign also reached more county adults with no college education and lower household incomes than those with higher education and income levels.
- Perceptions of the Do Worthwhile Work campaign were also positive and the campaign met its workforce recruitment goals.
- County residents exposed to Do Worthwhile Work had more-favorable beliefs about mental health careers compared with those who did not see the campaign. About one-half said they would consider applying to work at LACDMH.

efforts to reduce stigma related to mental health conditions, change attitudes about mental health treatment, and increase awareness of mental health resources. A portion of MHSA-related funds is specifically allocated for prevention and early intervention activities and cannot be used for other purposes (e.g., treatment, housing). This funding supported these two social marketing campaigns.

Both the Take Action for Mental Health and the Do Worthwhile Work campaigns promoted community connectedness. Take Action for Mental Health brought together neighborhoods and communities across the county to celebrate community and community connections during national Mental Health Awareness Month in May. The campaign events sought participation from youth and individuals with diverse racial, cultural, economic, and other backgrounds as important subpopulations to reach with the activities. The events were complemented (1) by outdoor advertising and social media posts used to promote the events and disseminate core messages and (2) by partnerships with Anschutz Entertainment Group (known as AEG, a global sports and live entertainment marketer) and the Los Angeles Dodgers designed to further the reach of Take Action for Mental Health efforts. Those partnerships concentrated on increasing awareness of LACDMH resources, particularly the county mental health Help Line that connects residents to information and assistance.

The Do Worthwhile Work campaign was aimed at (1) promoting careers with LACDMH, (2) recruiting individuals from diverse communities while

communicating messages designed to destigmatize mental health work and promote a vision of community connection, and (3) making a positive difference through such work. Do Worthwhile Work campaign outreach was through social media, online advertising, and outdoor digital signs and billboards. A key component of the Do Worthwhile Work marketing was the same partnerships with AEG and the Dodgers employing digital ads that was used for the Take Action for Mental Health campaign.

To gain insight into the reach and impact of the 2023 Take Action for Mental Health and Do Worthwhile Work campaigns, LACDMH and California Mental Health Services Authority (CalMHSA) commissioned the RAND Corporation to conduct an evaluation. RAND researchers previously evaluated LACDMH social marketing campaigns, including the WhyWeRise campaigns conducted in 2018 to 2022 (Collins et al., 2018, 2019, 2021; Collins, Eberhart, and Roth, 2022; Collins, Eberhart, et al., 2022a; Collins, Eberhart, et al., 2022b; Collins, Eberhart, et al., 2022c). We used two approaches in evaluating the 2023 LACDMH campaigns. To evaluate the Take Action for Mental Health community events, we conducted a brief survey of the events' attendees. This survey provided data specific to the Take Action for Mental Health attendee experience "in the moment" and addressed event attendees' immediate reactions to the events. Later, we fielded an online survey of representative samples of Los Angeles County youth ages 14 to 25 (reflecting a transition-aged youth target population) and adults 26 and older. This survey allowed us to (1) gain a complete picture of those reached by Take Action for Mental Health across the population of Los Angeles County and (2) evaluate potential impact of the campaign across the county. This countywide survey was also used to evaluate the reach, perceptions, and potential impact of Do Worthwhile Work. All evaluation activities were reviewed and approved by RAND's Human Subjects Protection Committee, which serves as RAND's Institutional Review Board.

In this report, we first describe the methods and findings from the countywide survey of adults and youth pertaining to the Take Action for Mental Health campaign, followed by the methods and results of our survey conducted at Take Action for Mental Health events. Next, we present the methods and findings from the components of the countywide survey evaluating Do Worthwhile Work. Finally, we provide an overall discussion of the findings along with our conclusions and recommendations.

Take Action for Mental Health

Take Action for Mental Health was a 2023 campaign in support of the county's prevention and early intervention services mission goals. The campaign involved community events and other social marketing efforts. The goals of the Take Action for Mental Health campaign were the following:

1. promoting community connectedness
2. increasing county residents' knowledge about LACDMH and other mental health resources in their communities
3. mobilizing residents to address mental health challenges
4. improving well-being
5. reducing mental health stigma.

Although LACDMH pursued these campaign goals among all county residents, they were particularly interested in promoting the campaign within diverse communities (e.g., county residents of color) and among transition-aged youth (ages 14 to 25).

The LACDMH provided grants to 109 community-based organizations to host 496 events in communities across the county. The focus of community events varied widely—from events directly addressing mental health (e.g., an event called Our Rest is Our Resistance, hosted by Black Women for Wellness) to cultural events (e.g., an event called Amor de Cocina hosted by VivaPlay). LACDMH hosted 64 additional events spread across the department's service areas, including one flagship event in each of the service areas. At all campaign events, the Take Action for Mental Health logo was displayed. These events were complemented by messaging on billboards and transit promoting the events and the website TakeActionLAC.com, which provided information about events and links to mental health resources. These materials also supported campaign goals with messages promoting community connection, resources, and action around mental health

(e.g., "Bringing communities together for mental health. Find local events at TakeActionLAC.com"). Radio ads and social media posts from LACDMH accounts provided similar information.

The social marketing campaign also involved partnerships with popular sports and entertainment organizations in Los Angeles County: the Los Angeles Dodgers and AEG. Take Action for Mental Health promotional materials were prominently displayed during the Major League Baseball team's games and LA Galaxy soccer games and at AEG venues (e.g., L.A. LIVE entertainment complex, Crypto.com arena). For example, digital advertisements with Take Action for Mental Health branded materials were displayed scrolling across LED screens during Dodger and Galaxy games. LACDMH partners also promoted the Take Action for Mental Health campaign through traditional and social media. For example, Take Action for Mental Health advertising was played during radio broadcasts of Dodger games and branded materials were posted on the Dodger and AEG social media sites. Materials shared by Take Action for Mental Health partners included information about the LACDMH Help Line. Take Action for Mental Health events and other social marketing efforts were conducted in spring and summer 2023 and were concentrated during the month of May to coincide with Mental Health Awareness Month.

Survey of Los Angeles County Residents

Methods

Data Collection

We designed and analyzed a survey of Los Angeles County residents to understand (1) the reach of the social marketing campaign, including the events; (2) how residents perceived events and campaign messages; and (3) Take Action for Mental Health's potential impact on outcomes targeted by the campaign. Two samples were surveyed to ensure that our analyses could address the reach and impact of Take Action for Mental Health on both transition-aged county youth (ages 14–25; hereafter referred to as "youth") and adults (ages 26 and older; hereafter referred to as "adults"). The surveys were fielded by Ipsos from June 30 to August 2023. The survey was offered in both Spanish and English, was available online, and took an average of 13 minutes to complete. Consent from a parent or guardian, as well as youth assent, was obtained for all participants younger than 18.

Measures

Demographic and Mental Health Characteristics

We assessed a variety of demographic characteristics, including age, race/ethnicity, gender identity, and history of mental health challenges. Survey respondents were asked whether they had ever experienced a mental health problem and whether they had experienced one they thought might require treatment in the past 12 months. Psychological distress was measured using the Kessler Psychological Distress Scale (K-6) (Kessler et al., 2003). Those whose score was 13 or higher were classified as currently experiencing serious psychological distress.

Exposure to Take Action for Mental Health

We used the following two items to measure general exposure to Take Action for Mental Health (i.e., exposure through an unspecified source):

1. "Have you heard of Take Action for Mental Health LA County?"
2. "Since March 2023, have you seen this image [the Take Action for Mental Health logo, presented alongside the item]?"

Response options were yes or no. This question was asked before any other items in the survey referring to the campaign.

To understand how they were exposed, we asked a series of questions about exposure through events or event promotion: "Did you attend or participate in any Take Action for Mental Health LA County events in May or June 2023?" Response options were yes, in person; yes, online; no; or unsure. Those who recognized the campaign logo or had heard of Take Action for Mental Health LA County were asked whether they were exposed to the campaign on a billboard, bus stop or bus, or on the radio. Respondents were also asked: "Have you visited the website TakeActionLAC.com?" and "Have you seen any social media posts from LACDMH about Take Action for Mental Health LA County?" Response options for these items

were yes or no. Those indicating campaign exposure through one or more of these methods were considered exposed through events or event promotions. Remaining exposure questions asked about exposure through the campaign partnerships with the Dodgers or AEG. Participants reported whether they had attended a Dodger game, listened to Dodger games on the radio, followed the Dodgers on social media, visited the Dodger website, or read the *Dodger Insider* online magazine since March 2023. We also assessed whether participants attended a Galaxy soccer game, listened to any Galaxy games on the radio, followed the Galaxy on social media, or visited the Galaxy website since March 2023. Finally, we assessed whether participants visited the Crypto.com (formerly Staples Center) Arena, attended an event at L.A. Live, or spent time at the L.A. Live complex since March 2023. If participants endorsed any of these exposures, they were asked whether they saw a Take Action for Mental Health LA County ad at the venue(s) indicated. A yes response to seeing an ad in any of these instances was considered an indication of exposure through the partnerships with AEG or the Dodgers.

Perceptions of the Campaign and Its Effects

Survey participants who reported attending events, exposure to event-promoting materials, or exposure through Dodger or AEG events or venues were asked a series of items about their perceptions of these forms of outreach and their effect (e.g., "made you want to take action for mental health," "connected you to information and resources," "made you feel more connected to community"). These were presented as statements, and participants rated each statement on a five-point scale (strongly agree to strongly disagree). Responses were recoded to reflect any agreement (agree or strongly agree) versus none.

Measures of Campaign-Specific Outcomes

Although perceptions are important indicators, people are often poor judges of what affects them and how (Collins et al., 1988; Nisbett and Wilson, 1977). An alternative methodological approach is to compare targeted outcomes between those who attended Take Action for Mental Health events or encountered Take Action for Mental Health promotional materials with those who did not. This approach can reveal key differences between the exposed and unexposed but caution must be used in interpreting them—differences may indicate selective exposure to the campaign (preexisting differences in who did and did not encounter messages/attend events) rather than changes in outcomes caused by the campaign.

We asked all participants, regardless of exposure to the campaign, to respond to a set of statements. Many were created specifically for understanding the Take Action for Mental Health campaign, while others were created by RAND researchers to assess prior LACDMH campaigns with similar goals. To avoid influencing responses to these with later survey items, these statements appeared at the outset of the survey, before exposure to either of the LACDMH campaigns was assessed. Participants were asked to rate their extent of agreement on a five-point scale (strongly agree to strongly disagree). Responses were recoded to reflect any agreement (agree or strongly agree) versus none.

Three of the statements assessed county residents' perceptions of community connectedness and its impact on mental health. These items asked participants to rate their level of agreement with the statements, "I feel connected to my community," "Connecting with others in our community can improve well-being," and "If we can talk about mental health issues, we can heal them." Four statements reflected county residents' awareness of LACDMH resources, community mental health resources, and community well-being and healing resources. Seven statements assessed county residents' mobilization around mental health (see Table 1).

County residents' perceptions of LACDMH were assessed by asking county residents' level of agreement with two statements: "The LACDMH is here for me if I need it" and "The LACDMH cares about my well-being."

We assessed awareness of the LACDMH Help Line with a yes-or-no item. Those who were aware of the Help Line were asked whether they had called or texted the Help Line since March 2023 (response options were "Yes, once," "Yes, more than once" and "No," and were recoded to yes or no during analysis).

TABLE 1

Items Assessing Mobilization to Address Mental Health Challenges

Item
I can help change how my family, friends, and community talk about and deal with mental health.
I know how I could be supportive of people with a mental illness if I wanted to be.
I plan to break down barriers that keep people with mental health challenges from getting treatment.
I have the power to change how our communities deal with mental health issues.
I know how to take action for my mental health.
I plan to take action to prevent discrimination against people with mental illness.
I can recognize the signs that someone may be dealing with a mental health problem or crisis.

Stigma

Although not the main target of the campaign, stigma reduction is implicit in many of the Take Action for Mental Health messages and one goal of Proposition 63 prevention and early intervention funding. We used previously validated stigma measures to assess preferences to maintain social distance from people living with mental illness, likelihood to conceal a hypothetical mental health challenge, and stigma-based beliefs about mental health challenges (Evans, Henderson, and Thornicroft, 2013; Link et al. 1999).

Well-Being

We assessed three aspects of well-being (loneliness, hopefulness, and social support) using previously validated scales and items (Hughes et al., 2004; Rosenberg, 1965).

Analyses

All analyses were conducted separately for the youth and adult samples. For each sample, we conducted analyses to describe the characteristics of study participants, Take Action for Mental Health exposure, and perceptions of the campaign. We also compared responses on items addressing the 14 campaign-specific beliefs, Help Line awareness, stigma, and well-being between those who were exposed to the Take Action for Mental Health campaign and those who were not.

Sample weights were applied so that youth and adult results represent those for the Los Angeles County population ages 14 to 25 and 26 and older, respectively. We report unweighted frequencies and percentages, weighted percentages and significance tests. All percentages are weighted unless otherwise indicated. All reported differences are statistically significant at $p < 0.05$. The data analysis for this report was generated using SAS/STAT software (2023).

Results

Demographic and Mental Health Characteristics

We obtained surveys from 1,234 Los Angeles County residents, including 329 youth ages 14 to 25 and 905 adults 26 and older. Characteristics of those responding can be viewed in columns 1 and 2 of Tables 2 and 3. The samples were diverse and consisted of participants from all age groups, gender identities, racial and ethnic backgrounds, educational histories, and income levels measured by the survey. Because respondents to our survey somewhat overrepresented Los Angeles County residents with certain characteristics and underrepresented others, these data were weighted to represent the county population in each age group (as described by census data). Effects of the weights can be observed by comparing columns 2 and 3 in Tables 2 and 3.

Exposure to the Take Action for Mental Health Campaign

One in four county youths and one in five county adults were exposed to some aspect of Take Action for Mental Health (see bottom row of Tables 4 and 5). Applying this percentage to the total population of Los Angeles County youth 14 to 25 years old and adults 26 or older (as reported in the American Community Survey), **Take Action for Mental Health reached 390,895 county youth and 1,333,454 county adults in 2023.**

Details regarding exposure to the campaign among subgroups of the Los Angeles County population are presented in the remainders of Tables 4 and 5 for youth and adults, respectively. **Youth were exposed to the campaign at statistically similar rates regardless of their age, gender, or racial/**

TABLE 2

Characteristics of Youth Participants in the Countywide Take Action for Mental Health Survey (n = 329)

Characteristic	Unweighted Number of Youth Participants	Unweighted Percentage of Youth Participants	Weighted Percentage of Youth Participants
Age			
14–17	107	33	32
18–25	222	67	68
Race/ethnicity			
Hispanic, English-language survey preference	164	51	61
Hispanic, Spanish-language survey preference	23	7	4
Non-Hispanic White	68	21	17
Non-Hispanic Black	29	9	7
Non-Hispanic Asian or Pacific Islander	34	11	11
Multiple races/ethnicities	1	0	0
Gender			
Male	155	47	50
Female	164	50	46
Transgender	4	1	1
Genderqueer, gender nonconforming	6	2	2
Use a different term	4	1	0
Ever had a mental health problem	133	41	31
Past 12 months perceived need for mental health treatment	104	32	26
Past 30 days serious psychological distress	70	21	19

NOTE: Frequencies sum to less than 329 due to missing responses. Education and income are not shown for youth because they are difficult to interpret for this population.

ethnic background. Among adults, the campaign was also approximately equally likely to reach male and female county residents. Some of the county's prior campaigns were far less likely to reach men than women. **Take Action for Mental Health was more likely to reach Hispanic adults in Los Angeles County than adults in the county who identified as non-Hispanic White**, while reach to other racial/ethnic groups did not differ from non-Hispanic White adults. **The campaign was also more likely to reach those with lower incomes (less than $50,000 annually) and education (high school or less).**

More county youth who reported ever having mental health problems were exposed to the Take Action for Mental Health campaign than youth without a history of mental challenges. This finding may indicate that such individuals are more likely to be at mental health events or to be exposed to campaign ads, or that those with prior mental health issues are more likely to recall campaign ads (or some combination of both).

TABLE 3

Characteristics of Adult Participants in the Take Action for Mental Health Event Survey (n = 905)

Characteristic	Unweighted Number of Adult Participants	Unweighted Percentage of Adult Participants	Weighted Percentage of Adult Participants
Age			
26–44	259	29	41
45–64	369	41	39
65+	277	31	20
Race/ethnicity			
Hispanic, English-language survey preference	210	24	22
Hispanic, Spanish-language survey preference	162	18	22
Non-Hispanic White	345	39	31
Non-Hispanic Black	94	11	8
Non-Hispanic Asian or Pacific Islander	72	8	16
Multiple races/ethnicities	3	0	1
Gender			
Male	382	42	47
Female	508	56	51
Transgender	5	1	0
Genderqueer, gender nonconforming	12	1	2
Use a different term	7	1	0
Education			
No high school diploma or GED	74	8	20
High school/GED	117	13	21
Some college/associate's degree	284	31	26
Bachelor's degree or higher	430	48	34
Household income			
Less than $25,000	187	21	11
$25,000 to $49,999	175	19	15
$50,000 to $74,999	139	15	15
$75,000 to $99,999	129	14	13
$100,000 to $149,999	134	15	19
$150,000 or more	141	16	26
Ever had a mental health problem	284	31	28
Past 12 months perceived need for mental health treatment	182	20	18
Past 30 days serious psychological distress	65	7	9

NOTE: Frequencies sum to less than 905 due to missing responses.

TABLE 4

Subgroups of Youth Exposed to Take Action for Mental Health at Similar Rates

Characteristic	Percentage Exposed to Campaign
Age	
14–17	18
(18–25)	29
Race/ethnicity	
Hispanic, English-language survey preference	27
Hispanic, Spanish-language survey preference	44
(Non-Hispanic White)	33
Non-Hispanic Black	18
Non-Hispanic Asian or Pacific Islander	14
Multiple races/ethnicities	—
Gender	
Male	24
(Female)	27
Uses another term	32
Ever had a mental health problem	39*
(Never had a mental health problem)	20
Past 12 months perceived need for mental health treatment	33
(Past 12 months no perceived need for mental health treatment)	23
Past 30 days serious psychological distress	38
(Past 30 days No or less than serious psychological distress)	23
Total youth	26

NOTE: Asterisk indicates significant differences in exposure to the campaign compared with the reference group in parentheses. Dash indicates a value not reported or tested because only one person represented the sample group. Education and income are not shown for youth because they are difficult to interpret for this population.

TABLE 5

Some Subgroups of Adults 26 and Older Were More Likely to Report Exposure to the Take Action for Mental Health Campaign Than Other Subgroups

Characteristics	Percentage Exposed to Campaign
Age	
26–44	25
(45–64)	19
65+	12
Race/ethnicity	
Hispanic, English-language survey preference	25*
Hispanic, Spanish-language survey preference	31*
(Non-Hispanic White)	11
Non-Hispanic Black	25
Non-Hispanic Asian or Pacific Islander	12
Multiple races/ethnicities	8
Gender	
Male	19
(Female)	21
Uses another term	20
Education	
(No high school diploma or GED)	32
High school/GED	23
Some college/associate's degree	15*
Bachelor's degree or higher	16*
Household income	
(Less than $25,000)	37
$25,000 to $49,999	30
$50,000 to $74,999	10*
$75,000 to $99,999	18*
$100,000 to $149,999	20*
$150,000 or more	13*
Ever had a mental health problem	24
(Never had a mental health problem)	19
Past 12 months perceived need for mental health treatment	15
(Past 12 months no perceived need for mental health treatment)	21
Past 30 days serious psychological distress	12
(Past 30 days no or less-than-serious psychological distress)	21
Total adults	20

NOTE: Asterisk indicates significant differences in exposure to the campaign compared with the reference group in parentheses.

How Los Angeles County Residents Were Exposed to Take Action for Mental Health

There were two arms to the 2023 Take Action for Mental Health campaign: (1) events and their promotion and (2) partnerships with the Dodgers and AEG. The two forms of outreach were about equally effective in reaching county youth. As indicated in the bottom row of Table 6, 12 percent of youth recalled exposure through the Dodgers or AEG, 15 percent through events and event-related promotional materials. Similarly, **county adults were about equally likely to be reached by these two arms of the Take Action For Mental Health campaign**, with 7 percent and 5 percent reached by the partnership and events and event-promotion efforts, respectively (see the bottom row of Table 7). Comparison of the columns in these tables suggests differences in the characteristics of those reached by the campaign arms. **Among youth and adults, the partnerships with the Dodgers and AEG did slightly better at reaching Hispanic county residents than the events and event promotion.** Among adults, the events and their promotion did better at reaching those in the younger group, ages 26 to 44, while the partnerships excelled at reaching seniors (ages 65 and older). The most dramatic difference in audiences for the two campaign arms was observed among non-Hispanic Black adults. **Only 1 percent of Black adults reported exposure to Take Action for Mental Health through the partnerships with the Dodgers and AEG, while 19 percent reported exposure through the events and event outreach.** This

TABLE 6

Recalled Source of Exposure to the Take Action for Mental Health Campaign Among County Youth

Characteristics	Partnership with Dodgers or AEG	Events and Event-Related Outreach	Source Not Recalled
Age			
14–17	31	26	18
18–25	69	74	82
Race/ethnicity			
Hispanic, English-language survey preference	65	56	70
Hispanic, Spanish-language survey preference	4	3	15
Non-Hispanic White	19	30	3
Non-Hispanic Black	9	8	1
Non-Hispanic Asian or Pacific Islander	3	4	11
Multiple races/ethnicities	0	0	0
Gender			
Male	56	56	27
Female	39	40	66
Uses another term	4	3	7
Ever had a mental health problem	54	50	45
Past 12 months perceived need for mental health treatment	31	35	35
Past 30 days serious psychological distress	44	38	18
Total youth	12	15	8

TABLE 7

Recalled Source of Exposure to the Take Action for Mental Health Campaign Among County Adults

Characteristics	Partnerships	Events and Event-Related Outreach	Source Not Recalled
Age			
26–44	53	78	45
45–64	33	20	42
65+	14	2	13
Race/ethnicity			
Hispanic, English-language survey preference	35	23	27
Hispanic, Spanish-language survey preference	40	38	36
Non-Hispanic White	13	7	19
Non-Hispanic Black	1	19	9
Non-Hispanic Asian or Pacific Islander	10	13	8
Multiple races/ethnicities	1	0	0
Gender			
Male	45	42	43
Female	55	58	52
Uses another term	0	0	5
Education			
No high school diploma or GED	19	27	38
High school/GED	35	44	16
Some college/associate's degree	21	10	18
Bachelor's degree or higher	25	19	28
Household income			
Less than $25,000	22	30	18
$25,000 to $49,999	25	29	20
$50,000 to $74,999	9	10	9
$75,000 to $99,999	14	10	13
$100,000 to $149,999	9	5	29
$150,000 or more	21	16	13
Ever had a mental health problem	27	32	35
Past 12 months perceived need for mental health treatment	10	11	14
Past 30 days serious psychological distress	11	0	3
Total adults	7	5	11

suggests the importance of continuing the events in future years to reach this group.

Figure 1 explores overlap in the audiences reached by the two arms of the campaign. The figure indicates that more than one-third of campaign-exposed county youth (34 percent) were reached by both the Take Action for Mental Health partnership effort and community events or event promotion. Rather than being duplicative, this overlap in reach can be important for reinforcing campaign messages. Only 16 percent of campaign-exposed county adults were exposed to both campaign partnership efforts and community events or event promotion. Thus, **among adults, the campaign arms served to expand each other's reach rather than to reinforce messages.** This finding suggests that it may be important to continue both arms to reach sufficient numbers of county adults or to otherwise expand the venues in which promotional messages appear. Figure 1 also shows that many of those who recognized the Take Action for Mental Health logo or said they had heard of the campaign did not recall how they were exposed—about one-third of campaign-exposed youth and about one-half of campaign-exposed adults. This finding may indicate a lack of engagement with some of the messages and materials.

Perceptions of the Campaign and Its Effects

Perceptions of Take Action for Mental Health were largely positive among county youth and adults exposed to the campaign, and they perceived it as having the effects on them that were intended by LACDMH. Table 8 shows ratings of each outreach form among those reporting exposure through that medium or venue. **A central goal of the Take Action for Mental Health campaign was to increase awareness of community mental health resources. Among the youth and adults who reported attending an event, more than 80 percent reported that the events made them more aware of mental health resources in their communities. Most county youth and adults who were exposed to the campaign reported feeling connected to their communities as a result.**

Youth had perceptions of the Take Action for Mental Health social media outreach that were more positive compared with campaign events and other media for two items ("made you want to take action for mental health" and "made you feel supported"). There were no significant differences in perceptions among adults, though patterns for most measured outcomes are suggestive of more-positive perceptions of the community events' impact than other forms of outreach. Between 89 percent and 100 percent of adults said the events made them want to take action,

FIGURE 1

How Los Angeles County Residents Were Exposed to the Take Action for Mental Health Campaign (Reported Source of Exposure Among Those Exposed)

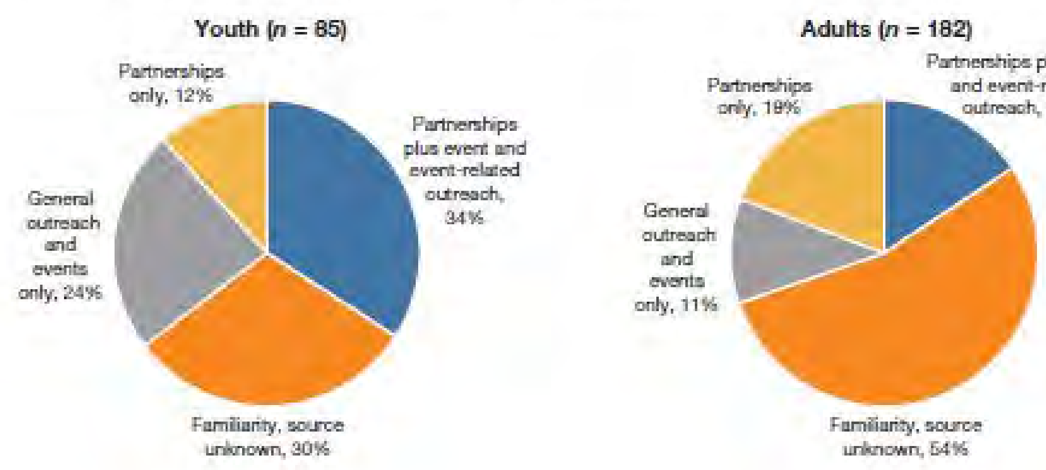


TABLE 8

Perceptions of the Take Action for Mental Health Campaign Among Those Exposed, by Type of Exposure

	Youth (% agreeing)				Adults (% agreeing)			
Survey Statement	Events	Radio and Outdoor Ads	Social Media	Partnerships	Events	Radio and Outdoor Ads	Social Media	Partnerships
Made you want to take action for mental health*	65	54	97	61	100	49	66	69
Connected you with information and resources to support your own and others' well-being	82	—	74	79	100	—	100	75
Made you feel more connected to community	65	—	82	60	94	—	66	64
Made you feel more supportive of people experiencing mental health challenges	71	—	73	71	92	—	59	76
Made you feel supported*	64	—	92	55	89	—	92	73
Made you more aware of mental health resources in your community	78	80	82	67	97	84	100	88
Made you want to visit the Take Action for Mental Health website	—	63	—	—	—	54	—	—

NOTE: Asterisk indicates a significant difference across message source for youth. Dash indicates question not asked about this form of outreach. There were no significant differences among adults.

connected them to community, and made them aware of resources. In our samples, the small numbers of individuals exposed to each specific form of outreach, particularly among adults, make it difficult to interpret these patterns. Future LACDMH campaigns may consider these differences when tailoring materials to various age groups.

Potential Impact of Take Action for Mental Health

Exposure to the campaign was associated with differences across most of the outcomes it targeted. Next, we look at differences for each campaign goal in turn.

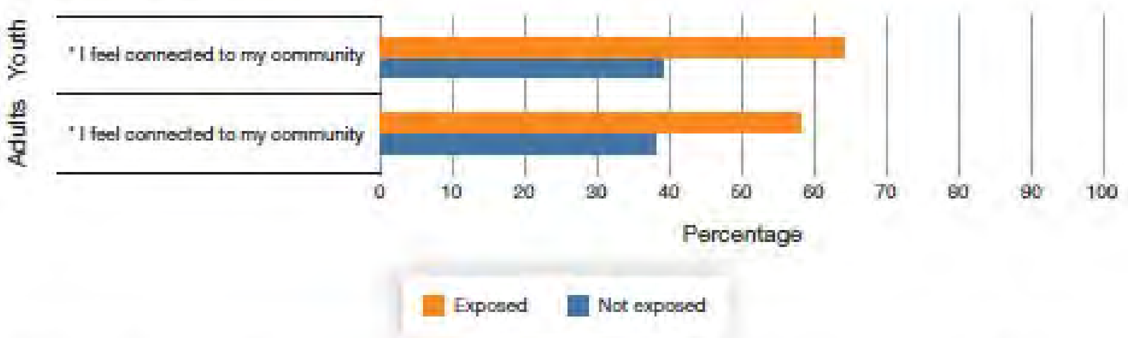
Community Connection and Belief in the Power of Community Connection

The Take Action for Mental Health campaign appeared to reach its goal of promoting community connection. Los Angeles County residents who were exposed to the campaign were significantly more likely to report that they felt connected to their community. Specifically, 64 percent of county youth and 58 percent of county adults who were exposed to the campaign agreed that they felt connected to community, compared with 39 percent of unexposed county youth and 38 percent of unexposed county adults (see Figure 2).

Making these connections also appears to have grown more important for county adults. County adults who were exposed to the campaign were significantly more likely than unexposed peers to agree that connecting with others in our community can improve well-being (see Figure 3). They were also more likely to believe that talking about mental health can be healing. In contrast, there were no differences in agreement with these items between campaign-exposed and unexposed youth.

FIGURE 2

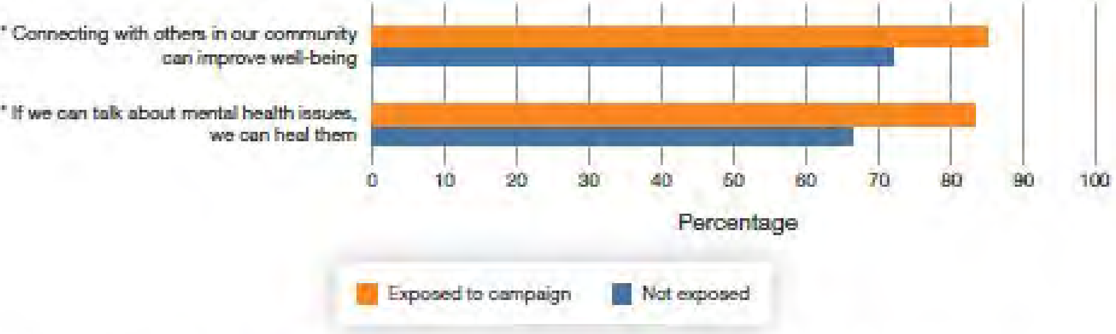
Youth and Adults Exposed to the Take Action for Mental Health Campaign Felt More Connected to Community



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

FIGURE 3

Adults Exposed to the Take Action for Mental Health LA County Campaign Were More Likely to Believe in the Power of Connecting with Community



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within the adult population.

Knowledge about LACDMH and Community Mental Health Resources

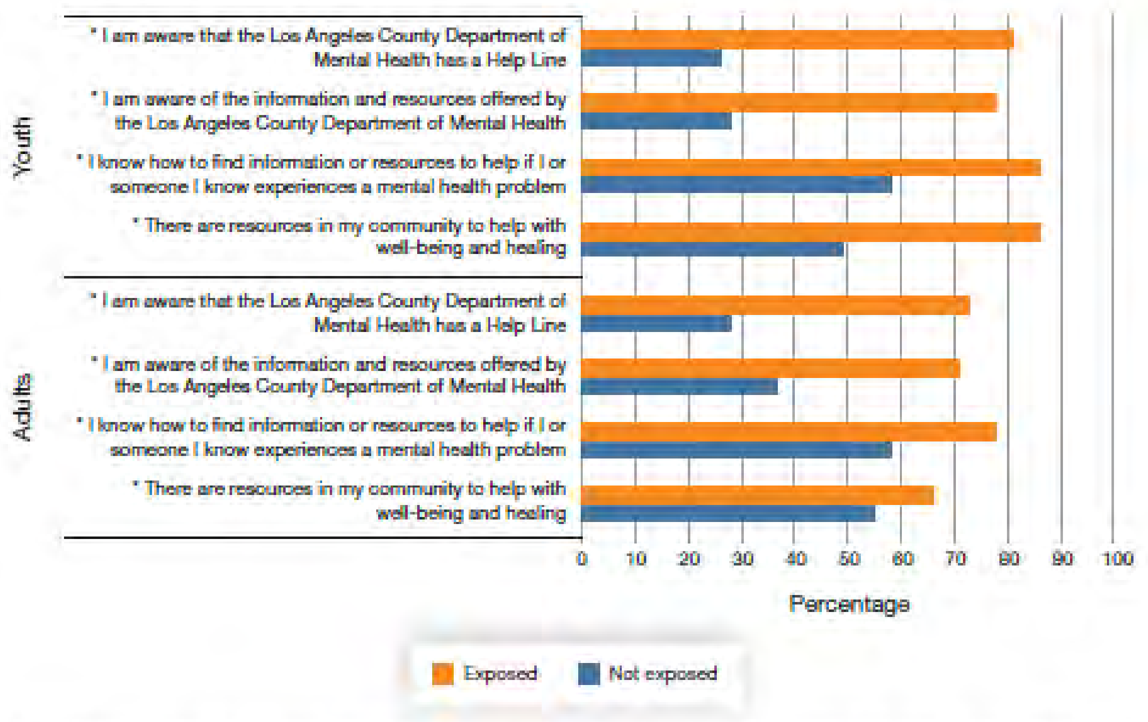
A central goal of the Take Action for Mental Health campaign was to increase awareness of LACDMH resources. The campaign appears to have achieved important impacts in this area, especially among county youth. **Youth who were exposed to the campaign were significantly more likely to report that they knew about LACDMH resources, the LACDMH Help Line, and mental health resources in their communities than unexposed peers.**

Among county adults, those who were exposed to the campaign were also more likely than unexposed peers to report that they knew about the LACDMH Help Line and LACDMH resources (but not community mental health resources). General awareness of mental health and well-being resources were more common among exposed youth than exposed adults, although direct comparisons of the exposed groups were not conducted. Figure 4 provides more information.

We assessed use of the LACDMH Help Line among county residents who reported that they were aware of the Help Line. **County residents who were exposed to the Take Action for Mental Health campaign were much more likely to report that they**

FIGURE 4

Youth and Adults Exposed to the Campaign Had Greater Awareness of Mental Health Resources



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

used the Help Line, although the difference was not statistically significant, likely as a result of low rates of Help Line use overall. Specifically, the percentage of exposed county youth (8 percent) who reported using the Help Line was four times the percentage of unexposed youth who did so (2 percent). Two percent of exposed county adults reported using the Help Line, compared with 1 percent of unexposed county adults (results not tabled).

Mobilization to Address Mental Health Challenges

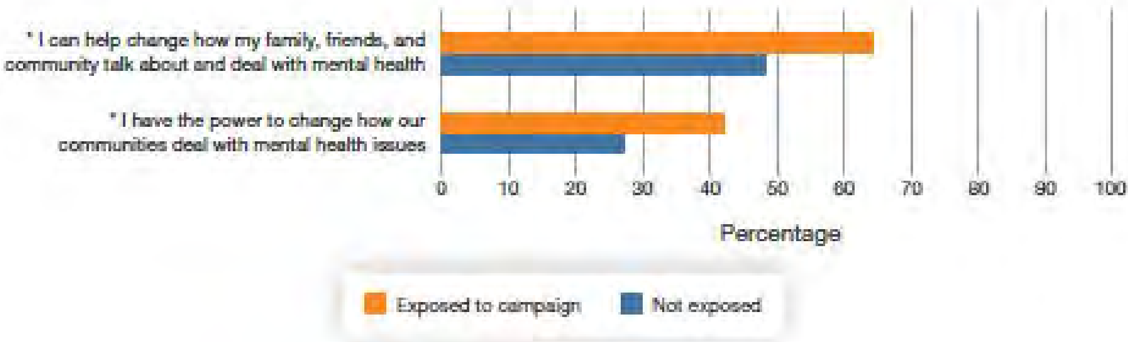
Key differences in mobilization to action were associated with Take Action for Mental Health exposure among county adults, with those exposed more likely to feel ready (or intend) to act to address mental health challenges when compared with their unexposed peers. Of the nine items assessing mobilization, seven revealed significant differences in agreement among exposed versus unexposed adults. Two items where such differences were observed reflected campaign-exposed adults' perceived power to change how family, friends, and communities talk about and deal with mental health (see Figure 5).

Los Angeles County adults who were reached by the Take Action for Mental Health campaign were also more likely to agree they had the knowledge needed to take action to address their own or others' mental health, relative to their peers not exposed to the Take Action campaign (see Figure 6). Although these differences were fairly small, involving about 15 percent of county adults, the consistency of these differences across varying survey items is noteworthy, as is the large number of county adults that a 15-percent difference reflects.

The largest differences observed for exposed versus unexposed adults, among the nine mobilization measures, were for items tapping plans to mobi-

FIGURE 5

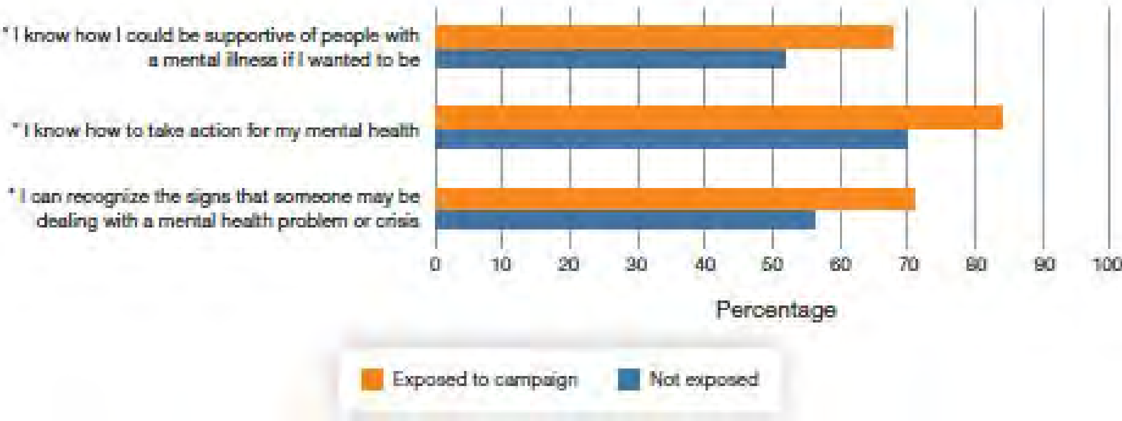
Adults Exposed to the Take Action for Mental Health Were More Likely to Feel They Could Change How Their Communities Talk About and Deal with Mental Health



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within the adult population.

FIGURE 6

Adults Exposed to the Take Action for Mental Health Campaign Were More Likely to Know How to Take Action for Their Own and Other's Mental Health



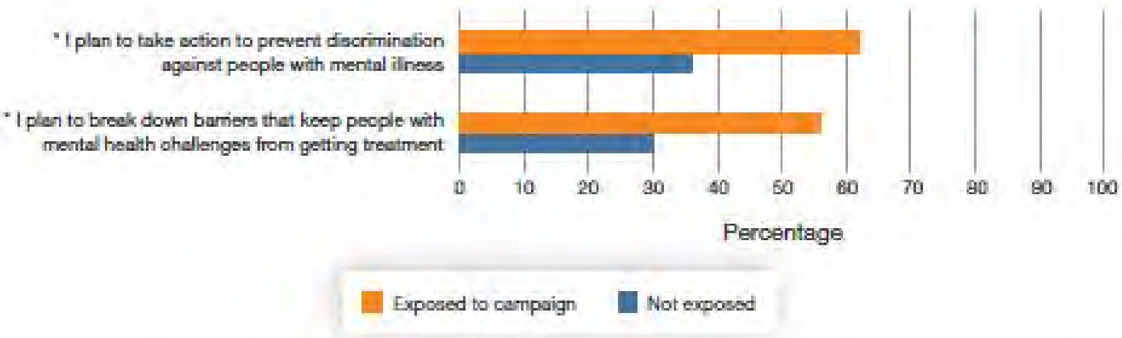
NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within the adult population.

lize against mental health discrimination and barriers to treatment. For each of these items, Take Action for Mental Health–exposed adults were between 70 percent and 80 percent more likely to agree that they had such plans than adults not exposed to the campaign (see Figure 7). This finding may suggest a particular anti-stigma bent to any changes the campaign might have wrought in plans for action.

In contrast to the many observed associations between mobilization beliefs and campaign exposure among county adults (seven), few were present among youth. We found only two statistically significant associations in this subpopulation: Youth who reported exposure to Take Action for Mental Health were (1) more likely to say they could change how their families and communities talk about and deal with mental health than their unexposed peers and (2) more likely to plan action to prevent mental health discrimination (see Table 9). It is unclear why

FIGURE 7

Adults Exposed to the Take Action for Mental Health LA County Campaign Were More Likely to Plan to Prevent Mental Health Discrimination and Break Down Barriers to Care



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within the adult population.

TABLE 9

Mobilization to Address Mental Health Issues Was Largely Unrelated to Campaign Exposure Among Youth

Survey Statement	Youth Agreeing (%)	
	Not Exposed	Exposed
I can help change how my family, friends, and community talk about and deal with mental health	55	78*
I know how I could be supportive of people with a mental illness if I wanted to be	59	74
I plan to break down barriers that keep people with mental health challenges from getting treatment	40	59
I have the power to change how our communities deal with mental health issues	31	50
Connecting with others in our community can improve well-being	74	85
If we can talk about mental health issues, we can heal them	65	77
I know how to take action for my mental health	63	71
I plan to take action to prevent discrimination against people with mental illness	42	67*
I can recognize the signs that someone may be dealing with a mental health problem or crisis	59	76

NOTE: Asterisk indicates percentages of exposed and not exposed youth agreeing with the statement differ.

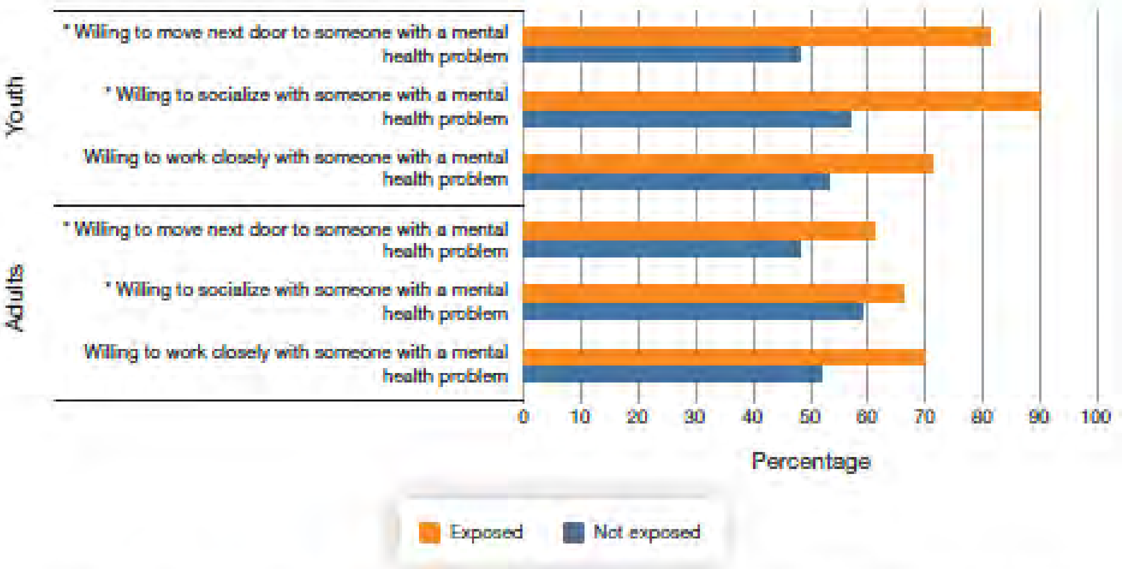
the campaign was less effective at mobilizing youth than adults.

Stigma

Take Action for Mental Health appeared to reduce some key stigmatizing attitudes about mental health problems in exposed county residents. Campaign-exposed adults showed a greater willingness to work with and live near people experiencing mental health challenges (see Figure 8). Significantly, **more county youth who were exposed to the campaign endorsed willingness to live near and to socialize with someone experiencing mental health challenges.** These differences, if attributable to the campaign rather than preexisting differences

FIGURE 8

Youth and Adults Exposed to the Campaign Were More Willing to Associate Closely with People with Mental Health Problems



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

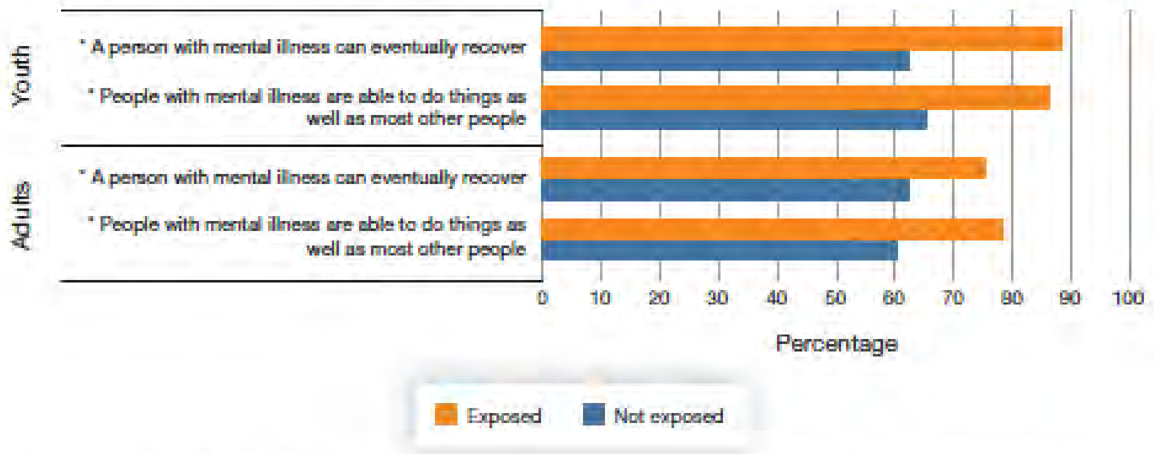
in the campaign audience, are important. Few efforts at stigma reduction have been able to change *measures of social distance*, as these items are referred to in research literature. In general, contact between those with and without mental health challenges is necessary. It may be that the community events resulted in such contact, or it may be that differences in social distance existed prior to exposure to any element of Take Action. It is unclear why the differences were observed, but this finding is a promising one for the campaign.

Campaign-exposed youth and adults were also significantly more likely than their unexposed peers to believe that it is possible to recover from mental health challenges and that those who are experiencing mental health challenges can do things as well as most people (see Figure 9). Such beliefs are indicators of a decline in mental health stigma, indicating people's beliefs about the essential worth of people regardless of their mental health. Differences associated with campaign exposure on these measures complement those noted above for social distance and for plans to take action against mental health discrimination.

Few other differences were observed between exposed and unexposed county residents (see Table 10). On measures tapping concealment of mental health symptoms we observed only one: **Significantly more exposed county adults agreed that they would delay treatment for mental health problems due to fears that others might find out.** This difference might suggest that the campaign increased desires to conceal mental health problems among adults. This has occurred in other social marketing around mental health when messages focus on overcoming the stigma of mental illness. We see nothing similar in the campaign materials for Take Action for Mental Health, but LACDMH should take care in future years, particularly in discussing messaging with community organizations, who may not be aware of this possible effect of their efforts. Taken together with other stigma-related results, it is possible that the Take Action for Mental Health social marketing campaign had a positive impact on beliefs about others' mental health challenges but was inef-

FIGURE 9

Youth and Adults Exposed to the Campaign Had Stronger Beliefs in Recovery from Mental Illness and the Worth of Those Experiencing Mental Health Challenges



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

TABLE 10

Associations Between Campaign Exposure and Stigma

	Los Angeles County Population (% agreeing)			
	Youth		Adults	
Stigma-Related Belief	Not Exposed	Exposed	Not Exposed	Exposed
Social distance				
Willing to move next door to someone with an MHP	48	81*	48	61*
Willing to socialize with someone with an MHP	57	90*	59	66
Willing to work closely with someone with an MHP	53	71	52	70*
Beliefs about mental health challenges				
A person with mental illness can eventually recover	62	88*	62	75*
Treatment can help people with mental illness lead normal lives	75	87	84	91
People with mental illness are able to do things as well as most other people	65	86*	60	78*
People like me sometimes experience mental health challenges	65	79	60	63
Concealment				
Would delay treatment for MHP fearing others might know	39	34	18	33*
Would try to hide MHP from family/friends	38	41	30	30
Would try to hide MHP from co-workers/classmates	60	56	49	46

NOTES: MHP = mental health problem.
Asterisk indicates differences between those exposed and not exposed are statistically significant within population (youth or adult).

fective or problematic in addressing stigmatizing beliefs about mental health issues for oneself.

Well-Being

No differences were observed between exposed and unexposed county youth and adults in terms of loneliness, hopefulness about the future, or perceptions of social support (see Table 11). It is possible that it is harder to cause change in well-being than in attitudes and awareness with a brief social marketing campaign.

We ran statistical interaction analyses to test potential racial/ethnic differences in the association between campaign exposure and targeted outcomes. **We found no evidence that effects of the campaign differed by race/ethnicity.**

Survey of Take Action for Mental Health Event Attendees

We surveyed Take Action for Mental Health LA County event attendees. Event surveys evaluated attendees' demographic characteristics; their perceptions of the event; and their attitudes, beliefs, and intentions to act related to mental health challenges. Attendees were surveyed at two types of events: (1) events hosted by community-based organizations and (2) flagship events hosted by LACDMH service areas.

Method

Community-based organizations that hosted Take Action for Mental Health events surveyed attendees using a RAND-designed survey and received technical assistance from RAND. This assistance consisted of providing community-based organizations with training on best practices for fielding surveys, survey supplies (i.e., paper and/ or virtual surveys, participant recruitment materials) and with guidance throughout the survey period. The initial training consisted of two RAND scientists leading a 90-minute webinar that provided guidance on recruiting participants, collecting and storing survey data, and protecting participants' rights. Each community-based organization received 120 scannable paper surveys and, if the organizations hosted virtual events, organization-specific links to a virtual survey. We also provided community-based organizations with poster templates and event observation forms for survey events. Community-based event staff were encouraged to announce the survey at their event and to actively approach event participants to invite them to participate in the study. Each organization aimed to collect 120 surveys total across all their events; the number of surveys collected per event was left to the discretion of the community-based organizations. On completion of all Take Action for Mental Health events, community-based organizations returned all survey materials to us for analysis.

The RAND Survey Research Group fielded surveys at the larger service-area wide events hosted by the LACDMH. The Survey Research Group collected surveys at one flagship event in each of seven of the eight LACDMH service areas. The eighth service area did not host a flagship event for community members but instead hosted a press event that was not appropriate for data collection. We attempted to survey up to 100 individuals per event. For some events, the actual number of attendees during the period that we were surveying was far fewer than 100; for others,

TABLE 11

Associations Between Campaign Exposure and Well-Being Indicators

	Los Angeles County Population (% agreeing)			
	Youth		Adults	
Indicator	Not Exposed	Exposed	Not Exposed	Exposed
Lonely	39	36	30	25
I get the social and emotional support I need	78	87	86	88
I feel hopeful about the future	72	73	64	74

it was far more. Service-area event attendees were invited to complete the survey either on a scannable paper form or by following a QR code that provided a link to the online survey.

Participants were eligible for the survey if they (1) attended either a community-based organization or service-area event, (2) were age 14 or older, (3) were able to read and understand survey materials, and (4) had the capacity to engage in the informed consent process. Participants were allowed to complete only one survey across the evaluation period, so people who attended multiple events were excluded after completing one survey. Paper surveys were translated into Spanish, Korean, Vietnamese, Tagalog, and Chinese. Virtual surveys were presented in English or Spanish. Surveys took approximately five minutes to complete. Participants at the service-area events received a $10 gift card as an incentive.

Measures

Measures assessing response to Take Action for Mental Health largely matched those tapping perceptions of campaign events included in the countywide survey described above; some measures were slightly reworded to reflect the context in which data were collected.

Demographics

The survey measured gender (male, female, nonbinary, other), age (14 to 15, 16 to 25, 26 to 39, 40 to 59, 60 or older), and race/ethnicity (White/Caucasian, Latino/Hispanic, Black/African American, Asian/Pacific Islander, American Indian/Native American). As in the countywide survey, we created categories of Hispanic county residents surveyed in English and Hispanic county residents surveyed in Spanish because these groups may respond differently to survey items. Too few surveys were completed in other languages to examine those language preferences separately.

Take Action for Mental Health Brand Awareness

One item assessed event attendees' awareness of the Take Action for Mental Health campaign brand. The item showed the three Take Action for Mental Health promotional logos and asked respondents if they saw any of them at the event.

Perceived Impact of Take Action for Mental Health Events

We used 19 items to assess the impact of the Take Action for Mental Health campaign events on targeted outcomes of community connectedness, knowledge about LACDMH and community mental health resources, mobilization to address mental health challenges, and stigma. Participants indicated extent of agreement on a five-point scale (strongly agree to strongly disagree) for all items; items were recoded to reflect any agreement versus none (exact item wording is provided in the "Results" subsection below).

Analyses

To account for the differing approach to data collection and potentially different reach and outcomes, all analyses were conducted separately for the events hosted by community-based organizations and those hosted in LACDMH service areas. For each group, we conducted analyses to describe the characteristics of study participants, Take Action for Mental Health branding exposure and perceptions of the events. The data analysis for this report was generated using SAS/STAT software (2016).

Results

Characteristics of Take Action for Mental Health Event Attendees

We obtained 8,243 completed surveys from 340 events. Most surveys were completed in English (87 percent), but others were completed in Spanish (9 percent), Chinese (3 percent), Korean (0.4 percent), and Tagalog (0.1 percent). Most of the surveys (89 percent) were collected by participating community-based organizations on paper (87 percent) and online (2 percent). The remaining surveys (11 percent) were collected by the Survey Research Group. Most participants at service-area events completed online surveys (7 percent of all surveys) but some completed paper surveys (4 percent). Between three and 131 surveys were collected per event, and the typical number was about 23.

Data describing the characteristics of those who completed the survey can be seen in Table 12. Although we cannot know to what extent they reflect

TABLE 12

Characteristics of Participants in the Take Action for Mental Health Event Attendee Survey

Characteristic	Frequency	Percentage (%)
Age		
14–15	411	5
16–25	1,369	17
26–39	2,303	28
40–59	2,568	32
60+	1,483	18
Gender		
Male	2,702	33
Female	5,036	62
Uses another term	264	3
Race/ethnicity		
Hispanic, English-language survey preference	2,578	32
Hispanic, Spanish-language survey preference	673	8
Non-Hispanic White	1,093	13
Non-Hispanic Black	2,054	25
Non-Hispanic Asian or Pacific Islander	1,264	16
Non-Hispanic Native American	117	1
Multiple races/ethnicities	175	2
Parent of a child younger than 16		
Yes	3,355	41
No	4,725	58

NOTE: Frequencies sum to < 8,243 due to missing responses.

the characteristics of all attendees at Take Action for Mental Health events, they suggest that the audience for most events included strong representation of Hispanic residents and non-White residents. Audiences also spanned a wide age range. Most of those responding (almost two in three attendees) were female, suggesting that they may have been the primary audience for the events.

Exposure to the Take Action for Mental Health Branding at Events

Most (88 percent) of those completing an event survey remembered seeing the Take Action for Mental Health logo. This finding is suggestive of strong branding of the events, which can help to tie participants to other Take Action for Mental Health events and messaging.

Impact of the Take Action for Mental Health Campaign on Event Attendees

Perceptions of the events were very positive, with the vast majority saying the event they attended made them feel more connected to their communities and supported, connected them with mental health resources, and increased their understanding of and support for people experiencing mental health

problems (i.e., decreased their mental health stigma) (Table 13). **Those who attended community-based events and those who attended service-area events endorsed positive perceptions of the Take Action for Mental Health campaign at what appear to be similar rates.**

Take Action for Mental Health events, both those hosted by community-based organizations and by LACDMH service areas, appeared to have a strong mobilizing effect on attendees. Nearly all participants reported that the events made them more likely to seek and provide support to family and friends, recognize symptoms of mental health problems in themselves, and engage with informal and professional mental health support. See Table 14 for these results.

Responses to each of the items assessing stigma are consistent with the goal of reducing it to support early mental health intervention (see Table 15). **When asked whether, if they were to experience an emotional problem, they would seek professional help, nearly all survey participants said that they would do so. However, between one-half and three-quarters of participants reported that they would delay seeking mental health treatment** due to stigma.

Take Action for Mental Health LA County Summary and Recommendations

Summary

The Take Action for Mental Health campaign reached a substantial proportion of Los Angeles County residents: approximately one in four youth and about one in five adults, or more than 1.7 million county residents. These numbers are less than those obtained with prior campaigns (e.g., WhyWeRise reached 75 percent of Los Angeles County youth in 2019 and one-half of adults in 2020; Collins et al., 2020; Collins, Eberhart, and Roth, 2022a) but they are not unreasonable given the more limited outreach for Take Action for Mental Health, with the focus centered on expanding community events rather than mass marketing. The campaign appeared to have strong reach in diverse communities, including

TABLE 13

Event Attendees' Perceptions of the Take Action for Mental Health Events Were Almost Uniformly Positive

Survey Statement	Community-Based Organization Events (Percentage Agreeing)	Service-Area Events (Percentage Agreeing)
The event made me feel more connected to community	94	96
The event made me feel supported	94	95
The event connected me with information and resources to support my own and others' well-being	95	96
The event made me more aware of mental health resources in my community	92	96
I know how to find information or resources to help if I or someone I know experiences a mental health problem	92	93
I know how I could be supportive of people with a mental illness if I wanted to be	91	93
I can recognize the signs that someone may be dealing with a mental health problem or crisis	88	92
The event made me feel more supportive of people experiencing mental health problems	93	95
The event increased my understanding of how trauma, stress, and social problems affect mental health	89	91

TABLE 14

Nearly All Event Attendees Said the Events Increased Their Intentions to Take Action for Mental Health

Survey Statement	Community-Based Organization Events (Percentage Agreeing)	Service-Area Events (Percentage Agreeing)
As a result of attending today's event, I will be more likely to have a conversation with friends and family about their mental health	89	94
As a result of attending today's event, I will be more likely to share my feelings with friends or family when I am sad or anxious	87	92
As a result of attending today's event, I will be more likely to consider whether my feelings or behavior might be signs of a mental health problem	87	91
As a result of attending today's event, I will be more likely to engage in self-care activities to help my mind and body recharge	92	94
As a result of attending today's event, I will be more likely to seek professional help if I think I might be experiencing a mental health problem	87	91

TABLE 15

Nearly All Event-Attendees Endorsed Anti-Stigma Beliefs and Intentions, But Many Feared Being Stigmatized Themselves

Survey Statement	Community-Based Organization Events (Percentage Agreeing)	Service-Area Events (Percentage Agreeing)
Anti-stigma		
People like me sometimes experience mental health challenges	87	92
I plan to take action to prevent discrimination against people with mental illness	88	94
If I had a serious emotional problem, I would seek professional help	89	93
Stigma		
If I had a mental health problem, I would delay seeking treatment for fear of letting others know	54	75
If I had a mental health problem, I would delay seeking treatment for fear of being told I have a mental health problem	43	69

youth who have experienced mental health challenges and adults who reported Hispanic ethnicity and lower levels of education and income. Looking across different campaign activities, **campaign events were perceived more positively among adults, whereas campaign social media efforts were perceived more positively among youth.**

Both youth and adults reported positive perceptions of the campaign and felt it connected them to mental health resources in their communities. Take Action for Mental Health appeared to have a positive impact on several targeted outcomes: Residents exposed to the campaign had greater feelings of connectedness to their community and greater awareness of LACDMH and community mental health resources, and adults in particular reported increased mobilization to address mental health challenges in their communities. Those exposed to

the campaign had more knowledge of how to take action for their own and others' mental health. Those exposed also had lower levels of most stigmatizing attitudes around mental health. However, the campaign had limited impact on improving aspects of well-being, reducing internalized stigma, and promoting mental health treatment-seeking. The campaign appeared to have a similar impact on county residents with different racial/ethnic backgrounds.

The Take Action for Mental Health events attracted a diverse audience with a wide age range, and attendees recognized and had positive perceptions of the campaign materials. The events fulfilled LACDMH's goals for promoting community connectedness, knowledge of mental health resources, and low levels of stigma but had limited impact on attendees' internalized stigma.

The countywide survey's cross-sectional design limits the ability to confirm causality, but the observed patterns are consistent with the campaign's effectiveness. Similarly, the results from event surveys should be interpreted with caution because of the potential for selection bias and the inability to test causal impact. However, overall results suggest that the Take Action for Mental Health campaign appears to have met many of its goals in promoting community connectedness, awareness of resources, and positive beliefs about mental health.

Recommendations

- The campaign reached reasonable numbers but smaller proportions of the county population than in past years. Similarly, many of those aware of the campaign did not recall the specifics of their exposure, suggesting low levels of engagement with the materials. Future campaigns could utilize more-engaging messaging and a higher number of messages to expand campaign reach.
- In addition, CalMHSA and Los Angeles County should **consider expanding outreach methods that more efficiently reach larger numbers of individuals,** such as mass media buys (as a complement to events, which are less efficient in reaching large numbers but may be more effective in changing attitudes and knowledge).
- Future campaigns should continue to **partner with trusted community-based organizations,** who were effective partners for the 2023 campaign.
- In particular, future campaigns should **continue to promote events that intend to reach the Black community,** as events and related outreach were a key way to reach Black county residents.
- Although the campaign appeared effective in reducing mental health stigma directed at others, future efforts should **address residents' stigmatizing beliefs about their own mental health** that might keep them from help-seeking.

Do Worthwhile Work

The Do Worthwhile Work campaign sought to promote (1) interest in mental health careers broadly and, specifically, mental health careers with the LACDMH; (2) traffic to the campaign website (doworthwhilework.com) that contained information about mental health careers; and (3) positive beliefs and reduced stigma about mental health careers. Do Worthwhile Work used a few key messages in online ads, social media, and outdoor digital advertising. The messages included "Connect to your community by serving it," "Want to make a difference every day?," "You are needed," and "Ready to be an agent of change?" with the tagline "Do Worthwhile Work" and "Join LA County Dept. of Mental Health." The ads were accompanied by images of men and women from diverse backgrounds and were presented in English and Spanish. As with the Take Action for Mental Health campaign described earlier in this report, the Los Angeles Dodgers baseball team and AEG were campaign partners. Digital ads were prominently displayed during Dodger games and at AEG venues (e.g., L.A. LIVE entertainment complex, Crypto.com arena, and at LA Galaxy games).

We included items in the previously described survey (see the "Methods" subsection in the "Survey of Los Angeles County" section earlier in this report)

of a representative sample of Los Angeles County residents to understand (1) the reach of the Do Worthwhile Work campaign, and (2) the campaign's impact on respondents (i.e., how residents perceived the campaign and how those reached by the Do Worthwhile Work campaign differ from others in terms of attitudes, beliefs, and behavior related to mental illness and careers in mental health).

Method

Data Collection

Items assessing the Do Worthwhile Work campaign were included in a countywide survey fielded by Ipsos. For a detailed description of data collection procedures, see the "Methods" subsection in the "Survey of Los Angeles County" section earlier in this report. As noted there, a total of 906 usable adult surveys and 329 youth surveys were collected. Demographic characteristics of participants are also provided in that earlier section of this report. Survey weights were used to produce results that are representative of the demographic characteristics of Los Angeles County.

Measures

Demographics, recalled exposure to the campaign, perceptions of the outreach materials, and targeted campaign outcomes were each assessed with multiple measures. All items where respondents were asked to rate agreement used a five-point scale (strongly agree, moderately agree, neither agree nor disagree, moderately disagree, strongly disagree). These items were recoded during analysis to reflect any agreement (strong or moderate) versus all other responses.

Exposure to the Do Worthwhile Work Campaign

To assess exposure to the Do Worthwhile Work campaign, we first asked, "Have you heard of LA County's Do Worthwhile Work campaign?" (respondents could select yes or no). Next, we asked: "Since June 2023, have you seen one of these images or a similar image for the Do Worthwhile Work campaign?" (respondents could select yes or no). Participants were presented with images used in the campaign; the order of the images was randomized.

To determine the source of any exposure, we asked, "Since June 2023, have you seen or heard ads for Do Worthwhile Work in any of these places? (check all that apply)"; response options consisted of a billboard, bus stop or bus, on the radio, and on social media. We also asked whether participants attended any Galaxy games or went to the Crypto.com Arena or to the L.A. LIVE plaza. Among those who did, we asked whether they saw or heard Do Worthwhile Work ads when they were there (since June 2023); respondents could select yes or no.

Understanding and Perceptions of the Do Worthwhile Work Campaign

To assess participants' understanding of the Do Worthwhile Work Campaign among those reporting exposure, we asked, "Pick the best answer: What is Do Worthwhile Work? A campaign to recruit and train LA County . . .," and we included the following response options for participants to complete the sentence: teachers and school administrators; emergency medical workers and hospital administrators; mental health workers and administrators; and law enforcement officers and administrators.

Three items assessed perceptions of the campaign among those who reported exposure. Participants indicated their level of agreement or disagreement that the ads were "easy to understand," "appealing," and "meant for people in my community." Participants who reported exposure to the campaign ads also rated their agreement or disagreement that the ads made them feel "needed," "motivated . . . to make a difference," and "motivated . . . to seek employment at the LA County Department of Mental Health."

Campaign Targeted Outcomes

Participants who reported exposure to the campaign were asked, "Have you visited the website doworthwhilework.com?" and respondents could select yes or no. Eight items asked of all respondents were used to assess perceptions of mental health workers (who were defined as "anyone who works in a mental

health setting, including therapists, community health workers, other types of care providers, and mental health program managers"). The items tapped stigma associated with mental health work, the importance of mental health workers' contributions, and their ties to community and community service.

Analyses

All analyses were conducted separately for the youth and adult samples. For each group, we conducted analyses to describe the characteristics of those exposed to the campaign, perceptions of mental health workers among those exposed and campaign-targeted outcomes among those exposed versus unexposed. Details of the analytic approach are identical to those for Take Action for Mental Health LA County and noted in the "Methods" subsection in the "Survey of Los Angeles County" section earlier in this report.

Results

Campaign Exposure

More than one in five county youth (22 percent) and nearly one in ten county adults (9 percent) reported exposure to Do Worthwhile Work. Tables 16 and 17 present the characteristics of county residents exposed to the campaign. In most cases, the various subgroups of youth were equally likely to be exposed, but there was one exception. **Forty-one percent of youth recalling Do Worthwhile Work exposure reported severe levels of psychological distress; they were more than twice as likely to report Do Worthwhile Work exposure than youth with less distress.** These differences may reflect differential reach to troubled youth or may indicate that such youth are more likely to remember ads related to mental health issues.

There was differential exposure to Do Worthwhile Work among county adults depending on their demographic characteristics. **Spanish language–preferring Hispanic adults were dramatically more likely to report exposure to the campaign than non-Hispanic White adults,** with 21 percent of this group recalling exposure to Do Worthwhile Work, while only 6 per-

TABLE 16

Subgroups of Youth Were Exposed to Do Worthwhile Work at Similar Rates

Characteristic	Percentage Exposed to Campaign
Age	
14–17	23
(18–25)	22
Race/ethnicity	
Hispanic, English-language survey preference	20
Hispanic, Spanish-language survey preference	32
(Non-Hispanic White)	32
Non-Hispanic Black	33
Non-Hispanic Asian or Pacific Islander	15
Multiple races/ethnicities	—
Gender	
Male	21
(Female)	24
Uses another term	19
Ever had a mental health problem	31
(Never had a mental health problem)	19
Past 12 months perceived need for mental health treatment	26
(Past 12 months no perceived need for mental health treatment)	21
Past 30 days serious psychological distress	41*
(Past 30 days no or less-than-serious psychological distress)	18
Total youth	22

NOTE: Education and income are not shown for youth because they are difficult to interpret for this population.
Asterisk indicates significant differences in exposure to the campaign compared with the reference group in parentheses.
A dash indicates a value not reported or tested because only one person represented the group in the sample.

TABLE 17

Some Subgroups of Adults Were More Likely to Report Exposure to Do Worthwhile Work Than Other Subgroups

Characteristics	Percentage Exposed to Campaign
Age	
26–44	12
(45–64)	8
65+	6
Race/ethnicity	
Hispanic, English-language survey preference	11
Hispanic, Spanish-language survey preference	21*
(Non-Hispanic White)	6
Non-Hispanic Black	7
Non-Hispanic Asian or Pacific Islander	0.4*
Multiple races/ethnicities	—
Gender	
Male	10
(Female)	9
Uses another term	4
Education	
(No high school diploma or GED)	16
High school/GED	15
Some college/associate's degree	6*
Bachelor's degree or higher	5*
Household income	
(Less than $25,000)	17
$25,000 to $49,999	17
$50,000 to $74,999	7*
$75,000 to $99,999	10
$100,000 to $149,999	10
$150,000 or more	3*
Ever had a mental health problem	10
(Never had a mental health problem)	9
Past 12 months perceived need for mental health treatment	5*
(Past 12 months no perceived need for mental health treatment)	10
Past 30 days serious psychological distress	14
(Past 30 days no or less-than-serious psychological distress)	9
Total adults	9

NOTE: Asterisk indicates significant differences in exposure to the campaign compared with the reference group in parentheses. A dash indicates a value not reported or tested because only one person represented the group in the sample.

cent of White adults did so. **Asian or Pacific Islander adults were much less likely to be exposed than White adults (0.4 versus 6 percent)** indicating either a lack of attention to or recall of the ads in this group or poor reach to venues frequented by individuals of this background. **Results also indicate stronger reach to county adults with lower levels of education** (those without an associate's degree or higher). Those with incomes in the $50,000 to 74,999 per year and those who reported an annual household income of $150,000 or greater were less likely to be exposed than those with the lowest incomes (less than $50,000).

Perceptions of the Do Worthwhile Work Campaign

Among county residents exposed to the Do Worthwhile Work ads in the community or through campaign partners, perceptions of Do Worthwhile Work ads were positive (see Table 18). About three in four youth and just slightly higher proportions of adults who reported seeing the community ads said they felt that ads were easy to understand, meant for their community, and appealing. Two in three youth and just slightly more adults said the ads made them feel motivated to make a difference. **Fifty-five percent of youth and 57 percent of adults felt motivated to seek a job with LACDMH after seeing Do Worthwhile Work ads in the community.** This is fairly high endorsement given that not all of those exposed to the ads were likely to be seeking jobs or interested in relevant fields of work.

Perceptions of Do Worthwhile Work partnership ads appeared to be even more positive than perceptions of community ads. Nearly all county adults who engaged with partnership ads reported that the ads made them feel needed and motivated to engage with LACDMH. County youth reported simi-

TABLE 18

Perceptions of the Do Worthwhile Work Ads Were Viewed Positively by a Majority of Youth and Adults

	Los Angeles County Population (Percentage Agreeing)	
	Youth	Adults
The Do Worthwhile Work community ad(s) . . .		
made me feel needed	58	67
motivated me to make a difference	66	72
motivated me to seek employment at the LACDMH	55	57
was appealing	75	80
was easy to understand	80	77
was meant for people in my community	76	81
The Do Worthwhile Work partnership ad(s) . . .		
made me feel needed	64	89
motivated me to make a difference	65	98
motivated me to seek employment at the LACDMH	49	91
was appealing	71	100
was easy to understand	68	98
was meant for people in my community	85	94

lar but somewhat less favorable perceptions of partnership ads. It is possible that county youth of nonworking age responded less favorably to partnership ads because these youth are not in the job market. Future partnership ads could be targeted specifically to county residents of working age.

Campaign Targeted Outcomes: Perceptions of Mental Health Workers and Visits to the Do Worthwhile Work Website

A higher proportion of county residents who were exposed to the Do Worthwhile Work campaign endorsed favorable beliefs about mental health workers than did their unexposed peers (see Table 19). The strongest differences, among both youth and adults, were in the percentage agreeing that "People in my community are likely to be mental health workers." About twice as many of those exposed to Do Worthwhile Work (43 percent regardless of age) agreed with this statement as compared with those unexposed (20 percent and 21 percent among youth and adults, respectively; see Figure 10). Agreement with the statement "I could have a good, fulfilling life as a mental health worker" also showed a very strong difference between the exposed and unexposed in both age groups (see Figure 11). However, in a somewhat troubling reversal from expectations, those exposed to Do Worthwhile Work (both youth and adults) were more likely than those not exposed to agree that people would think less of them if they were to take a job as a mental health worker. This finding is inconsistent with responses to the other items and may be a methodological problem rather than a true reflection of potential campaign effects. This item was the only one reflecting a negative belief about mental health work, among a series of positively worded items. It may be that survey respondents inadvertently chose "agree" if they were going through the items quickly and had agreed with the questions before and after this one. Alternatively, it might indicate public stigma—the belief that other people view mental health workers negatively, although the participant does not.

The campaign may have been more effective in changing the attitudes of county adults than those of youth, although we did not specifically test for this (see Table 19). **Significantly more exposed adults agreed with three of the five other positive beliefs about mental health workers that we asked about compared with unexposed adults.** Among county

TABLE 19

Youth and Adults Exposed to Do Worthwhile Work Generally Reported More Positive Perceptions of Mental Health Workers

	Los Angeles County Population (Percentage Agreeing)			
	Youth		Adults	
	Not Exposed	Exposed	Not Exposed	Exposed
People in my community are likely to be mental health workers	20	43*	21	43*
Mental health workers can make a difference in their communities	71	71	78	96*
Mental health workers save lives	76	76	79	88
A good way to serve my community is to be a mental health worker	52	70	54	64
Mental health workers can help reduce social injustice and inequity	54	64	56	81*
Mental health workers are heroes	63	78	62	89*
I could have a good, fulfilling life if I was a mental health worker	31	56*	38	65*
If I were to take a job as a mental health worker, people would think less of me	8	42*	6	21*

NOTE: Asterisk indicates that differences between those exposed and unexposed are statistically significant within population (youth or adult).

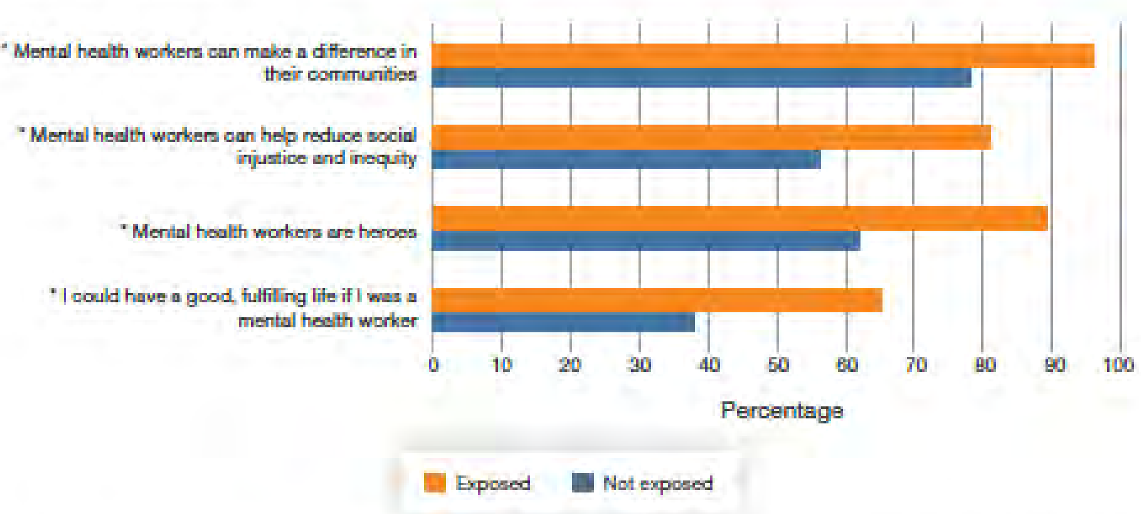
FIGURE 10

Youth and Adults Exposed to the Do Worthwhile Work Campaign Were More Likely to Think People in Their Community Are Likely to Be Mental Health Workers

NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

FIGURE 11

Adults Exposed to the Do Worthwhile Work Campaign Were More Likely to Have Positive Perceptions of Mental Health Workers



NOTE: Asterisk indicates that differences between those exposed and not exposed are statistically significant within population (youth or adult).

youth, significant differences between exposed and unexposed groups were observed only for the two positive beliefs already mentioned.

We ran statistical interactions to test potential racial/ethnic differences in the association between campaign exposure and targeted outcomes. **We found no evidence that effects of the campaign differed by race/ethnicity.**

Do Worthwhile Work Summary and Recommendations

Summary

Overall, findings from this evaluation suggest **that Do Worthwhile Work reached a substantial portion of Los Angeles County residents,** with especially strong reach among youth who reported psychological distress. The campaign reached a diverse group of county residents, especially Hispanic residents with a Spanish-language preference and those with lower levels of educational attainment and household income. This may be particularly valuable for filling positions for community health workers, for whom education requirements are lower, and for whom it is important to be a trusted community member. In Hispanic communities, these individuals may be labeled *promotor* or *promotora*, and they help connect Hispanic communities to resources and provide information. The campaign did well in reaching an important subgroup for filling such roles.

Perceptions of the Do Worthwhile Work campaign were largely positive. County residents largely agreed that the campaign materials were easy to understand, appealing, and consistent with the preferences of their communities. Do Worthwhile Work also appeared to meet the goals of LACDMH for the recruitment campaign. **County residents who reported exposure to the Do Worthwhile Work campaign were more likely to endorse positive perceptions of mental health workers and career paths, were more likely to think people in their communities were likely to be mental health workers, and had greater knowledge of ways to engage with LACDMH. Importantly, the campaign appeared to have a similar impact on people regardless of their diverse racial/ethnic backgrounds.**

These positive findings should be considered in the context of the limitations in this evaluation. As with the Take Action for Mental Health campaign, it is not possible to draw causal inferences from this cross-sectional study. Differences between those exposed and unexposed to the campaign may be due to pre-existing differences between those who pay attention to and remember mental health campaigns and those who do not. Additionally, the positive perceptions and increased mobilization observed among those who reported exposure to the Do Worthwhile Work campaign may not translate to changes in the mental health workforce in Los Angeles County. Despite these limitations, it appears that the Do Worthwhile Work campaign met many of LACDMH's goals.

Recommendation

- In addition to the dissemination strategies used in 2023, LACDMH should **consider strategically targeting dissemination of future mental health workforce campaigns to reach county residents with specific educational and demographic backgrounds that fit identified gaps in their workforce.** The current Do Worthwhile Work campaign was more effective in reaching county residents who did not have a college education, which is appropriate for recruiting certain types of workforce (i.e., community health workers) but may not coincide with all target populations for future recruitment.

General Conclusion

The Take Action for Mental Health and Do Worthwhile Work campaigns reached a large number of Los Angeles County residents, especially Hispanic and Latino residents and youth. Those attending Take Action for Mental Health events overwhelmingly viewed them in a positive manner. Both Take Action for Mental Health and Do Worthwhile Work social marketing campaigns were also received well by county residents. Moreover, those exposed to both LACDMH campaigns felt more mobilized around mental health and mental health careers, were more

likely to be aware of mental health resources, and showed lower levels of stigmatizing beliefs about mental health problems compared with county residents who did not engage with the campaigns. Findings suggest that both social media– and community event–based components of Take Action for Mental Health were effective. At the same time, the LACDMH campaigns may need to be updated to address internalized stigma of mental illness and aspects of well-being other than community connectedness.

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About This Report

This report describes the evaluation of two initiatives of the Los Angeles County Department of Mental Health (LACDMH): Take Action for Mental Health Los Angeles County and Do Worthwhile Work. These two 2023 initiatives were part of the department's prevention and early intervention for mental health mission.

Funding

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CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

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- Power of the Pack Program: DBA Wolf Connection
  Wolf Connection's Wolf Therapy® is an education and empowerment program with wolfdogs as the centerpiece. With the help of these magnificent animals, humans from all walks of life learn to connect more fully with themselves and their environment, and understand their unique role in a human "pack" or community. Serves children and youth (ages 11-18) residing in the Antelope Valley (Service Area 1). Wolf Connection's multi-session Empowerment Programs have transformed the lives of young people in the Antelope Valley who collectively experience a disproportionate rate of poverty, foster care, teen pregnancy, gang activity, and incarceration. Priority populations include:
    - Child Welfare at-risk or involved youth;
    - Justice Involved at-risk or involved youth; and
    - Youth in alternative schooling.

  This programming is currently ongoing.

- Active Parenting Program
  The Active parenting program by Pacific Asian Counseling Services was developed to provide parenting information to parents of young children. The goal of the program is to help improve parent and child relationships, provide support to families, and provide encouragement on how to improve communications within the family system. Workshops were provided three times a month to families via zoom, with a total of 90 participants in the program. Based on parent discussions and feedback in the workshops, parents have indicated improved ability to listen to their child and to provide support when they're upset.

  This programming is currently ongoing.

Table 25. FY 2022-23 Demographics – Active Parenting Program

Count (n = 90)			
▪ Ethnicity		▪ Sex Assigned at Birth	
Hispanic or Latino as follows:		Male	21
Mexican/Mexican American/Chicano	30	Female	69
Non-Hispanic or Non-Latino as follows:		▪ Current Gender Identity*	
African	35	Male/Man	21
Chinese	6	Female/Woman	69
European	4	▪ Race	
Filipino	7	Native American Indian/Alaska Native	1
Japanese	1	Asian	15
Vietnamese	1	Black or African-American	35
Other	1	White	4
More than one Ethnicity	5	Other	30
** Participants can select more than one response option*		More than one race	5

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

delivered prevention services to members of the AV communities, including but not limited to those who are at identified risk, underserved and those who may be at risk but not in the know about mental health issues, yet might need this support. The goal for this program is to reach those who already have identified mental health needs, those who may be at-risk of developing mental health issues, and to increase community accessibility to mental health services. An additional goal of this program is to continue to collaborate with our community partners both mental health and non-mental health organizations to promote de-stigmatization and access to care, as needed.

Services were delivered in various ways: in-person, phone, and virtually. The first goal was to promote protective factors that could lead to improved mental, emotional and relational functioning. An additional goal was to reduce prolonged suffering (risk factors) of our community members that could be the result of an undetected, untreated mental illness.

The number of surveys collected for the Community Outreach Services (COS) under the Antelope Valley Community Family Resource Center (AV-CFRC) came to a total of 943 surveys, while the number of people served in this program was approximately 12,000 unduplicated individuals. Unfortunately, there was a gap between service delivery and survey administration, and only a percentage of the individuals served elected to respond to the surveys. In addition, it was the first full fiscal year of program implementation, which caused some onboarding delays in the consistent implementation and collection of outcome measures. That said, there was a significant positive response to the single event services provided, as evidenced by verbal testimonials and via the one-time event surveys (N = 158), as they demonstrated that over 75% of those who completed one-time event surveys reported feelings of social connectedness/sense of belonging and hopefulness as well as access to resources. Over 80% reported learning something new/useful about community programs/resources/tools. Additionally, over 87% reported that they would return for future events/activities and recommend others (See Table 26 for specific details).

Table 26. Results of Single Event Survey – AV-CFRC

Client Satisfaction Survey Questions	Protective & Risk & Evaluation Tool	Negative	Neutral	Positive	% Positive
1. I/My family was able to connect with others.	Social Connectedness/Sense of Belonging	10	23	125	79%
2. I discovered something new about myself/my family.	Knowledge of human behavior. Support for development of skills/concrete & possible emotional resources	21	32	105	65%
3. I learned something new/useful to me and my family.	Hopefulness, resources (emotional &/or concrete)	6	22	130	82%
4. I learned about community programs/resources that would be useful to me/my family.	Concrete supports and resources	8	23	127	80%
5. As a result of today's event, I will do something different with my family.	Hopefulness, resources (emotional &/or concrete)	12	27	119	75%
6. I learned some tips/tools/resources that can	Concrete supports, emotional/coping skills development, and resources	7	20	131	83%

Client Satisfaction Survey Questions	Protective & Risk & Evaluation Tool	Negative	Neutral	Positive	% Positive
strengthen my/my family's well-being.					
7. Based on your experience today, how like are you to attend future events?	Received Help and Found to be Beneficial - Program Evaluation: Resources & Support	3	17	138	87%
8. Based on your experience today, how likely are you to recommend our event to a friend/family member?	Received Help and Found to be Beneficial - Program Evaluation: Resources & Support	2	11	146	92%

This programming is currently ongoing.

Table 27 FY 2022-23 Demographics – AV-CFRC

Count (n = 943)			
▪ Primary Language		▪ Ethnicity	
Arabic	3	Hispanic or Latino	
Armenian	1	Caribbean	7
English	602	Central American	115
Farsi	1	Mexican/Mexican-American	223
Russian	2	Puerto Rican	5
Spanish	287	South American	10
Tagalog	1	Other Hispanic	184
American Sign Language	1	Non-Hispanic or Non-Latino follows:	
Other responses	8	African	101
Declined to answer	29	Asian	4
▪ Current Gender Identity*		Cambodian	1
Male/Man	207	Chinese	2
Female/Woman	641	Eastern European	3
Undecided	2	European	4
Declined to Answer/Missing/Unknown	93	Filipino	4
▪ Sex Assigned at Birth		Middle Eastern	5
Male	221	Vietnam	1
Female	681	Other Non-Hispanic or Non-Latino	61
Declined to Answer/Missing/Unknown	41	Declined to Answer/Missing/Unknown	361
▪ Sexual Orientation*		▪ Race	
Gay or Lesbian	7	American Indian or Alaska Native	16
Heterosexual or Straight	562	Asian	5
Bisexual	7	Black or African-American	268
Something else	1	Native Hawaiian	1
Undecided/Unknown at this time	1	White	139
Declined to Answer/Missing/Unknown	133	More than one race	33
▪ Disability		Other	222
No	575	Declined to Answer/Missing/Unknown	259
Yes	185	▪ Age	
Another type of disability	191	15 and under	17
Declined to Answer/Missing/Unknown	183	16-25	114
▪ Veteran Status		26-59	561
Yes	18	60+	142
No	852	Declined to Answer/Missing/Unknown	109
Declined to Answer/Missing/Unknown	73	** Participants can select more than one response option*	

Joint collaboration to support philanthropic engagement and strategic consultation on various complex countywide Board directed initiatives and priorities. This program partners with the following LA County Departments:

- Arts & Culture,
- Children and Family Services,
- Consumer and Business Affairs,
- Economic Opportunity,
- Mental Health,
- Public Health,
- Public Social Services, and
- Probation

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

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

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

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

Since the transition to PEI, 4,669 participants received a total of 27,192 referrals or linkages for services and supports.

For participants new to CANs during Fiscal Year 2022-23, there were statistically significant increases in average scores between baseline and their most recent follow-up assessments on both the BUPPS Protective Factors (23.0 to 23.6) and WHO Well-being Subscale (16.5 to 17.4) between baseline and their most recent follow-up assessments. This suggests that new participants had improved well-being since enrolling in CANs.

This programming is currently ongoing.

Table 28. FY 2022-23 Outcomes

Name of Outcome Measure	Total Number of Reported Cases with both a Pre and Post Score	Average Pre- Score	Average Post Score	Average Score Change Percentage
BUPPS Protective	644	23.0	23.6	0.6%
BUPPS Well-being	646	16.5	17.4	0.9%

Table 29. FY 2022-23 Demographics – CANs

Count (n=4,163)			
▪ Primary Language		▪ Ethnicity	

Count (n=4,163)			
Armenian	15	Hispanic or Latino as follows:	
Cambodian	628	Caribbean	16
Cantonese	5	Central American	219
English	1,810	Mexican/Mexican American/Chicano	1,379
Farsi	4	Puerto Rican	14
Mandarin	4	South American	34
Russian	4	Other Hispanic/Latino	81
Spanish	1,302	Non-Hispanic or Non-Latino as follows:	
Tagalog	4	African	507
Vietnamese	1	Asian Indian/ South Asian	13
American Sign Language	1	Cambodian	642
Other	31	Chinese	8
Declined to answer/ask or Missing or Unknown	354	Eastern European	7
▪ Sex Assigned at Birth		European	56
Male	1,243	Filipino	15
Female	2,583	Japanese	5
Another Category	1	Korean	2
Decline to answer	336	Middle Eastern	6
▪ Current Gender Identity*		Vietnamese	3
Man	1,240	Other	243
Woman	2,566	More than one ethnicity	174
Transgender man/Transmasculine	10	Declined to answer/ask or Missing or Unknown	739
Transgender woman/Transfeminine	2	▪ Race	
Non-Binary	14	American Indian or Alaska Native	41
Another Category (e.g. Two-spirit)	4	Asian	677
Undecided/ unknown at this time	6	Black or African-American	783
Not sure what question means	2	Native Hawaiian/ Pacific Islander	31
Declined to answer/ask or Missing	331	White	1,005
▪ Sexual Orientation*		More than one race	207
Heterosexual or Straight	3,424	Other**	572
Gay or Lesbian	120	Prefer not to answer	847
Bisexual or Pansexual	61	▪ Disability	
Something else	9	No	3,135
Undecided/ unknown at this time	8	Yes	593
Not sure what this question means	57	Mental domain	238
Declined to answer/ask or Missing or Unknown	488	Physical/mobility domain	261
▪ Age		Chronic health condition	117
Age 15 and under	7	Difficulty seeing	70
Between 16 and 25	637	Difficulty hearing	64
26-59	2,490	Another communication disability	9
60+	678	Another type of disability	48
Declined to answer/ask or Missing or Unknown	351	Decline to disclose type of disability	82
▪ Veteran Status		Declined to answer/ask or Missing or Unknown	435
Yes	35	** Participants can select more than one response option*	
No	3,774		
Declined to answer/ask or Missing or Unknown	354		

- Community Schools Initiative (CSI)
  LACOE Community Schools Initiative (CSI) focuses on both academic and out-of-school factors that impact high school students' lives. The Community School Model is an evidence-based school improvement framework that recognizes the roles of family and community, and the importance of collaborating with educators to address external factors influencing student achievement, such as family circumstances, traumatic events

(including adverse childhood experiences), poverty, and health concerns, while incorporating cultural differences, and student engagement. The CS model's aim is to address longstanding inequities throughout Los Angeles County by serving the most underserved students and families. The services provided include concrete supports, school resources, staff support, mental health services, on site well-being centers to provide health services and referrals/linkages to community resources.

CS targets high school students from 15 school districts. Currently each of the 15 districts has one identified high school site. LACOE Community Schools served a total of 9,523 students and families in this reporting period collecting a total of 5,965 single event surveys.

This programming is currently ongoing.

Table 30. FY 2022-23 Demographics of Parent Participants – Community Schools Program

Count (n = 590)			
▪ Primary Language		▪ Ethnicity*	
English	286	Hispanic or Latino as follows:	
Korean	1	Other (Hispanic/Latino)	271
Spanish	148	Non-Hispanic or Non-Latino as follows:	
Tagalog	1	African	27
Other	7	Filipino	13
Declined to answer/Missing/Unknown	147	Other	126
▪ Current Gender Identity		Declined to answer/Missing/Unknown	183
Male	139	▪ Race*	
Female	290	American Indian/ Alaska Native	6
Non-Binary	2	Asian	10
Prefer to self-describe	2	Black or African-American	27
Declined to answer/Missing/Unknown	157	Native Hawaiian/ Pacific Islander	15
▪ Sex Assigned at Birth		White	84
Male	139	Other	295
Female	290	Declined to answer/Missing/Unknown	183
Declined to answer/Missing/Unknown	161	** Participants can select more than one response option*	

Table 31. FY 2022-23 Demographics of Student Participants – Community Schools Program

Count (n =4,892)			
▪ Primary Language		▪ Race*	
Armenian	11	American Indian/ Alaska Native	96
English	3,936	Asian	325
Cantonese	8	Black or African-American	295
Korean	10	Native Hawaiian/ Pacific Islander	45
Mandarin	15	White	688
Spanish	372	Other	3,701
Tagalog	12	Declined to answer/Missing/Unknown	571
Other	110	▪ Current Gender Identity	
Declined to answer/Missing/Unknown	418	Male	2151
▪ Ethnicity*		Female	2115
Hispanic or Latino as follows:		Non-Binary	84
Other (Hispanic/Latino)	3,280	Prefer to self-describe	67
Non-Hispanic or Non-Latino as follows:		Declined to answer/Missing/Unknown	475
African	295	▪ Sex Assigned at Birth	
Filipino	186	Male	2151
Other	1,389	Female	2115

Count (n =4,892)			
Declined to answer/Missing/Unknown	571	Declined to answer/Missing/Unknown	626
		** Participants can select more than one response option*	

Table 32. FY 2022-23 Demographics of Staff Participants – Community Schools Program

Count (n =570)			
▪ Current Gender Identity		▪ Race*	
Male	167	American Indian/ Alaska Native	9
Female	290	Asian	33
Non-Binary	2	Black or African-American	34
Prefer to self-describe	2	Native Hawaiian/ Pacific Islander	12
Declined to answer/Missing/Unknown	109	White	188
▪ Ethnicity*		Other	183
Hispanic or Latino as follows:		Declined to answer/Missing/Unknown	152
Other (Hispanic/Latino)	167	▪ Sex Assigned at Birth	
Non-Hispanic or Non-Latino as follows:		Male	167
African	34	Female	290
Filipino	7	Declined to answer/Missing/Unknown	113
Other	251	** Participants can select more than one response option*	
Declined to answer/Missing/Unknown	152		

In FY 22-23, UCLA Center of Excellence provided training supports to the LACOE Community Schools Initiative (CSI) and the LAUSD Trauma- and Resilience-informed Early Enrichment (TRiEE) program. Below is a summary of the trainings they delivered.

Program	**Topic**	**Audience**
LACOE CSI	Training of Trainers Series – Session 1: Trauma and Resilience Informed Care Foundations for Educators	CSI Teachers, Social Workers (2 sessions)
	Training of Trainers Series – Session 2: Maintaining Professional Wellbeing for Educators	CSI Teachers, Social Workers (2 sessions)
	Trauma Sensitive Communication in Schools	4 CSI High Schools
	Trauma and Resilience Informed Care Foundations for Educators	3 CSI Schools
	Trauma Sensitive Communication in Schools	Open to All 80 School Districts (2 sessions)
	Trauma and Resilience Informed Care Foundations for Educators	Open to All 80 School Districts (3 sessions)
LAUSD TRiEE	SEEDS Trauma Informed Care for Preschools and Kindergartners (SEEDS PD) series	New TRiEE PSWs, LAUSD EEC Principals and other LAUSD staff (6 sessions)
	SEEDS PD Facilitator Training	New TRiEE PSWs (6 sessions)

Program	Topic	Audience
	SEEDS PD Facilitator Refresher Workshops	Open to all TRiEE PSWs and TRIEE Project Leads (2 sessions)
	SEEDS PD Connection Cafes (ongoing skill-building sessions)	Open to all TRiEE PSWs and TRiEE administrators at all 39 EEC sites (8 sessions)
Countywide	5th Annual School & Community Symposium- On the Path to Collective Healing	Open to All 80 School Districts

- Friends of the Children LA (FOTC-LA)
  FOTC-LA ("Friends") aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at high risk of entering foster care, and who are facing challenges like intergenerational poverty and multiple adverse childhood experiences. The program currently focuses on children residing in the Antelope Valley, where professional "friends" support a child and their family for 12+ years. The focus is on developing parental resilience, social connections, knowledge of parenting and child development, concrete supports, and social and emotional competence of children. The number of surveys collected equals the number of caregivers participating in this program.. Some caregivers have more than one child enrolled in the program. The program only collects demographics for the children.
  Thirty-four (34) caregivers completed the 2022 survey, and 42 caregivers completed the 2023 Protective factors survey. Data was matched for the 33 caregivers that completed both the 2022 and 2023 Caregiver Survey. Caregivers showed increased scoring particularly as it relates to the area of child development and knowledge of parenting. In response to the question "I know how to help my child learn," caregivers averaged higher in 2023 than in 2022, with the mean shifting from a score of 2.61 to a score of 2.85. This increase of 0.24 was statistically significant. Caregivers averaged slightly higher in 2023 for the item, "I praise my child(ren) when they behave well," from a score of 2.85 in 2022 to 2.91 in 2023, indicating an increase in protective factors.

  Table 3 represents the matched data from the protective Factors Surveys (PFS) completed by 33 caregivers in years 2022-2023 for the Friends of the Children Antelope Valley program. From 2022-2023, there were slight, albeit not statistically significant, increases in the mean scores of family functioning, nurturing and attachment, and social support (as measured by the PFS-2). During these programmatic years, there were small, statistically insignificant decreases in social support (as measured by the PFS) and concrete supports.

  This programming is currently ongoing.

Table 33. Friends of the Children 2022-2023 Protective Factor Survey Results

Protective Factor	2022 (Mean)	2023 (Mean)	% Change [Difference]	P-value
Family Functioning/Resiliency (N=33)	4.06	4.10	+.99% [+.04]	.793
Nurturing and Attachment (N=33)	4.48	4.52	+.89% [+.04]	.659
Social Support (N=33)	4.35	4.22	-2.99% [-.13]	.342
Social Support- PFS-2 (N=32)	4.13	4.38	+6.05% [+.25]	.065
Concrete Supports (N=33)	3.84	3.48	-9.38% [-.36]	.083

Table 34. FY 2022-23 Demographics of Children Participants – FOTC-LA

Count (n = 48)			
▪ Primary Language		▪ Race	
English	43	Black or African-American	24
Spanish	5	White	5
▪ Sex Assigned at Birth		Other	19
Male	32	▪ Age	
Female	16	<16	48

- Incubation Academy – Transforming Los Angeles

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

  This programming is currently ongoing.

Table 35. FY 2022-23 Demographics – Incubation Academy

Count (n = 4,163)			
▪ Primary Language		▪ Ethnicity	
Cambodian	628	Hispanic or Latino as follows:	
Armenian	15	Caribbean	16
Cantonese	5	Central American	219
English	1,810	Mexican/Mexican American/Chicano	1,379
Farsi	4	Puerto Rican	14
Russian	4	South American	34
Mandarin	4	Other Hispanic/Latino	81
Spanish	1,302	Non-Hispanic or Non-Latino as follows:	
Tagalog	4	African	507
American Sign Language	1	Asian Indian/South Asian	13
Vietnamese	1	Cambodian	642
Other	31	Chinese	8
Declined to answer/Missing/Unknown	354	Eastern European	7
▪ Current Gender Identity*		European	56
Male/Man	1,240	Filipino	15
Female/Woman	2,566	Japanese	5
Transgender Man	10	Korean	2
Transgender Woman	2	Middle Eastern	6
Genderqueer/Non-Binary	14	Vietnamese	3
Another Category	4	Other Non-Hispanic	243
Undecided/Unknown at this time	6	More than one ethnicity	174
Not Sure what this question means	2	Declined to answer/Missing/Unknown	739
Declined to answer/Missing/Unknown	331	▪ Race	
▪ Disability		American Indian or Alaska Native	41
No	3,135	Asian	677
Yes	593	Black or African-American	783
Mental domain	238	Native Hawaiian or Pacific Islander	31
Physical/mobility domain	261	White	1,005
Chronic health condition	117	More than one race	207

Count (n = 4,163)			
Difficulty seeing	70	Other	572
Difficulty hearing	64	Declined to answer/Missing/Unknown	847
Another type of communication disability	9	▪ Sexual Orientation*	
Another type of disability	48	Gay or Lesbian	120
Declined to answer/Missing/Unknown	435	Heterosexual or Straight	3,424
▪ Age		Bisexual or Pansexual	61
<16	7	Undecided/Unknown at this time	8
16-25	637	Queer	9
26-59	2,490	Not sure what this question means	57
60+	678	Declined to answer/Missing/Unknown	488
Declined to answer/Missing/Unknown	351	▪ Veteran Status	
▪ Sex Assigned at Birth		Yes	35
Male	1,243	No	3,774
Female	2,583	Declined to answer/Missing/Unknown	354
Another Category	1	** Participants can select more than one response option*	
Prefer not to answer	336		

- Los Angeles Unified School District (LAUSD)

  LAUSD School Mental Health (SMH) program conducts a variety of mental health promotion and risk prevention activities with students and their parents. In FY 2022-23, LAUSD put forth a total of 87 mental health workshops, trainings, and interventions. Some of these programs included Bounce Back, CBITS, Erika's Lighthouse, FOCUS Resilience Curriculum, Second Step, Seeking Safety and various additional parent education workshops and classroom interventions. These programs served over one million students and parents.

  Referrals for services are received from administrators, teachers, support staff, students, and their families. SMH services promote parent involvement in the educational process, provide consultation to teachers, provide direct mental health services in crisis and emergency situations, participate in multi-disciplinary school teams, and identify and assist with appropriate referrals to community agencies.

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

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

  This programming is currently ongoing.

Table 36. FY 2022-23 Demographics - LAUSD

Count (n = 1,101,329)			
▪ Primary Language		▪ Ethnicity	
Arabic	26	Hispanic or Latino as follows:	
Armenian	90	Caribbean	17
Cambodian	3	Central American	803
Cantonese	15	Mexican/Mexican American/Chicano	928
English	17,062	Puerto Rican	11
Farsi	43	South American	131
Korean	29	Other Hispanic/Latino	25,201
Mandarin	11	Non-Hispanic or Non-Latino as follows:	
Russian	85	African	11
Spanish	9,980	Asian Indian/ South Asian	137
Vietnamese	16	Cambodian	25
American Sign Language	7	Chinese	113
Other	356	European	9
Declined to answer/missing	1,073,606	Eastern European	34
▪ Sex Assigned at Birth		Filipino	504
Male	20,185	Japanese	43
Female	17,014	Korean	98
Decline to answer	1,064,130	Middle Eastern	72
▪ Disability		Vietnamese	52
No	32,075	Other	4,661
Yes	5,471	Declined to answer/missing	1,068,479
Mental domain	424	▪ Race	
Physical/mobility domain	39	American Indian or Alaska Native	36
Difficulty seeing	11	Asian	499
Difficulty hearing	82	Black or African-American	3,239
Another communication disability	487	Native Hawaiian/ Pacific Islander	45
Another type of disability	4,428	White	2,268
▪ Age		More than one race	746
Age 15 and under	26,288	Other	27,091
Between 16 and 25	8,357	Declined to answer/missing	1,067,405
Declined to answer/missing	1,066,684	** Participants can select more than one response option*	

- Los Angeles Unified School District Trauma and Resilience Informed Early Enrichment (TRiEE)

TRiEE is a trauma-informed mental health prevention initiative, a unique adaptation of the Community Schools model for early education centers (EECs). TRiEE promotes professional development and wellbeing for school staff, facilitates parent involvement, connects families to community resources, and enhances students' self-regulation skills. TRiEE is dedicated to building school capacity to increase protective factors and reduce risk factors for children, youth, and families. Services are currently being implemented at 39 Early Education Center (EEC) sites throughout Los Angeles County, serving children 0-6 y/o and their families. Services are provided to the whole school community including staff, students, and families by Psychiatric Social Workers (PSW) on campus, in person or by phone. The program served a total of 4,615 children, youth, and families.

Some barriers faced by the program were limited direct access to parent/caregivers due to covid restrictions in place, as restrictions decreased, survey completion increased. In addition, referrals were limited due to the wait times and response times from programs, which reduced the number of successful referrals.

This program will end in Fiscal Year 2023-24.

Table 37. FY 2022-23 Demographics – TRiEE

Count (n = 4,615)			
▪ Primary Language		▪ Ethnicity	
Arabic	15	Hispanic or Latino as follows:	
Armenian	34	Other Hispanic	3,467
Cambodian	2	Non-Hispanic or Non-Latino as follows:	
Cantonese	1	African	745
English	2481	Asian	117
Farsi	10	Filipino	47
Korean	2	Other	239
Mandarin	5	▪ Race	
Other Chinese	10	American Indian/ Alaska Native	9
Russian	10	Asian	157
Spanish	1962	Black or African-American	765
Tagalog	13	Native Hawaiian/ Pacific Islander	15
Vietnamese	9	White	3669
Other	61	▪ Sex Assigned at Birth	
		Male	2,176
		Female	2,439

- Medical-Legal Community Partnership

  Medical Legal Community Partnership-Los Angeles (MLCP-LA) is a collaboration between the LAC Department of Health Services, LAC Department of Mental Health, and four Legal Partners (Neighborhood Legal Services of Los Angeles is the lead and three subcontractor nonprofit law firms). MLCP-LA integrates attorneys and legal advocates within LAC DHS hospitals and clinics to deliver legal assistance to patients and support clinical teams, through training and individualized technical assistance. Through legal interventions, MLCP-LA's Legal Partners intend to help alleviate legal needs which cause great distress, jeopardize health, and increase the risk for homelessness. MLCP-LA's legal partners actively offer and promote LAC DMH's mental health supports to all clients.

  Services to patients are delivered through a combination of in-person weekly appointments at LAC DHS hospitals and clinics along with telephonic remote visits. Services can range from single meetings concluding in counsel and advice to resolve simple issues to longer term interventions that can range months or years including negotiations, filings, or representation.

  MLCP-LA Legal Partners helped patients address legal barriers which positively increase protective factors and decrease risk factors. For protective factors, MLCP-LA’s interventions aim to engage the client in their own legal advocacy where possible. For example, a patient may be provided an opportunity to obtain certain documents or take an affirmative step (like sending a school district a letter on behalf of their child requiring an accommodation), with the support of the legal team. MLCP-LA believes these opportunities reinforce and improve problem-solving skills, self-efficacy, conflict resolution, and even parental sense of competence (for education issues). MLCP-LA’s interventions also directly look to eliminate insurance barriers or denials that limit access

to medically necessary care. MLCP-LA also directly facilitates patient and clinical team communication where a patient could benefit from additional education regarding their care.

MLCP-LA's work improves circumstances that decrease risk factors. MLCP-LA's work around domestic violence and civil harassment restraining orders helps to provide survivors of violence opportunities to remain safe from violence, allowing them to focus on stability and seeking the mental health care needed to alleviate the trauma. In additions MLCP-LA works to ensure all patients have access to housing without harassment/discrimination, able to receive communication in their preferred language, support in evictions, advocacy to improve housing conditions, and assistance with accessing benefits that supplement income. Through the elimination of these barriers and stressors, patients can focus on maintaining stability and provided access to mental health support to help them manage their stressors.

This programming is currently ongoing.

Table 38. FY 2022-23 Demographics – Medical-Legal Community Partnership

Count (n = 959)			
▪ Current Gender Identity*		▪ Ethnicity	
Male/Man	411	Hispanic or Latino as follows:	
Female/Woman	547	Caribbean	1
Another Category	1	Central American	128
▪ Disability		Mexican/Mexican American/Chicano	295
No	126	Puerto Rican	
Declined to answer/Missing/Unknown	7	South American	23
Yes	826	Other Hispanic/Latino	112
Mental domain	138	Non-Hispanic or Non-Latino as follows:	
Physical/mobility domain	357	African	66
Chronic health condition	185	Asian Indian/South Asian	11
Difficulty seeing	25	Chinese	3
Difficulty hearing	9	Eastern European	2
Another type of communication disability	18	European	35
Another type of disability	48	Filipino	8
Declined to answer/Missing/Unknown	73	Korean	1
▪ Veteran Status		Middle Eastern	4
Yes	17	Vietnamese	1
No	932	More than one ethnicity	12
Declined to answer/Missing/Unknown	10	Other	71
▪ Race		Declined to answer/Missing/Unknown	186
American Indian or Alaska Native	4	▪ Sexual Orientation*	
Asian	28	Gay or Lesbian	17
Black or African-American	111	Heterosexual or Straight	745
Native Hawaiian or Pacific Islander	1	Bisexual or Pansexual	6
White	62	Something Else	3
More than one race	7	Declined to answer/Missing/Unknown	188
Other	638	▪ Primary Language	
Declined to answer/Missing/Unknown	108	Armenian	1
▪ Age		English	424
<16	14	Mandarin	2
16-25	50	Spanish	520
26-59	611	Other	11
60+	284	Declined to answer/Missing/Unknown	1
		** Participants can select more than one response option*	

- My Health LA Behavioral Health Expansion Program

  On October 1, 2014, DHS formally launched the My Health LA (MHLA) Program with the goal of increasing access to primary health care services for low income, uninsured residents of Los Angeles County. On November 20, 2018, the Board of Supervisors approved numerous changes to the MHLA agreement with Community Partner Clinics (CPs). A workgroup was formed to understand gaps in behavioral healthcare access and how to address those gaps. The group identified as a priority the need to better support CPs who provide mental health care services to MHLA participants in a primary care setting. It was determined DMH would fund and support mental health prevention services and/or activities (MHPS) to reduce/manage risk factors associated with the onset of serious mental illness, as well as to cultivate and support protective factors of MHLA participants at CPs through a Prevention Program. As of September 2019, approximately 142,000 individuals were enrolled in the program.

  In this third year of this piloted program of integrating MHPS into CPs, a primary objective was to address any implementation challenges that surfaced in year one, and where feasible, make the necessary program modifications to further the original mission and objectives established in year one. As in year one of this piloted program, the ongoing Covid-19 Pandemic continued to impact each of the participating CPs' workforce. These community-based health care clinics remained on the front line in their respective communities for handling Covid-19 education and information dissemination, treatment, testing, and vaccinations. The CP staff had again been pulled in multiple directions to help their community manage the Pandemic while continuing with their implementation efforts of this MHPS Program. Program implementation challenges included staffing logistics (discontinuation of MHPS contracts and staffing shortages) and revisions to business workflows (claiming and billing processes).

  Data collection shifted from the use of the PHQ9 and GAD-7 outcome measures to the Brief Universal Prevention Program Survey (BUPPS). The BUPPS was selected for the MHPS program as a tool designed specifically to report prevention outcome data DMH-wide, as well as to target program needs directly and track changes more effectively. This data was collected, aggregated, analyzed, and reported for the entire fiscal year. The number of unique MHLA patients receiving at least one MHPS for the period of July 1, 2022 through and including June 30, 2023 was 27,267.

Table 39. FY 2022-23 Outcomes – MHPS

Name of Outcome Measure	Total Number of Reported Cases (at least one pair of pre and post BUPPS scores)	Average BUPPS Pre-scores	Average BUPPS Post-scores	Average BUPPS Percentage Score Change	Average Number of MHPS Sessions
BUPPS Protective Factors subscale	664	19.4	22.6	16.2%*	4.9
WHO Wellbeing subscale		14.7	18.2	23.9%*	

*Please note the greater increase reported from pre to post MHPS in the WHO Wellbeing subscale vs. the BUPPS Protective Factors subscale scores, which reflects greater gains reported in feeling states (WHO) vs. coping and/or resilience skills learned (BUPPS).

Among those who were assessed at both the beginning of the program and end of the program, the average BUPPS protective factors score increased from 19.4 to 22.6 a 16.2% increase and WHO wellbeing increased from 14.7 to 18.2 a 23.9% increase. This indicates there was an overall increase in protective factors and wellbeing through the course of programming (Table 13).

This programming ended in December 2023.

Table 40. FY 2022-23 Demographics – MHLA

Count (n = 27,267)			
▪ Primary Language		▪ Ethnicity	
Armenian	4	Hispanic or Latino as follows:	
English	779	Other Hispanic/Latino	12,846
Farsi	2	Non-Hispanic or Non-Latino as follows:	
Korean	25	African	16
Other Chinese	4	Asian Indian/ South Asian	7
Russian	4	Cambodian	2
Spanish	12,533	Chinese	3
Tagalog	4	Filipino	81
Vietnamese	1	Japanese	
American Sign Language	1	Korean	25
Other	72	Vietnamese	1
Declined to answer/ask or Missing or Unknown	20	Other	197
▪ Sex Assigned at Birth		Declined to answer/ask or Missing or Unknown	271
Male	4,538	▪ Race	
Female	8,906	Asian	246
Decline to answer	5	Black or African-American	16
▪ Age		Native Hawaiian/ Pacific Islander	1
26-59	13,381	White	54
60+	68	Other	12,861
		Decline to answer	271

- Prevention & Aftercare (P&A)

  Prevention and Aftercare (P&A) is a DCFS-monitored program of ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others. The services increase protective factors by providing support and community to mitigate the adverse effects of Adverse Childhood Experiences (ACEs) and social determinants of health. Program services are delivered in-person and virtually and can be from one time to a year or ongoing.

  Prevention and Aftercare program services are to be offered and rendered to all families Countywide, who meet one or more of the following criteria:

  1. Children and families at-risk of child maltreatment and/or DCFS involvement self-referred or referred by community stakeholders such as DMH Specialized Foster Care (SFC) offices, schools, hospitals, and law-enforcement agencies.
  2. Children and families with unfounded, closed child abuse DCFS referrals.
  3. Children and families with evaluated out DCFS child abuse and/or neglect referrals.
  4. DCFS referred clients, who are receiving Family Reunification services.

5. DCFS referred children and families who have exited the public child welfare system and are in need of services to prevent subsequent child maltreatment and/or DCFS involvement.

Negative outcomes identified by MHSA, and which participants of P&A may be risk of these outcomes as a result from untreated, undertreated or inappropriately treated mental illnesses are: 1) suicide, 2) incarceration, 3) school failure or dropout, 4) unemployment, 5) prolonged suffering, 6) homelessness, and 7) removal of children from their homes.

It was estimated 37,565 people attended P&A single events. With only one person per family completing a survey, there were 3,437 surveys collected. As a result of attending 1x events, families report the following:

- 85.2% Connected with others
- 81.6% Discovered something new about themselves or their family
- 87.3% Learned about community programs and resources that are useful to themselves and/or their family
- 83.1% Learned something different to do with family
- 86.9% Learned tips/tools that can strengthen themselves and/or their family's wellbeing

The following findings are based on 787 Protective Factors Surveys administered at baseline and after completion of multi-session P&A case navigation services. There was a general increase in protective factors from families from baseline to end of services. The most notable increases were in:

- Parent/caregiver resilience: score increased from 2.6 to 3.1
- Social connections: score increased from 2.6 to 3.0
- Knowledge of parenting and child development: score decreased from 3.0 to 2.9
- Social and emotional competence of adults: 3.8 to 4.1

This programming is currently ongoing.

Table 41. FY 2022-23 Demographics – Prevention & Aftercare (P&A)

Count (n = 787)			
▪ Primary Language		▪ Ethnicity	
Arabic	2	Hispanic or Latino as follows:	
English	506	Caribbean	6
Other Chinese	1	Central American	91
Farsi	1	Mexican/Mexican American/Chicano	401
Tagalog	1	Puerto Rican	5
Other	4	South American	10
Spanish	272	Non-Hispanic or Non-Latino as follows:	
▪ Sex Assigned at Birth		African	68
Male	122	Asian Indian/South Asian	2
Female	665	Chinese	1
▪ Current Gender Identity*		Eastern European	2
Male/Man	123	European	21
Female/Woman	663	Filipino	7
Another Gender Identity	1	Japanese	1
▪ Sexual Orientation*		Korean	1
Gay or Lesbian	11	Middle Eastern	5
Heterosexual or Straight	690	Other	87

Count (n = 787)			
Bisexual	12	More than one ethnicity	23
Undecided/Unknown at this time	7	Declined to answer/Missing/Unknown	56
Something Else	3	▪ Race	
Declined to answer/Missing/Unknown	64	American Indian or Alaska Native	50
▪ Disability		Asian	12
No	520	Black or African-American	128
Yes	217	Native Hawaiian or Pacific Islander	5
Mental domain	71	White	153
Physical/mobility domain	39	More than one race	28
Chronic health condition	86	Other	389
Difficulty seeing	20	Declined to answer/Missing/Unknown	22
Difficulty hearing	10	▪ Age	
Declined to answer/Missing/Unknown	50	16-25	63
▪ Veteran Status		26-59	650
Yes	10	60+	24
No	742	Declined to answer/Missing/Unknown	50
Declined to answer/Missing/Unknown	35	** Participants can select more than one response option*	

- Prevent Homelessness Promote Health (PH^2)

  Prevent Homelessness Promote Health (PH^2) is a collaboration between Los Angeles County Department of Health Services (DHS): Housing for Health (HFH) and Department of Mental Health (DMH). It is a Countywide program that conducts field-based outreach services to assist previously homeless individuals and families who are experiencing untreated serious and persistent medical and mental illness avoid returning to homelessness due to lease violations.

  The DMH Prevent Homelessness Promote Health - PH^2 employs an interdisciplinary, multicultural, and bilingual staff, utilizing a collaborative approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH), and community housing agencies. This program provides services within the 8 Service Areas of Los Angeles County. All initial outreach is provided in the community where the individual lives, to promote access to care. The PH^2 team conducts triage, coordination of services, and brief clinical interventions, as well as incorporating Motivation Interviewing (MI), Harm Reduction, Trauma Informed therapy, Solution Oriented therapy, Cognitive Behavior therapy, and Seeking Safety. Services are delivered primarily in person or can be delivered by phone or virtually.

  Individuals are referred with the following identified problems, among others: Aggressive/Violent Behavior, Destruction of Property, Failure to Pay Rent, Fire Safety/Health Hazard, Hoarding, Infestation of Unit, Legal Issues, Relationship Conflicts, and Substance Abuse. The PH^2 team meets with individuals weekly, depending on acuity and need. The program may see participants from two weeks to 18 months, with an average of six months.

  The cumulative number of new individuals served during this reporting period is 156.

  The effectiveness of the program can be demonstrated by examining three sources of data in the Integrated Behavior Health Information System (IBHIS):

  - The first tool is the Service Request Log (SRL). The SRL documents the name of the individual being referred and other pertinent details of the referral.

- The second tool is the PH^2 Referral Log. This log contains referring party information (agency), reason for referral, service provider area, type of housing, eviction status, safety issues, referral type (physical or mental health related), type of housing voucher, gender identity, sexual orientation, disability and veteran status.
- The third tool is the PH^2 Activity Log. The purpose of this log is to capture what type of services were offered and/or provided that prevented the return to homelessness. The PH^2 Activity Log is completed for each corresponding billable note in IBHIS (direct or indirect). The categories include resources offered, linkages obtained, peak eviction risk, eviction prevented, eviction date (if applicable) and closure reason.

Housing insecurity is addressed when an individual's protective factors are increased and/or their risk factors are decreased. The PH^2 Activity Log in IBHIS tracks Peak Eviction Risk Level during the participant's engagement in PH^2. Meanwhile, linkage to resources like mental health services, medical care, In Home Supportive Services, and food and other basic necessities, indicate progressive housing stabilization. As such, the number of referrals with linkages and the number of evictions prevented serve as good proxies for reduced homelessness and the conditions caused or exacerbated by homelessness.

This programming is currently ongoing.

Table 42. FY 2022-23 PH^2 Linkages to Each Resource

Mental Health Services	593
Psychoeducation	620
Department of Health Services	96
Shelf Stable Food	297
Emergency Services	105
Basic Necessities	72
Transportation	39
Primary Care Physician	53
IHSS	54
Cal Cards	20
Clothing	26
Housing & Supportive Services	54
Other (FSP, Cal Fresh, Food bank, Lifeline, Pet Supplies, PPE, etc.	202

Table 43. FY 2022-23 PH^2 Risk Factors

Risk Factor	Count
Aggressive/Violent Behavior	66
Destruction of Property	61
Failure to Pay	62
Fire Safety/Health Hazard	45
Hoarding	44
Infestation	31
Needs MHS Connection	34
Other	34
Relationship Conflicts	79
Substance Abuse	84
Unit Abandonment	1

Table 44. FY 2022-23 Demographics – PH^2

Count (n = 132)			
▪ Primary Language		▪ Ethnicity	
English	103	Hispanic or Latino as follows:	
Spanish	7	Mexican/Mexican American/Chicano	11
Declined to answer/Missing/Unknown	22	Other Hispanic/Latino	13
▪ Sex Assigned at Birth		Non-Hispanic or Non-Latino as follows:	
Male	86	African	39
Female	47	Chinese	1
▪ Current Gender Identity*		Eastern European	1
Male/Man	76	Caribbean	1
Female/Woman	44	Japanese	1
Transgender man/Transmasculine	2	Other	34
Declined to answer/ask or Missing or Not sure what question means	15	More than one ethnicity	4
		▪ Race	
▪ Sexual Orientation*		Native Hawaiian/ Pacific Islander	1
Heterosexual or Straight	50	Asian	2
Gay or Lesbian	8	Black or African-American	39
Queer	3	White	30
Another Sexual Orientation	1	More than one race	4
Declined to answer/ask or Missing or Unknown	69	Other**	56
▪ Disability		Native Hawaiian/ Pacific Islander	
No	28	▪ Veteran Status	
Yes	53	Yes	2
Mental domain	42	No	82
Physical/mobility domain	28	Declined to answer/ask or Missing or Unknown	48
Chronic health condition	24	▪ Age	
Difficulty seeing	1	26-59	90
Difficulty hearing	1	60+	42
Another communication disability	1	Decline to answer/Missing/Unknown	24
Another type of disability	1	** Participants can select more than one response option*	
Declined to answer/ask or Missing or Unknown	50		

**Ethnicity and race were collected as one category by IBHIS. Therefore, participants identified as Hispanic or Latino were coded as “Other” race.

▪ SEED School of Los Angeles (SEED LA)

SEED LA is the County’s first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The curriculum, grounded in science, technology, engineering, and mathematics (STEM), will prepare youth for career and college

pathways in the transportation and infrastructure industry. The school provides on-site support, wellness services and socio-emotional counseling for students.

This programming is currently ongoing.

- Strategies for Enhancing Early Developmental Success (SEEDS) Trauma-Informed Care for Infants & Toddlers
  In fall 2020, SEEDS launched its Trauma-Informed Care for Infants & Toddlers ("SEEDS Infants & Toddlers series"), a four-part trauma-informed, attachment-based virtual training series designed for professionals who work with young children and families. As of the writing of this report, SEEDS has completed 14 cohorts of this training series with 379 total participants.

  SEEDS Infants & Toddlers series explores how to co-regulate with and promote self-regulation in infants and toddlers, including those who have experienced trauma and other early adversities. Self-regulation skills in young children have been found to be highly predictive of positive educational, social, and mental health outcomes throughout childhood, adolescence, and later in adult life.

  In total, the series provides 6 hours of specialized training in trauma-informed care for young children (ages birth to 3 years old), including:
  - Part 1: Learning how to recognize the types of cues that infants and toddlers demonstrate
  - Part 2: Practicing how to understand (or seek to understand) the meaning of these cues in light of what we know about early childhood trauma and early adversities
  - Part 3: Preparing to respond to infant and toddler cues in hot moments (that is, when the child and/or the adult is distressed, upset, or dysregulated)
  - Part 4: Preparing to respond to infant and toddler cues in cool moments (that is, when the child and the adult are comfortable, calm, and able to play, engage, or have fun together)

  Two cohorts were completed with 62 participants in FY 2022-2023. On an item measuring global satisfaction with the series (rated on a 10-point scale, with 1 = extremely unsatisfied and 10 = extremely satisfied), participants' mean rating was 9.38, suggesting a high level of satisfaction overall with the training series.

  In addition, participants completed a 10-item measure (with possible scores ranging for 0 to 10) to assess their knowledge of concepts and skills covered in SEEDS Infants & Toddlers series. At the pre-training assessment, participants had a mean score of 7.62, whereas at the post-training assessment they had a mean score of 8.44, indicating a mean improvement of .82.

  This programming is currently ongoing.

Table 45. FY 2022-2023 Outcomes - SEEDS

Knowledge/Skill Domain	**Pre-training % correct**	**Post-training % correct**	**Change from pre- to post-**
1. Trauma-informed approach/using observation with infants	91%	96%	+5%
2. Co-regulating using sensory inputs	44%	56%	+12%
3. Self-regulation in infants and toddlers	80%	78%	-2%
4. Trauma-informed approach: using observation with toddlers	76%	78%	+2%

Knowledge/Skill Domain	Pre-training % correct	Post-training % correct	Change from pre- to post-
5. Trauma-informed approach: what types of questions to ask ourselves before intervening	93%	93%	+0%
6. Goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship	62%	70%	+8%
7. Relationships as crucial for infants' and toddlers' development	95%	96%	+1%
8. Responding in hot moments	89%	89%	+0%
9. Child-led play, skills of duplicate and elaborate	58%	89%	+31%
10. Hot and cool moments	75%	100%	+25%

The percentage of participants that answered correctly improved in a number of different domains (ranging from increases of 5% to 31%), including the skills co-regulating using sensory inputs and trauma-informed approach of using observation with toddlers, using the skills of duplicate and elaborate in child led play, and promoting self-regulation in hot and cool moments and the knowledge domain goal for adult caregivers is not to prevent the child's dysregulation, but to attempt co-regulation to strengthen relationship (Table 17).

- Transition Age Youth (TAY) Drop-In Centers
  Drop-In Centers are designed to be an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) Transition-Age Youth (TAY), ages 16-25, who may be homeless or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. The complex trauma may manifest in TAY's inability to maintain relationships, keep jobs, or stay in school, often putting them at risk of unemployment, school dropouts, incarceration, and homelessness. Without early intervention or prevention services, TAY are at risk of experiencing mental disorders that may impair their daily activities and functioning. TAY accessing Drop-In Centers have an opportunity to build trusting relationships with staff, and when ready and willing, connect to needed services and supports to best meet stability/recovery.

  This programming is currently ongoing.

- Veterans Peer Access Network (VPAN)
  Veteran Peer Access Network (VPAN) is a Prevention program which serves Veterans and Military family members in Los Angeles County. The goals are to: 1) increase protective factors such as financial stability, resiliency, socio-emotional skill building, and social connectedness, and 2) reduce risk factors such as suicidality, homelessness, and under/unemployment.

  1. Under VPAN, DMH and SoCal Grantmakers, as well as other Community-based Organizations (CBOs), provide peer support and linkage to services, reducing mental health services utilization. The goal of prevention services provided through VPAN CBOs is to implement a set of strategies that will augment existing programs. In addition, new preventative and trauma-informed community supports are provided to Veterans and Veteran family members in order to promote protective factors and diminish risk factors for developing a potentially serious mental illness.

  Peer services are provided from 8:00am-6:00pm, five days per week, Monday through Friday. Community events may be held on weekends. The program is delivered based

on the client's needs in-person, by phone, or virtually. In FY 2022-23, 13,642 veterans and military family members were served through VPAN CBOs.

2. The VPAN Support Line is dedicated to assisting active-duty military personnel, veterans, reservists, and guard members. The peers who staff the VPAN Support Line understand the unique sacrifices and emotional needs that come with military life. The VPAN Support Line offers Emotional First Aid related to stressors, referrals to community services, real-time psychoeducation on mental health services, and direct access to field-based teams for additional support and follow-up.

In FY 2022-23, the Veteran Support Line received a total of 12,515 calls, of which 422 were assigned to VPAN field staff for follow-up. Due to the nature of the support line, a referral is generated, and demographics collected only when the caller is requesting services and/or benefits.

3. In addition, under the VPAN Veteran System Navigators program, the Department of Military and Veterans Affairs (DMVA) provides benefits establishment, reducing potential negative outcomes like homelessness, food insecurity, and associated stress. Prevention programing serves to increase protective factors which include resilience, socio-emotional skill building in Veterans and Veteran family members, and social connectedness through specialty programming. The DMVA County Veterans Service Office has secured more than $ 27 million dollars in benefits for veterans, their dependents, and survivors. Veterans Systems Navigators lead the way in ensuring veterans in the community apply for and secure benefits they have earned, relieving financial stress during transition periods, preventing homelessness by assisting with housing resources, and enrolling veterans into Department of Veterans Affairs Healthcare/Mental Health to include Veterans Centers so veterans can receive the care they need and deserve.

DMVA served a total of 1,315 clients in FY 2022-23.

The different VPAN programs have different data collection procedures, with variable questions and response options, such that in many cases entire categories are missing. It is also possible that some participants are represented in multiple datasets. That said, the following are available demographic data on VPAN participants.

This programming is currently ongoing.

Table 46. FY 2022-23 Demographics – VPAN

Count (n = 13,642)			
▪ Sex Assigned at Birth		▪ Ethnicity	
Male	1,226	Hispanic or Latino as follows:	
Female	363	Mexican/Mexican-American/Chicano	199
Declined to Answer/Missing/Unknown	12,053	Non-Hispanic or Non-Latino as follows:	
▪ Veteran		Other Non-Hispanic	929
No	56	Declined to Answer/Missing/Unknown	12,514
Yes	372	▪ Current Gender Identity	
Declined to Answer/Missing/Unknown	13,214	Male / Man	1,126
▪ Race		Female / Woman	363
American Indian or Alaska Native	17	Transgender Woman	73
Asian	26	Declined to Answer/Missing/Unknown	12,080
Black or African-American	371	▪ Age	
Native Hawaiian or other Pacific Islander	14	0-15	1

Count (n = 13,642)			
White	238	16-25	480
Other	162	26-59	739
Declined to Answer/Missing/Unknown	12,814	60+	438
		Declined to Answer/Missing/Unknown	11,984

- Youth-Community Ambassador Network (Y-CAN)

  The Los Angeles Trust for Children's Health (The L.A. Trust) was contracted by California Mental Health Services Authority (CalMHSA) to support the Los Angeles County Department of Mental Health (LACDMH) by developing the Youth Community Ambassador Program. The aim is to co-create a Youth Peer Ambassador Program in partnership with students and LAUSD school mental health staff focused on prevention and navigation to care. The L.A. Trust provides oversight of the activities, training, staffing, and student stipend distribution, for up to 100 Youth -Community Ambassador Network participants (Y-CAN) program within the Los Angeles Unified School District (LAUSD). High school students within selected LAUSD school sites are recruited and vetted to serve on the Student Advisory Boards as trained Youth Community Ambassadors and serve as mental health access agents, navigators, and mobilizers within their school communities. Youth Community Ambassadors leverage their peer relationships to support mental health, driving a collective self-help model to promote healing, recovery, and youth empowerment.

  In FY 2022-23, 25,355 youth were served through CAN Youth., Due to the requirements for approval from LAUSD and parental consent delayed data collection such that surveys were only completed by 48 of 100 YCAN participants. Some additional barriers included staff turnover and students dropping out of the program due to scheduling conflicts.

  This programming is currently ongoing.

Table 47. FY 2022-23 Demographics – Y-CAN

Count (n = 48)			
▪ Primary Language		▪ Ethnicity	
English	45	Hispanic or Latino as follows:	
Spanish	1	Central American	4
Tagalog	1	Mexican/Mexican-American/Chicano	28
▪ Age		South American	1
15 and under	13	Non-Hispanic or Non-Latino as follows:	
16-25	35	African	6
▪ Sex Assigned at Birth		Filipino	4
Male	8	Decline to Answer	4
Female	40	▪ Race	
▪ Sexual Orientation		American Indian/ Alaska Native	2
Heterosexual or Straight	29	Black or African-American	10
Gay/Lesbian	3	White	7
Bisexual	6	Other	8
Something Else	6	More than one race	4
Undecided/Unknown	4	Declined to answer	15
▪ Disability			
Yes	3		
No	45		

FY 2024-25 and FY 2025-26 ■ PREVENTION

The following prevention programming will continue for Fiscal Years 2024-25 and 2025-26:

Program	Target Population
Abundant Birth Project This program is a private-public partnership that seeks to provide support to a minimum of 400 pregnant people in LA County from marginalized populations most likely to experience the worst birth outcomes with a variety of supports for 18 months (i.e. mental health, financial coaching, wellness supports, housing assistance, education, etc. This would be a randomized control study to evaluate the effects of this type of support.	Pregnant People and Parents with Children 0-18 Months Old
Center for Strategic Partnership Joint collaboration to support philanthropic engagement and strategic consultation on various complex countywide Board directed initiatives and priorities. The Center is committed to seeking change in four priority areas: 1) Child and Family Wellbeing, 2) Youth Development and Empowerment, 3) Health Equity, and 4) Economic Security. The Prevention Administration-SBCAP team oversees the projects invoicing and MOU amendments. Partnering LA County Departments including: Arts & Culture, Children and Family Services, Consumer and Business Affairs, Economic Opportunity, Mental Health, Public Health, Public Social Services, and Probation.	
Community Family Resource Center (CFRC) (Expansion to AV-CFRC) The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and families in the community it serves.	All Age Groups and Populations - Families
Community Resource Specialists Program To help build trauma-informed communities and resilient families through Community Resource Specialists (CRSs) who work in-home with families to ensure that food, medical or housing crises don't destabilize families.	Transition Age Youth within Deaf, BIPOC, Disabled, LGBTQIA2S and Asian Pacific Islander communities
Consumer Empowerment Network Educate LACDMH consumers on the history of MHSA, the role of LACDMH consumers and consumers from through the state, components and required processes, county, and state stakeholder events and opportunities to make public comments, recommendations, and legislative process.	LACDMH Consumers
Creative Wellbeing: Arts, Schools, and Resilience A non-traditional, arts and culture–based approach for promoting mental health in young people and caregivers. . The model offers non-traditional strategies for promoting mental health and wellness that include culturally relevant, healing-centered, arts-based workshops for youth, as well as professional development, coaching, and emotional support for the adults who work with them. Project activities support positive cognitive, social, and emotional development, and encourage a state of wellbeing.	24 years and below and Caregivers
Credible Messenger Mentoring Model This program consists of mentoring by peer youth to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services. Services are targeted to Youth 18-25 and include training of messenger peers, needs assessment of youth, 1:1 mentorship by youth with lived experience, group activities, crisis intervention, family engagement, referral, and resource linkage.	Transition Age Youth 18-25
Cultural Reflections Newsletter Provide opportunities for peer produced mental health related content to be developed and shared throughout the County.	LACDMH Consumers
DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities DPR Safe Passages Initiative utilizes trained gang interventionists and ambassadors to implement peace maintenance among gang neighborhoods to ensure safety to and from parks, and during park activities and provide crisis intervention services at the parks.	Children and youth under 18
Family Preservation/Solicitation	Specialized Foster Care population, children and families

Program	Target Population
Friends of the Children Los Angeles (FOTC-LA) (Expansion) FOTC aims to prevent foster care entry and improve family stability and wellbeing for families identified by DCFS as being at highest risk of entering foster care. FOTC provides professional 1:1 mentorship to children for 12+ years; starting around the age of 4-6 years old. Mentors are trained to support caregivers, promote self-advocacy and create opportunities for culturally responsive community and peer-to-peer connections.	Children and youth under 18, starting at 4-6 years old
Home Visitation (HV) Deepening Connections Healthy Families America (HFA) and Parents as Teachers (PAT) are evidence-based, research-proven, national home visiting programs that gather family information to tailor services to the whole family. The programs offer home visits delivered weekly or every two weeks to promote positive parent– child relationships and healthy attachment. This Home Visiting Program will prioritize areas where data indicates there is a high number of families involved with child protective services. Services are provided for moms in SA 1 and SA 2 and are provided until the focus child turns 5 years of age.	At-risk pregnant moms or moms with children under the age of 2 with risk factors specially child welfare involvement.
FosterALL WPW ReParenting Program FosterAll's WisdomPath Way Program addresses both the adults and children in foster care and provides positive outcomes to prevent additional trauma, stress and mental illness for both adults and children	Adults and Children Involved with Foster Care System
Hope & Healing: Mental Health Wellness Support to Victim Families & Relatives Bring Faith and Mental Wellness together to normalize the conversation and consciousness of families to seek mental health services and eliminate common stigmas preventing many traumatized persons from getting the help they need.	African American families who have suffered loss due to vioence
K-Mental Health Awareness & K-Hotline Seeks to normalize mental illness and treatment in the Korean community so individuals will seek therapy and services without shame or hesitation.	All Age Groups - Korean
Laugh Therapy & Gratitude (Spanish) Enlighten the public on therapeutic alternatives that don't necessarily require the use of drugs to improve one's state of mind and the importance of embracing emotions rather than masking them.	All age groups (multigenerational) - Latino
New Parent Engagement-Welcome to the Library and the World Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a virtual program every quarter.	New Parents and Caregivers
Neurofeedback This project supports children and youth by providing Neurofeedback Therapy to treat various conditions including anxiety, depression, pain, and trauma. Neurofeedback is a short-term treatment (20 sessions), complementary and alternative medicine (CAM), that uses electronic devices to help people with self-regulation and self-control. The Los Angeles County Department of Mental Health (LACDMH) offers appointed DO's and practitioners to deliver neurofeedback treatment to the client while monitoring progress and providing feedback.	Children and TAY (DO Clinicians will be trained)
Older Latino Adults & Caregivers (Spanish) Create opportunities for elderly Latino immigrants to prosper and grow independent by teaching them not fear technology but rather, use it as a helpful tool to stay connected to loved ones, learn new things, find entertainment, and use it as a tool for self improvement.	Older Adults - Latino
Open Arms Community Health & Service Center Provide quality health care, mental health support, housing, case management, employment referrals and supportive services such as food, clothing, hygiene kits, transportation anger management, substance use, sex trafficking, and parenting classes.	All Age Groups
Our SPOT Teen Program: Social Places and Opportunities for Teens After-School Program Our SPOT: Social Places and Opportunities for Teens is a comprehensive after-school teen program aimed at engaging and providing community youth with the support, life-skills and positive experiences that will empower them to create bright futures for themselves.	Children and youth under 18
Parks after Dark Parks at Sunset Designed for families and adults to participate in workshops and classes promoting self-care and healing, three evenings a week over 8-weeks. Activities include sports, fitness, arts and culture, movies and concerts and more.	24 years old and below - Families

Program	Target Population
PIER Program Expansion- First Episode Psychosis Program DMH has 5 PIER program sites that are almost at capacity. The request is to expand the number of sites and areas of availability of the program. PIER is a Coordinated Specialty Care program for adolescents and young adults, ages 12-25 who are either at Clinical High Risk for psychosis or have had their first psychotic episode. Currently, referrals from ELAC STAND (UCLA) , NAMI Urban LA, schools and various outpatient programs are exceeding the capacity of the current service level.	Adolescents and young adults, ages 12-25
School Readiness An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic math skills, and social skills, and other essential school readiness competencies.	2 to 4 Year Olds (Toddlers to Preschoolers)
Search to Involve Pilipino Americans (SIPA) Provide strength based, youth-centered mental health support services to youth and underserved individuals in SPA 4, with a focus on Historic Filipinotown and adjacent areas	Youth
Steven A. Cohen Military Family Clinic at VVSD, Los Angeles The Cohen Clinic offers personalized, evidence-based mental health care along with outreach and timely access to comprehensive case management support and referrals to address early intervention and suicide prevention, unemployment, finances, housing, and legal issues.	Veterans and Their Families
TransPower Project Increase access and remove treatment barriers such as lack of resources, transportation needs and privacy concerns by offering specialized affirmative mental health services at no cost.	Youth Trans* Population
Triple P Parent/Caregiver Engagement Triple P is an effective evidence based practice that gives parents and caregivers with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing.	Parents and caregivers
We Rise Parks at Sunset We Rise a prevention program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access resources and information on mental health support including free mental well-being workshops.	24 years old and below - Families
Wolf Connection Empowerment: Student Support *Funded in FY 22-23 through CalMHSA funding. New PEI Program. Wolf Connection's Wolf Therapy® is an education and empowerment program with wolfdogs as the centerpiece. With the help of these magnificent animals, humans from all walks of life learn to connect more fully with themselves and their environment and understand their unique role in a human "pack" or community. This program brings non-traditional wellbeing supports for youth and the adults that work with them.	Students in the AV ages 11-18: Priority will be given to Child welfare at-risk or involved, justice involved at-risk or involved, or attending alternative schooling.
Youth Development Regions This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs. The target population is youth 18-25 and is projected to serve approximately 6,500 youths annually. Services are provided through contracted CBOs and referral and linkage and will include school engagement, conflict resolution training, mentoring/peer support, educational support, employment/career services, arts/creative expression and social/emotional wellbeing resources.	Transition Age Youth 18-25

C. STIGMA AND DISCRIMINATION REDUCTION (SDR)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+
Program Description				
The purpose of SDR is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. The services include anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.				

FY 2022-23 ■ STIGMA AND DISCRIMINATION REDUCTION Data and Outcomes

C1. Mental Health First Aid (MHFA)

MHFA is an interactive 8-hour evidence-based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhances the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

C2. Mental Health Promoters/Promotores

The Promotores de Salud Mental/United Mental Health Promoters (UMHP) Program strives to reduce the stigma associated with mental illness among underserved cultural and linguistic communities in Los Angeles (LA) County by increasing awareness about mental health issues, removing barriers, and improving timely access to culturally and linguistically appropriate care and resources. The mental health Promoters/Promotoras provide in-person and/or virtual services in the community they reside to bring culturally and linguistically appropriate education and information to their communities through workshops (13 modules), group discussions, support groups, advocacy, peer support, outreach, and linkages to resources. The Promotores de Salud Mental Program was a pilot program initiated in 2010-2011 within the Latino, Spanish-speaking community. The UMHP Program is the multi-cultural expansion of the original program.The unified programs merge a community leadership/peer-to-peer approach with support, guidance, and training from LACDMH-licensed clinicians. In addition, Senior and Supervising Community Health Workers who once served as Promotores and/or peer advocates provide mentorship and share knowledge and lived experiences to support the Mental Health Promoters further. The Promoters/Promotoras have a high degree of passion, commitment to helping others, and a profound desire to improve their communities. They have served as leaders in peer support networks, health centers, and other community organizations that specifically targeted Spanish-speaking community members. Many have lived experience or have cared for family members with mental health conditions; thus, they possess a unique understanding and skill set. This experience, combined with the training provided by licensed clinicians, makes them effective in preventing and mitigating mental health disorders among underserved communities.

This program will continue in the upcoming fiscal years with Prevention and Early Intervention – Prevention funding.

Table 48. Community Workshops

Language	Number of Workshops
Spanish	7,246
Korean	518
Khmer	95
Chinese	38
Arabic	38
Amharic	1
English	1,510
Total Number of Community Workshops	9,446

C3. Peer, Family and Community Supports Towards Stigma and Discrimination Reduction: NAMI Urban LA and NAMI Greater LA

Provides Countywide community-based prevention programs and approaches and supports to reduce stigma and discrimination targeting people living with mental illness, their families, friends and communities. Activities/services include supports to families and communities navigating mental health treatment and recovery resources, evidence-based education classes, training, and advocacy. Program targets:

- Individuals with mental illness and their families
- Individuals who serve as Mental Health peers
- Mental Health professional and paraprofessionals
- Underserved Cultural Communities
- Individuals and families impacted by justice involvement

C4. LGBTQIA-2S

This is an invoice-billed unique contract that focuses on the TAY population, as well as their families and community. It provides educational and stigma addressing training to the community, as well as support groups, and is contracted with three agencies in different parts of LA County:

1. Penny Lane
2. AMAAD Institute
3. The Wall Las Memorias

C5. SDR Outcomes

Los Angeles County's Department of Mental Health has implemented Stigma Discrimination Reduction (SDR) programs in the form of training and education. Trainings are intended to decrease stigma and discrimination against people who have a mental health condition and increase knowledge about the topic of mental health. To determine the effectiveness of its SDR trainings, Los Angeles County uses the California Institute of Behavioral Health Services' (CiBHS) SDR Program Participant Questionnaire, a brief, multiple choice, survey that assesses the impact of trainings on participants': 1) attitudes and behavior toward persons with mental health conditions 2) knowledge about stigma towards persons with mental health conditions 3) awareness of ways to support persons who may need mental health resources, as well as training quality and demographics.

This write-up discusses the results of data analyses performed on the questionnaires administered to assess SDR trainings conducted during the 2022-2023 Fiscal Year (FY),

from July 1, 2022, through June 30, 2023. In FY 22-23, (16,218) surveys were collected, close to the number collected (16,572) in the previous FY.

The majority, 70%, (see graph, Survey Language) of surveys submitted were in Spanish, which fits the language demographics of training participants, as 55% reported Spanish as their preferred language (see graph, What language do you most often speak at home?).

Outcomes

Changes in Behavior

Seven questionnaire items (see graph, Changes in Behavior, for items and results) assess if the training met the goal of increasing participants' willingness to engaging in behaviors that support persons with mental health conditions. Item ratings are: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, Strongly Disagree, or Not Applicable. Agreeing suggests the participant believes the training met its goal (e.g., increase in willingness to "seek support from a mental health professional if I thought I needed it"). Results suggest the SDR programs: 1) decreased the likelihood of discriminating against persons who have a mental health condition 2) increased the likelihood of acting in support of individuals who have a mental condition 3) increased the likelihood of seeking support for themselves in times of need.

- On all 7 items, the majority of participants agreed the training had a positive influence, with a high of 93% agreeing (39%) or strongly agreeing (54%) with item 6: "As a direct result of this training I am MORE willing to seek support from a mental health professional if I thought I needed it."
- The results are highly similar to the previous FY's, when the majority of participants agreed the training had a positive influence on all 7 items, and, identically, item 6 had an agreement rate of 93% and the highest rate of all the items.

Figure 18. Survey languages

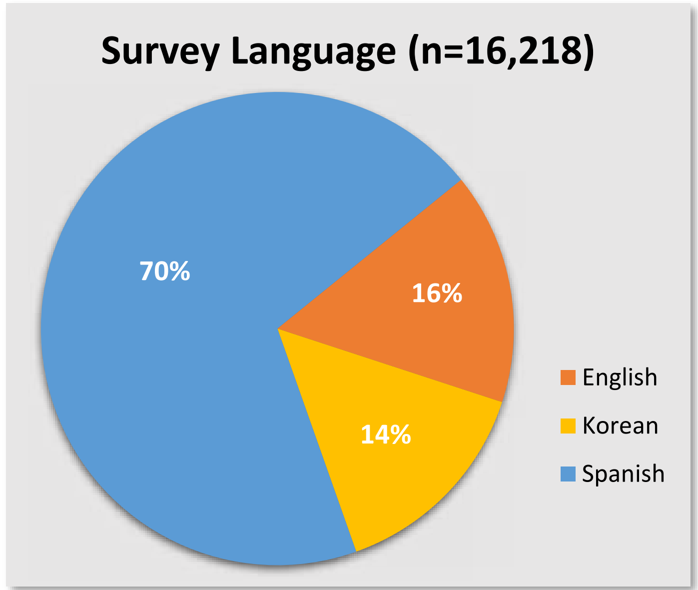
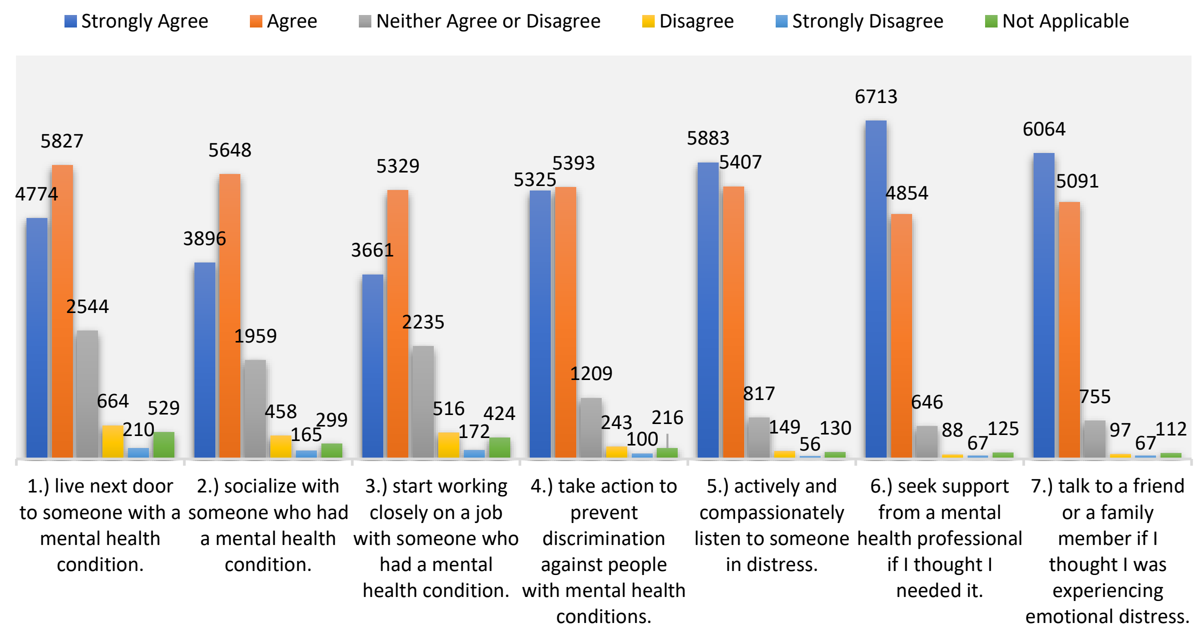


Figure 19. Changes in behavior

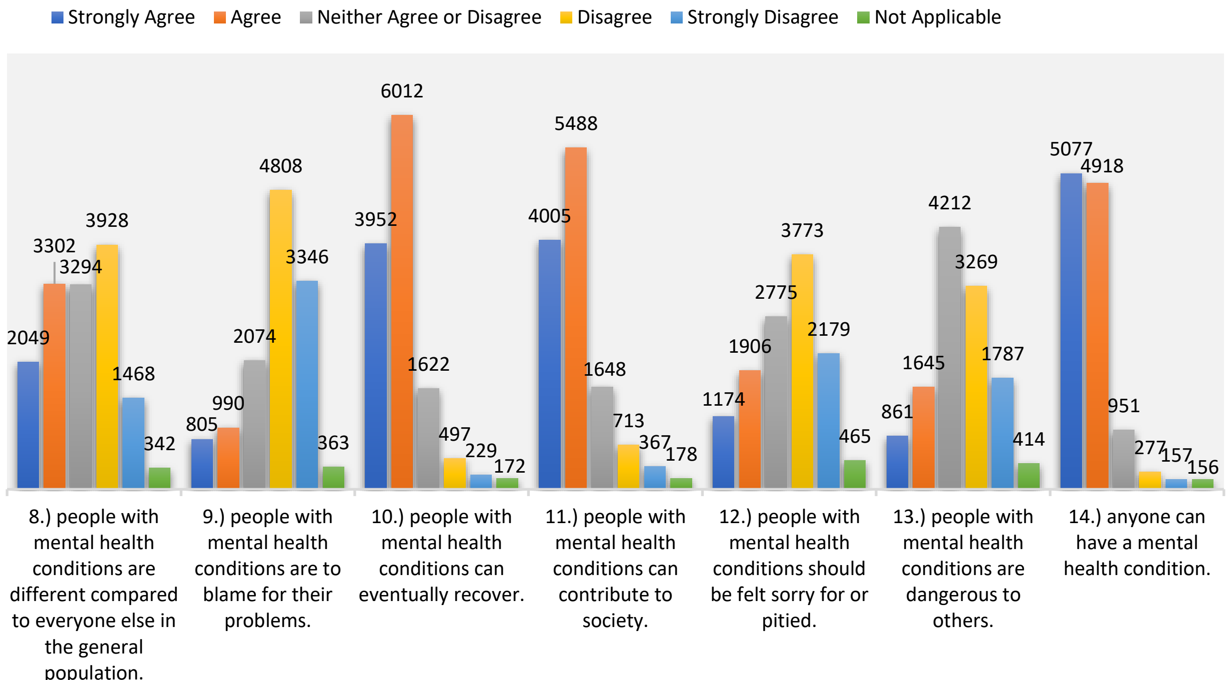


Changes in Knowledge and Beliefs

Seven items (see graph, Changes in Knowledge and Beliefs, for items and results) assess whether SDR trainings met the goals of increasing participants' knowledge about mental health and decreasing negative beliefs about people with mental health conditions. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree, or Not Applicable. On items 8, 9, 10 and 13, disagreeing suggests the participant believes training succeeded meeting its knowledge and beliefs goals (e.g., decreasing the belief "people with mental health conditions are dangerous to others") and agreeing suggests the opposite. On items 10,11, and 14 scoring is reversed. (e.g., increasing belief "people with mental health conditions can eventually recover").

- On four of 7 items, a majority of participants indicated the training had a positive influence, with a high of 87% agreeing (43%) or strongly agreeing (44%), with item 14, "As a direct result of attending this training I am MORE likely to believe anyone can have a mental health condition."
- On three of 7 items, a plurality of participants indicated the training had a positive influence, though not a majority. The phrasing of these items may play a role in their having lower levels of agreement. They are negatively worded, disagreeing with them indicates the training made an improvement, for example, item 12, "As a direct result of attending this training I am MORE likely to believe people with mental health conditions should be felt sorry for or pitied." Of the 14 main questionnaire items, participants showed the least change on the 4 negatively worded ones. In addition, average disagreement (48%) on the 4 negatively phrased items was 35% lower than average agreement (83%) with the positively phrased ones.

Figure 20. Changes in knowledge and beliefs



Three items (see Graph, Training Quality, for items and results) assess the quality of SDR trainings. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, and Strongly Disagree. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite. Participants tended to have very positive perceptions of the trainings' quality. At least 95% of participants agreed or strongly agreed with every item:

- a high of 97% agreed (22%) or strongly agreed (75%) with item 15, "The presenters demonstrated knowledge of the subject matter."
- a high of 97% agreed (23%) or strongly agreed (74%) with item 16, "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."
- These results are identical to the previous fiscal year's, when a high of 97% of participants agreed with items 16 and 17.

Figure 21. Training Quality

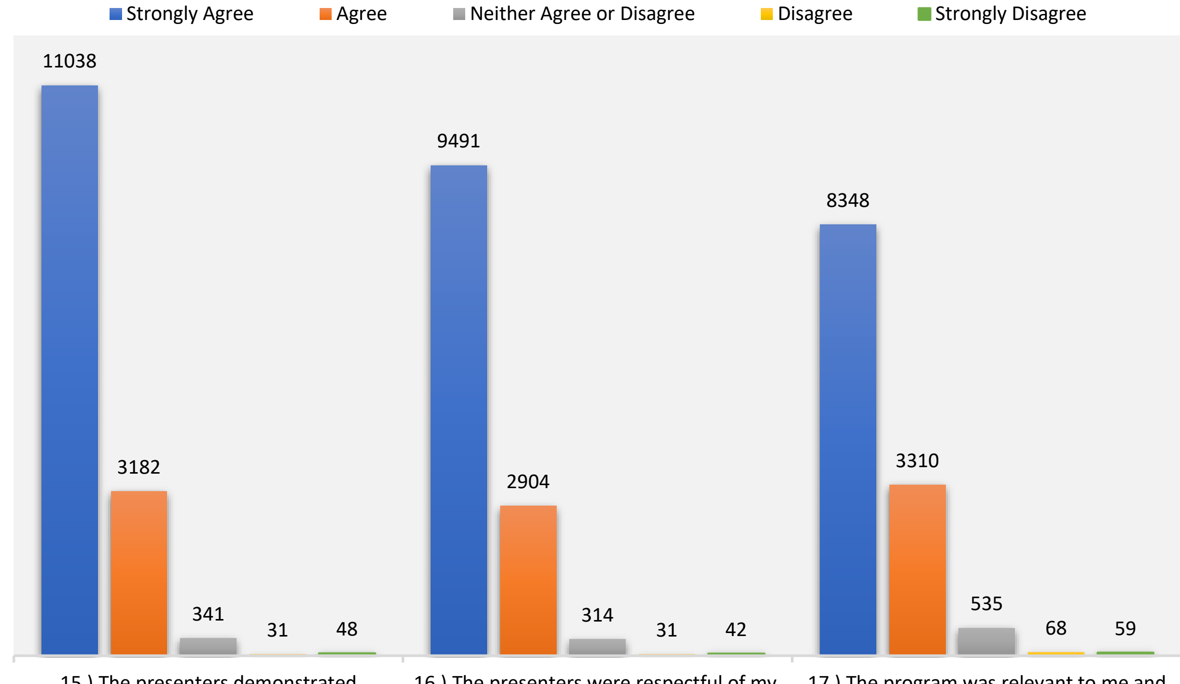


Table 49. Survey demographics (n = 16,218)

[illegible]	
Sex at Birth	**Percentage (%)**
Female	74%
Male	12%
Another category (e.g. Intersex)	0.1%
X	0.1%
Prefer not to answer	15%
Age	
0-15	1%
16-25	3%
26-59	63%
60+	18%
Decline to Answer	15%
Race	
White	33%
Another race	13%
Decline to answer	33%
Black or African American	2%
Asian	16%
More than one race	2%
American Indian or Alaska Native	1%
Native Hawaiian or other Pacific Islander	0.1%
Ethnicity	
Mexican/Mexican-American/Chicano (Hispanic/Latino)	39%
Decline to answer	18%
Korean	15%
Central American (Hispanic/Latino)	12%
Caribbean (Hispanic/Latino)	6%
South American (Hispanic/Latino)	3%
Other (Hispanic/Latino)	2%
European	1%
More than one ethnicity	1%
African	1%
Another ethnicity	1%
Chinese	0.4%
Puerto Rican (Hispanic/Latino)	0.4%
Filipino	0.4%
Asian Indian/South Asian	0.2%
Eastern European	0.2%
Middle Eastern	0.1%
Japanese	0.1%
Vietnamese	0.04%
Cambodian	0.04%
Armenian	0.03%
Primary Language	
Spanish	55%
Decline to answer	15%
Korean	15%
English	15%
Another Language	0.4%
Mandarin	0.2%
Armenian	0.2%
Tagalog	0.1%
Cantonese	0.1%
Arabic	0.04%
Russian	0.03%
Other Chinese	0.03%
Cambodian	0.03%
Japanese	0.02%
Vietnamese	0.02%
Farsi	0.02%
American Sign Language	0.02%
Hmong	0.01%
Veteran	
No	83%
Yes	1%
Decline to answer	16%
Disability	
No	77%
Yes	6%
Decline to answer	17%

[illegible]	
Gender Identity*	**# of Participants**
Woman	12,131
Prefer not to answer	2,163
Man	1,856
Non-binary (e.g., genderqueer or gender expansive)	38
Transgender woman/Transfeminine	21
Not sure what this question means	13
Undecided/Unknown at this time	12
Transgender man/Transmasculine	12
Another category (e.g., Two-Spirit)	5
Questioning or unsure of gender identity	1
Sexual Orientation*	
Heterosexual/straight	9,516
Prefer not to answer/prefer no labels	6,140
Something else (e.g., queer, asexual)	273
Bisexual or pansexual	137
Gay or lesbian	108
Not sure what this question means	59
Undecided/unknown at this time	12
Questioning or unsure of sexual orientation	1
Type of Disability**	
A mental disability	355
A physical/mobility disability	247
A chronic health condition, such as chronic pain	236
Decline to answer	84
Difficulty hearing	81
Difficulty seeing	76
Another type of disability	73
Another communication disability	35

*Total number of gender identities and sexual orientations selected may add up to more than 16,218 as participants are allowed to select more than one response.
**Total number of disabilities selected may add up to more than the number of participants who answered “Yes” (987), as participants are allowed to select more than one response.

D. SUICIDE PREVENTION

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+

Program Description

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

In response to the needs in our community, the Los Angeles County Suicide Prevention Network, with support from LACDMH, has developed a strategic plan for suicide prevention to guide our efforts towards the goal of zero suicides in the County.

Some of the key elements to suicide prevention are:

- Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction;
- Promote early help seeking where people know the warning signs and resources and are confident to intervene with someone they care about or get help for themselves;
- Ensure a safe and compassionate response during and in response to crises by focusing on stabilization and linkages to services in the least restrictive setting; and
- Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death.

FY 2022-23 ■ SUICIDE PREVENTION Programs

D1. Suicide Prevention Outcomes

Los Angeles County's Department of Mental Health implemented its Suicide Prevention (SP) programs in the form of training and education. Training participants included, but were not limited to: first responders, teachers, community members, parents, students, and clinicians.

To determine the effectiveness of its SP services, Los Angeles County utilizes the California Institute of Behavioral Health Services' (CiBHS) SP Program Participant Questionnaire, a multiple choice survey, which assesses the impact of trainings on participants' attitudes, knowledge, and behaviors related to suicide, as well as training quality and participants' demographics. This write-up discusses the results of a data analyses performed on the 752 questionnaires received for SP trainings conducted during the 2022-2023 Fiscal Year (FY).

Note: The Questionnaire submission rate decreased 42.55% from FY 2021-22 (1309) to FY 2022-23 (752).

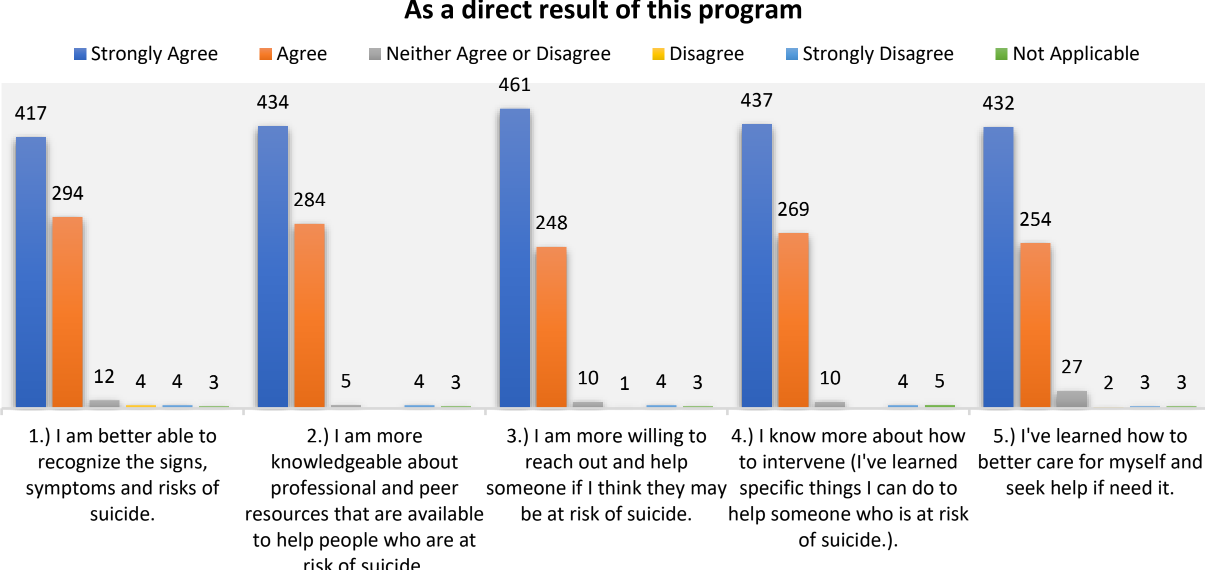
Program Outcomes

Changes in Attitudes, Knowledge, and Behavior

The three primary goals of the SP program are: 1) increasing knowledge about suicide and ways to help someone who may be at risk of suicide 2) increasing willingness to help someone who may be at risk of suicide 3) increasing the likelihood participants will seek support for themselves in times of need. The questionnaire includes five items (see Graph, Changes in Attitudes, Knowledge, and Behavior, for items and results) assessing the success of SP trainings in meeting program goals. Items may be rated: Strongly Agree, Agree, Neither Agree or Disagree, Disagree, Strongly Disagree, or Not Applicable. Agreeing with an item suggests the training met a program goal(s), disagreeing suggests the opposite. At least 95% of participants agreed or strongly agreed every item suggesting that, overall, the SP programs were quite successful in meeting their program goals.

- Participants had the highest percentage of agreement with the 2nd item; 98% agreed (39%) or strongly agreed (59%) that, "as a direct result of this program I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide."

Figure 22. Changes in Attitudes, Knowledge, and Behavior



Training Quality

The questionnaire includes three items (see Graph, Training Quality, for items and results) assessing the quality of SP trainings. Items may be rated: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree. Agreeing suggests the participant had positive perceptions about the training quality and disagreeing suggests the opposite.

- Participants tended to have highly positive views of the trainings' quality as at least 97% agreed or strongly agreed with all 3 items.
- A high of 99% of participants agreed (26%) or strongly agreed (73%) with item 6: "The presenters demonstrated knowledge of the subject matter."

Figure 23. Training Quality

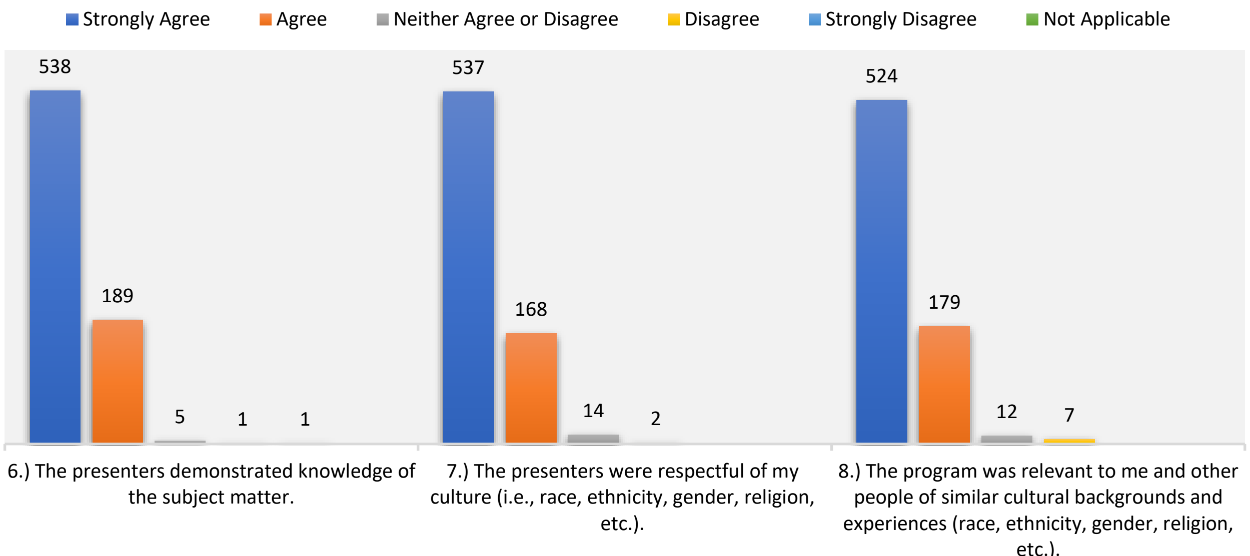


Table 50. FY 2022-23 Survey demographics (n=752)

Participant Characteristics	
Sex at Birth	**Percentage (%)**
Female	81%
Male	15%
Prefer not to answer	4%
Age	
16-25	7%
26-59	81%
60+	7%
Decline to Answer	5%
Race	
White	29%
Another race	22%
Decline to answer	15%
Black or African American	14%
Asian	11%
More than one race	7%
American Indian or Alaska Native	2%
Native Hawaiian or other Pacific Islander	0.4%
Ethnicity	
Mexican/Mexican-American/Chicano (Hispanic/Latino)	33%
Decline to answer	11%
Central American (Hispanic/Latino)	9%
European	8%
More than one ethnicity	7%
African	6%
Other (Hispanic/Latino)	5%
Another Ethnicity	4%
Filipino	3%
Chinese	2%
Vietnamese	2%
Asian Indian/South Asian	2%
Eastern European	2%
South American (Hispanic/Latino)	1%
Middle Eastern	1%
Korean	1%
Puerto Rican (Hispanic/Latino)	1%
Japanese	1%
Cambodian	1%
Caribbean (Hispanic/Latino)	0.4%
Primary Language	
English	75%
Spanish	17%
Decline to answer	3%
Armenian	1%
Vietnamese	1%
Another Language	1%
Korean	1%
Mandarin	1%
Tagalog	1%
Other Chinese	0.1%
Cambodian	0.1%
Cantonese	0.1%
Veteran	
Yes	1%
No	97%
Decline to answer	2%
Disability	
Yes	6%
No	88%
Decline to answer	6%

Participant Specific Characteristics	
Gender Identity*	**# of Participants**
Woman	595
Man	113
Prefer not to answer	25
Non-binary (e.g., genderqueer or gender expansive)	6
Questioning or unsure of gender identity	2
Another category (e.g. Two-Spirit)	1
Undecided/unknown at this time	1
Sexual Orientation*	
Heterosexual/straight	599
Prefer not to answer/prefer no labels	55
Bisexual or pansexual	39
Gay or lesbian	26
Something else (e.g., queer, asexual)	18
Questioning or unsure of sexual orientation	7
Not sure what this question means	1
Undecided/unknown at this time	1
Type of Disability**	
A chronic health condition (including chronic pain)	19
A mental disability	14
A physical/mobility disability	10
Another type of disability	7
Difficulty hearing	4
Difficulty seeing	3
Decline to answer	1
Another communication disability	1

*Total number of gender identities and sexual orientations selected may add up to more than 752 as participants are allowed to select more than one response.
**Total disabilities reported may add up to more than the number of participants who answered "Yes" (45), as participants are allowed to select more than one response.

D2. School Threat Assessment Response Team (START)

START has years of partnership with various threat management teams in the Los Angeles Community College District (LACCD), the largest community college system in the nation. Through its partnership with the Los Angeles County Sheriff's Department and the LACCD, START has established protocol for managing threats in educational settings. The services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. Additionally, START participates in LAUSD's Threat Assessment Response Partners (TARP) collaborative, and the higher education Threat Assessment Regional Group Evaluation Team (TARGET) to provide on-going consultations and trainings on threat cases. START will continue with its mission to be the driving force in establishing a safe, healthy school environment in the County.

In the period of FY 2022-2023, START conducted 93 presentations. The topics consisted of de-escalation, field safety, mental health awareness, START services, suicidal prevention, and targeted school violence (see Table 51).

Table 51.

Type of Organization	De-escalation	Field Safety	Mental Health Awareness	START Services	Suicidal Prevention	Targeted School Violence	Grand Total
Board of Supervisors	1						1
College/ University	8			2	1	8	19
Community Organization	4	2	2	1	2	6	17
Department of Health and Human Services	1						1
Department of Health Services	2			1			3
Department of Children and Family Services	3						3
Department of Public Health						3	3
Department of Mental Health	3	2				2	7
Education Office or Committee				1			1
Healthcare Provider	3						3
Law Enforcement			8	4		8	20
Public Counsel	1						1
Safety professional						1	1
School	2			1	1	9	13
Totals	**28**	**4**	**10**	**10**	**4**	**37**	**93**

The START Program served a total of 991 referrals in Fiscal Year 2022-23. Of the 991 referrals, 867 (87%) received screenings and/or threat assessments and 124 (13%) received consultations

Of all the referring parties, 749 were other mental health service providers, 112 schools, 41 college/university, and 62 law enforcement. These were the four primary referral sources.

Table 52. Referral Source

Referral Source	Client Count	Percentage
College/University	41	4.14%
Community Organization	6	0.61%
Department. of Children and Family Services	8	0.81%
Healthcare provider	10	1.00%
Law Enforcement	62	6.26%
Los Angeles County Office of Education	1	0.10%
Other Mental Health Provider	749	75.58%
School	112	11.30%
Self	2	0.20%
Grand Total	**991**	**100.00%**

Of the 991 referrals, 255 (26%) were received by e-mail, 683 (69%) by phone, and 53 (5%) through virtual meetings or in person.

Each refer-in client may receive more than one type of interventions. 455 clients received crisis intervention, 867 clients initial screening/threat assessment, and 435 outreach and engagement.

Table 53. Referrals by Types of Interventions

Crisis Intervention	Initial Screening/ Threat Assessment	Outreach & Engagement	Monitoring	Supportive Service	Consultation	Linkage	Grand Total
455	867	435	130	2	117	2	2,008
22.66%	43.18%	21.66%	6.47%	0.10%	5.83%	0.10%	100.00%

In terms of interventions, START collaborates with family, academic institutions, and other community organizations to mitigate or eliminate potential risk for targeted school violence. These include but are not limited to: School Districts in Los Angeles County, mental health professionals including both Department of Mental Health directly operated and contracted agencies, Probation Department, Department of Children and Family Services (DCFS), juvenile justice programs, mentoring programs, faith-based organizations, and cultural and diverse programs. The ultimate goal is to keep the community and individuals safe.

Among below service categories, the monitoring includes a combination of routine check-in or screening/assessment, intervention planning, identification of resources, and collateral contact with the family, the client's mental health treatment team, school, and other involved parties. All services take place at home, school, and community organizations convenient to the service target population.

The 991 referrals were provided with a wide variety of services. Each client may have received more than one type of intervention. The primary focus of interventions centered on crisis intervention, initial screening/threat assessment, and outreach & engagement.

Table 54: Number of Clients and Types of Services

Crisis Intervention	Initial Screening/ Threat Assessment	Outreach & Engagement	Monitoring	Supportive Service	Consultation	Linkage	Total
521	867	677	346	2	117	2	2532
20.58%	34.23%	26.74%	13.67%	0.08%	4.62%	0.08%	100.00%

D3. Veteran Suicide Review Team (VSRT)

The purpose of the Veteran's Suicide Review Team (VSRT) of Los Angeles County is to conduct a thorough review of suicides occurring within the county. These reviews will be used to better understand why our residents take their own lives and to take action to prevent future suicides. The Veterans Suicide Review Team (VSRT) evaluates the circumstances leading to and surrounding the suicide deaths of veterans who died in Los Angeles County in order to develop and enhance system-level intervention and prevention measures to prevent suicide among veterans. The Department of Mental Health coordinates weekly Co-Chair meetings to review the outreach to the next of kin of the identified decedents, the decedent status is confirmed at the weekly meetings and any issues are resolved before the case review. The Department of Mental Health is the administrative lead and is responsible for coordinating the monthly case review meeting which is attended by the departments/ organizations named below:

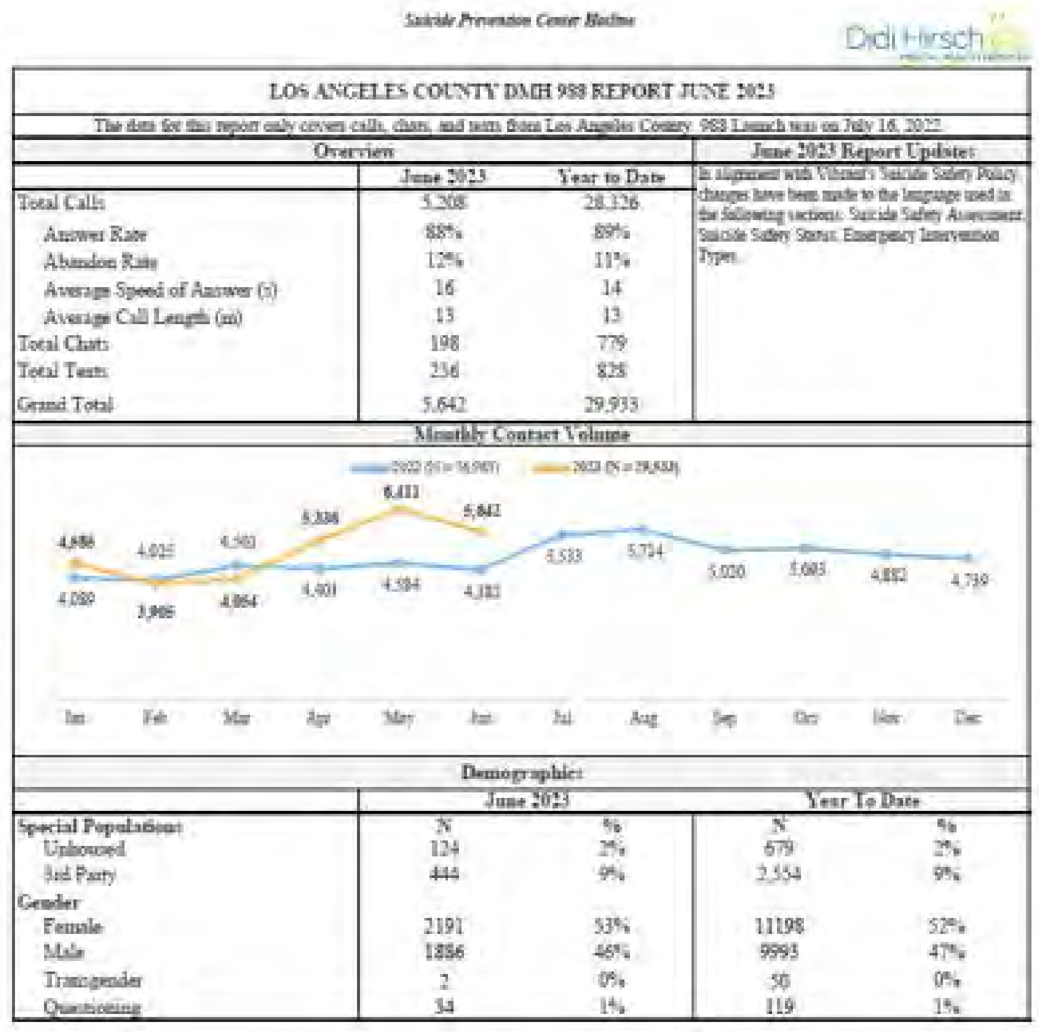
- California Department of Veterans Affairs, Veterans Services Division
- Didi Hirsch Suicide Prevention Center, Suicide Prevention Crisis Line
- LA Suicide Prevention Network Peer, Faith-Based/Clergy representatives
- Los Angeles Homeless Services Association (LAHSA), Planning and Systems Department, Veteran Systems Coordinator
- U.S. Vets, Director of Behavioral Health
- Federal Bureau of Investigation (Los Angeles), Threat Management Coordinator
- Los Angeles County Fire Department, Director of Behavioral Health
- Los Angeles Police Department, Mental Evaluation Unit (MEU)
- Los Angeles County Chief Executive Office, Chief Information Office
- Los Angeles County District Attorney's office
- Los Angeles County Public Defender's office
- Los Angeles County Military and Veteran's Affairs
- Los Angeles County Sheriff's Department, Mental Evaluation Team (MET)
- Los Angeles County Department of Medical Examiner-Coroner
- Los Angeles County Department of Mental Health
- Los Angeles County Department of Children and Family Services, Risk Management Division
- Los Angeles County Department of Health Services, Twin Towers Correctional Facility, Olive View Medical Center
- Los Angeles County Department of Human Resources, Occupational Health & Leave Management Division
- Los Angeles County Department of Public Health

- Los Angeles County Department of Public Health, Substance Abuse Prevention and Control
- Los Angeles County Department of Public Social Services, CalWORKs and GAIN Program Division Program Policy
- Department of Health Services (DHS)

Partners in Suicide Prevention(PSP) / DMH staff are scribes at the case review meetings. DMH provides meeting space and provides training to the Co-Chairs and critical partners utilizing the leading Mortality Review Subject Matter Expert, to deliver the trainings.

D4. 988 Call Center

The following is the 988 report for Fiscal Year 2022-23. 988 was launched on July 16, 2022.



Suicide Prevention Center Hotline

Didi Hirsch

LOS ANGELES COUNTY DMH 988 REPORT JUNE 2023

The data for this report only covers calls, chats, and texts from Los Angeles County. 988 Launch was on July 16, 2022.

Overview

	June 2023	Year to Date
Total Calls	5,208	28,326
Answer Rate	88%	89%
Abandon Rate	12%	11%
Average Speed of Answer (s)	16	14
Average Call Length (m)	13	13
Total Chats	198	779
Total Texts	236	828
Grand Total	5,642	29,933

June 2023 Report Updates:

In alignment with Vibrant's Suicide Safety Policy changes have been made to the language used in the following sections: Suicide Safety Assessment, Suicide Safety Status, Emergency Intervention Types.

Monthly Contact Volume

Demographics

	June 2023		Year To Date	
Special Populations	N	%	N	%
Unhoused	124	2%	679	2%
3rd Party	444	9%	2,554	9%
Gender				
Female	2191	53%	11198	52%
Male	1886	46%	9993	47%
Transgender	2	0%	50	0%
Questioning	34	1%	119	1%

Prepared by Research and Evaluation, 7/14/2023 Page 1 Source Data: iCarol

Suicide Prevention Center Hotline

Ethnicity

	White	Hispanic	Black	Asian	Native American	Pacific Islander	Other Race*
Current Month (N = 2,791)	37%	37%	13%	8%	1%	0%	4%
Year To Date (N = 14,571)	37%	38%	13%	9%	1%	0%	3%

*Responses include "Other" or "Two or more"

Age

	5 to 14	15 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 to 84	85 and up
Current Month (N = 2,849)	5%	30%	31%	13%	9%	7%	3%	1%	0%
Year To Date (N = 15,461)	5%	29%	29%	15%	9%	7%	4%	1%	0%

The 45-54 age group has the highest suicide rate in the U.S. (based on 2017 national statistics reported by AAS).
The suicide rate in the 55-64 age group has steadily increased in the past 10 years.

Sexual Orientation

	Bisexual	Gay	Lesbian	Straight	Other
Current Month (N = 1,310)	6%	4%	2%	84%	5%
Year To Date (N = 7,308)	6%	5%	1%	83%	4%

Prepared by Research and Evaluation, 7/14/2023 Page 2 Source Data: iCarol

Top Concerns	June 2023	YTD
Danger to Self*	62%	63%
Danger to Others	1%	1%
Substance Use	12%	12%
Emotional Distress	36%	36%
Other	27%	25%
Total Count	3254	17977

Notes

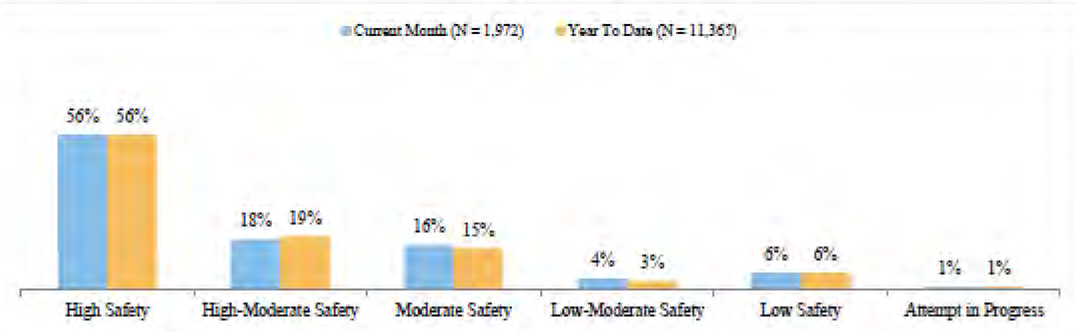
*Item responses that are categorized in danger to self include: suicide desire, cutting, suicide intent, information about suicide, suicide loss, past history of suicide, third party suicide, and suicidal thoughts. Counselors listen for the reasons contacts contacted the hotline, as well as other issues discussed by contacts and choose one or more categories to fit these issues. Percentages are calculated out of the total number of contacts in which the question for whether the contact had a concern was marked as was present.

Suicide Safety Assessment	June 2023	YTD
History*	28%	29%
Prior Suicide Attempt	22%	22%
Substance Abuse**	6%	7%
Suicide Survivor	8%	9%
Access to Gun	2%	2%
Total Count	2961	16412

Notes

*History of psychiatric diagnosis
**Prior or current
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 contacts in which suicide or crisis content was present.

Suicide Safety Status



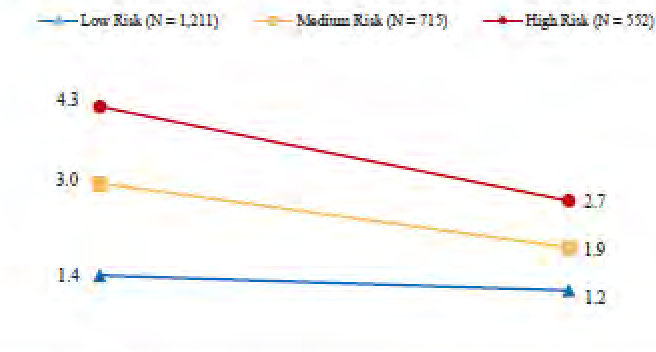
Percentages are calculated out of the total number of contacts with reported safety levels.

The Suicide Safety Status is replacing the Suicide Risk Status in this report. Please note that Suicide Safety Status and the Suicide Risk Status are inverse of each other.

Safety 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 contact's safety level is determined by the combination of core principles present. For example, a contact who reports having only suicidal desire, as well as buffers, would be rated as High Safety. A contact with suicidal desire, capability, and intent present would be rated as Low Safety, regardless of the presence of buffers.

Intervention Outcomes: Self-Rated Suicidal Intent - YTD

Contacts 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'?" Contacts rate their intent both at the start and end of the interaction. This data is on contacts for which information was reported.



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

Emergency Intervention Types

	June 2023		YTD	
	N	%	N	%
Resolved*	5,334	95%	28,415	95%
Interventions	308	5%	1,518	5%
Third Party Initiated	100	2%	510	2%
Self-Initiated	67	1%	333	1%
SPC Initiated - Voluntary	7	0%	29	0%
SPC Initiated - Involuntary	6	0%	32	0%
Mobile Outreach	128	2%	614	2%

*Did not require intervention

Self-Initiated	Contact decides to go to the ER/call 911/call PMRT on his/her own (or with help from a third party).
Third Party Initiated	3rd party contact will contact 911/PMRT OR 988 connects to ACCESS/PMRT.
SPC Initiated	SPC contacts 911 or PMRT on contact's behalf, could be either voluntary or involuntary.

Follow-Up Program

	June 2023		YTD	
	Contacted	Linked	Contacted	Linked
Short-Term*	50%	50%	40%	40%
Standard**	29%	6%	48%	11%
Extended***	100%	50%	100%	50%

*Offered to contacts at imminent risk who do not meet criteria for emergency intervention The follow-ups are made within 24 hours after the initial contact.

**Offered to moderate - high risk contacts. The follow-ups are made 1-7 days after the initial contact.

***Offered to contacts who received standard follow-up and need continued assistance (e.g., developing a safety plan and/or connecting to resources). The follow ups are made 1-8 weeks after the initial contact.

Referrals				
	June 2023		YTD	
	N	%	N	%
Outpatient	312	10%	1,862	11%
Social Services	508	17%	2,946	17%
Substance Use	27	1%	137	1%
Emergency Department	64	2%	388	2%
Not available	1,607	53%	9,224	53%
Other	527	17%	2,874	16%

E. Outreach for Increasing Recognition of Early Signs of Mental Illness

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

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

The Department's provider network provides a full continuum of services and generally do not have PEI services in stand-alone buildings. Individuals presenting for services are assessed and referred according to need. Consequently, this PEI component does not apply to the Los Angeles County and cannot be reported on.

Workforce Education and Training (WET)

Status	☐ New	☒ Continuing	☐ Modified	☐ Discontinued

Program Description

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

The County will transfer funds from its CSS account into the WET account to fund the following projects:

- Training and Technical Assistance
- Residency and Internship
- Financial Incentive
- Mental Health Career Pathway

FY 2022-23 ■ WORKFORCE EDUCATION AND TRAINING Data and Outcomes

A. Training and Technical Assistance:

1. Public Mental Health Partnership: UCLA Public Partnership for Wellbeing Agreement - UCLA Affiliation Agreement

The Public Mental Health Partnership (PMHP) focuses on training and technical assistance for the Full Service Partnership (FSP) and HOME Teams run by LACDMH. Since inception, the PMHP has created a large library of virtual trainings and resources that are now organized and housed on the Wellbeing for LA Learning Center website. These resources, while customized to meet the needs of the FSP and HOME Teams individually, can be applied across programs to help build key skills and promote best practices for supporting individuals experiencing homelessness.

During FY 2022-23, the PMHP delivered 291 live trainings representing 581 training hours delivered to 9,416 participants. The training team provided trainings on a wide variety of topics, including Person Centeredness, Cultural Humility, and Psychiatric Disorders & Symptoms. The training topics that were delivered to the most participants in FY 2022/23 included Manualized Evidence-Based Practices (1,359 participants) and Crises & Safety Intervention (974 participants). In addition, 8,447 PMHP Anytime Trainings were completed during the reporting period. This investment will shift over two fiscal years to DMH, with funding reduced to reflect DMH oversight.

Table 55. Public Mental Health Partnership Trainings

Topic Name	Number of Trainings	Training Hours	Number of Participants
Cultural Humility	14	38	610
Crisis & Safety Intervention	19	85	974
Continuous Quality Improvement	60	61	939
Ethical Issues	4	8	456
Manualized Evidence-Based Practices	25	55	1,359
Psychiatric Disorders & Symptoms	13	48	584
Co-Occurring Disorders	15	47	683
Service Delivery Skills	23	36	785
Team-Based Clinical Services	44	67	803

Topic Name	Number of Trainings	Training Hours	Number of Participants
Provider Wellbeing	30	27	611
Trauma	13	41	705
Person Centeredness	22	51	565
Everyday Functioning	5	6	176
Persistent & Committed Engagement	2	4	102
Whole Person Care	2	10	64
TOTAL:	291	581	9,416

2. Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T):
   This FY BASIC-T focused on completing the goals of their multi-year collaboration with the LACDMH United Mental Health Promoters program, culminating in the creation and launch of a novel UMHP-specific online learning portal that will continue to serve as a key resource for generations of UMHP community members to come. This fully bilingual (Spanish/English) website serves as the main training hub for the Department of Mental Health and its growing United Mental Health Promoter Program. The website provides a learning pathway for incoming Mental Health Promoters, as well as educational support for the existing Promoters, allowing the department to train more people in a more efficient way. LACDMH will be able to easily develop training material in other languages since the Wellbeing for LA Learning Center has that capability.

   In addition to investing time in the training of LACDMH providers, BASIC-T has also worked shoulder-to-shoulder with LACDMH to modernized its assessment capabilities by securing access to centralized online assessment portals with the leading Psychology Test Publishers, securing iPads for LACDMH pilot site providers to engage in state-of-the-art electronic assessment protocols, and working with LACDMH leaders to harmonize billing practices related to recent payment reform and its impact on psychological testing parameters.

   Simultaneously, BASIC-T pivoted toward laying the foundation for its forthcoming Psychologist Training Program and the Workforce Development and Professional Continuing Education Program. This revitalization of the disciplinary specialty of psychology within LACDMH aims to create the necessary infrastructure for the establishment of bilingual assessment hubs strategically deployed throughout LA County to help clarify diagnoses and guide targeted evidence-based intervention.

   Other Services Delivered Through the UCLA Public Partnership for Wellbeing include:

   DMH + UCLA General Medical Education (GME)
   Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the 11 trainees provided a total of 9,550 patient visits during their public psychiatry rotations.

ADULT PSYCHIATRY RESIDENCY TRAINING PROGRAM

This year, the UCLA Adult Psychiatry Residency Training Program focused on expanding learning opportunities for adult psychiatry residents and supporting them in providing high-quality care throughout LA County in DMH Clinics. By expanding clinical training sites to include telepsychiatry rotations with DMH the team was able to increase access to care for patients in the community.

CHILD PSYCHIATRY FELLOWSHIP PROGRAM

The Child Psychiatry Fellowship Program focuses on providing an enriching clinical rotation embedded in the community to enhance learning in child psychiatry. This year, child psychiatry trainees were exposed to community child psychiatry, including the multiple systems that compromise access to quality mental health care. Their DMH rotation at Augustus Hawkins continues to be the highest rated outpatient clinical rotation for the second-year child psychiatry fellows, in large part due to exceptional teaching by knowledgeable medical directors.

GERIATRIC PSYCHIATRY FELLOWSHIP PROGRAM

This year the Geriatric Psychiatry Fellowship Program continued to provide training opportunities for its fellows while administering high quality integrative geriatric care to home-bound older adults through participation in the DMH geriatric home-based care program. All three geriatric psychiatry fellows reported this rotation as high value to understanding the impact of older adults' home life on their mental and cognitive health.

FORENSIC PSYCHIATRY FELLOWSHIP PROGRAM

The Forensic Psychiatry Fellowship Program continued to provide unique educational experiences for fellows and provide them with opportunities to serve LACDMH forensic populations (e.g., individuals moving from incarceration to treatment settings). This year, the Forensic Psychiatry Fellowship Program helped relieve a backlog of 730 reports in LA County for mental health diversion, effectively helping individuals move from incarceration to treatment settings, including a relatively new pilot program which is being expanded based on results/impact.

Table 56. Outcomes FY 2022/2023

NCSP	# Fellows/Residents	Estimated # of patient visits
Adult Psychiatrist/Researcher	1	862
GME		
Adult Psychiatry Residency	3	1649
Child Psychiatry Fellowship	3	2476
Geriatric Psychiatry Fellowship	1	1680
Forensic Psychiatry Fellowship	3	3745
Total	**11**	**9550**

Total number of patient visits in FY2020-21 and FY2021-22 combined. Estimated # of patient visits for NCSP were not reported for this reporting period.

LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees

Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher.

NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with DMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country.

DMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include:

- Participating in coursework, the equivalent of a master's program or auditing as an option.
- Conducting up to 20% clinical work with DMH and participate in leadership activities.
- Conducting 1-4 projects, at least 1 of which is in partnership with DMH.
- Participating in a policy elective their second year when possible.
- Attending annual NCSP meetings and other local and national meetings.
- Access to research funds and a mentorship team

For FY 2023-24 and beyond:

- The Department may begin developing a curriculum for a new Child Psychiatry Fellowship class that will start in FY 2024-25 under the Charles Drew university Agreement.
- The Department will also have three early care Neuropsychologist providing services at DMH directly operated sites as part of the BASIC-T SOW under the UCLA Agreement.

3. Navigator Skill Development Program

The Health Navigation Certification Training targets individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. Training includes strategies for engaging consumers, enhancing motivation, self-awareness through a detailed evaluation, goal setting and achievement, navigating a medical visit (making appointment, filling out paperwork, communicating with the doctor, completing referrals, and follow-up care), monitoring a consumer's progress, completing documentation, billable activities, and integrating health navigation into the mental health agency. During FY 2022/23, two cohorts were delivered with 37 individuals completing the model.

The Peer Housing Navigation Specialists Training targets peer to prepare them to assist consumers with housing insecurities to work towards establishing and meeting steps to a goal of housing permanency. During FY 2022-23, two cohorts were delivered. For cohort (1), 27 individuals competed the training, of these 85% spoke a threshold language (other than English), and all represented un- or under- served communities. For cohort (2), 26 individuals competed the training, of these 61% spoke a threshold language (other than English), and all represented un- or under- served communities.

This program will continue in future years if the Department determines a need for this training.

4. Interpreter Training Program (ITP)
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 2022/2023 Outcomes:

Table 57. ITP Outcomes for FY 2022-23

Training	# of Attendees
Increasing Armenian Mental Health Clinical Terminology	5
Increasing Mandarin Mental Health Clinical Terminology	4
Increasing Spanish Mental Health Clinical Terminology	83
Introduction To Interpreting in Mental Health Settings	5
TOTAL	97

5. Learning Net System
The Department has developed an online registration system called eventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. eventsHub is fully operational with most if not all clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes. Enhancement and maintenance of eventsHub continues through the following FYs.

6. Licensure Preparation Program (MSW, MFT, PSY)
In an effort to increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors and Psychologists. During FY 2022/2023, the Department subsidized 92 individuals across these professions, with 54% self-identifying from a un- or under-served community, and 52% speaking a threshold language in addition to English.

7. Academy of Cognitive Therapy
Individual Cognitive Behavioral Therapy (Ind CBT) is one of the most frequently utilized evidence-based practice (EBP), with considerable research supporting its effectiveness and adaptability in clinical practice. Ind CBT integrates the rationale and techniques from both cognitive therapy and behavioral therapy, thereby challenging automatic negative thoughts with more direct methods of behavioral therapy. Ind CBT helps individuals deal with their difficulties by changing their thinking patterns, behaviors, and emotional responses. Treatment focuses on identifying more positive reinforcing thoughts to elicit a more desired behavior. The Ind CBT program targets its services to consumers age 16 years and older throughout the Los Angeles County (LAC). Specifically, the EBP will treat transition-age youth dealing with early onset of mental illness; adults facing traumatic experiences which lead to depression, anxiety, or post-traumatic stress disorder; and older adults to prevent or alleviate depressive symptomology. The treatment is intended for consumers seeking services to address depression, anxiety, or trauma in an individual or group setting consisting of 18 to 56 weeks of sessions.

8. Staff Development Training
Historically, public mental health systems across the county have experienced ongoing staffing shortages. Unfortunately, in recent years Covid-19 has extended and expanded

this shortage. The Department will fund a new program targeting further professional skill development of its existing workforce alongside an increase recruitment effort.

B. Residency and Internship

1. Charles R. Drew Affiliation Agreement: Psychiatric Residency Program

The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County.

The first class started in Academic Year 2018-2019 and at the program's capacity, we will have 24 trainees ranging from Post Graduate Year Is to IVs. The first class graduated in June 2022.

Table 58. Outcomes for FY 2022-23

Post Graduates	Number of Psychiatric Residents	Rotations
Year 1 Post Graduates	6	• 1 month of university onboarding is done at CDU • Veterans Administration (VA) Long Beach (Inpatient Psychiatry): 4 months • Rancho Los Amigos (Inpatient Medicine): 2 months • Rancho Los Amigos (Neurology): 2 months • Kedren (Outpatient Medicine): 2 months • Harbor-UCLA (Emergency Psychiatry): 1 month
Year 2 Post Graduates	8	• VA Long Beach (Inpatient Psychiatry): 3 months • VA Long Beach (Consultation and Liaison): 2 months • VA Long Beach (Emergency Psychiatry): 1 month • VA Long Beach (Substance Abuse): 2 months • VA Long Beach (Geriatric Psychiatry): 1 month • Kedren (Inpatient Psychiatry): 1 month • Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months *The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.
Year 3 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Compton MHC Child & Adolescent Psychiatry • Women's Community & Reintegration Center • Harbor UCLA Medical Center HIV Clinic
Year 4 Post Graduates	6	Rotations in DMH Directly Operated Clinics and Programs: • Augustus F. Hawkins MHC • West Central MHC • Street Psychiatry/HOME Team and Disaster Service • Collaborative Care/Telepsychiatry • CDU Didactics Training

2. Pathways to Health Meaningful Health Careers Academy

This program is also a component of the Charles R. Drew Affiliation Agreement. It provides:

Academic and community internship initiative to prepare young people for **health careers** with a partnership between the following:

- Los Angeles County Departments of Public Health and Mental Health

- Charles R. Drew University of Medicine and Science (CDU) in South Los Angeles
- Coachman Moore and Associates, Inc.
- Local community partners

Key Components
Summer academic enrichment.
- Introduction to public health course
- Introduction to Mental/behavioral health course
- “Rites of Passage”
- Literacy, math, and science tutoring
- College preparation workshops for students

Fall community-based internship.
- Tutoring and mentorship
- SAT Preparation or Math/Science Enrichment courses

3. DMH + UCLA General Medial Education (GME): UCLA Public Partnership for Wellbeing Agreement
Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. During the reporting period, the 12 trainees provided a total of 7,073 patient visits during their public psychiatry rotations.

C. Financial Incentive

1. Mental Health Psychiatrist (MHP) Student Loan Repayment Incentive
DMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MH Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000. During FY 2022/2023, 49 mental health psychiatrists participated in this program. This program is expected to increase awards during the following Fiscal Years.

2. MHSA Relocation Expense Reimbursement
Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by DMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves DMH within one-year from employment start date, the full reimbursement amount must be repaid. During FY 2021-22, no individuals were awarded. This program is expected to increase awards during the following Fiscal Years.

3. MHP Recruitment Incentive Program
This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of conts service in DMH and who have not participated in or received funds from

the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at DMH, and an additional payment of $25,000 upon completion of the second year of continuous service. During FY 2022/2023, 14 individuals participated in this financial opportunity. This program is expected to increase awards during the following Fiscal Years.

4. Stipend Program for Direct Service Positions
LACDMH provides students with education stipends in the amount of $18,500 in exchange for a contractual work commitment (a minimum of 1 year) to secure employment in a hard-to-fill/hard to recruit program/area. This program targets students who are linguistically opand/or culturally able to service the traditionally unserved and underserved populations of the County. Program eligibility includes Psychologists, MSWs, MFTs, LPCCs, and PNPs students in the final year of their educational degree program.

During FY 2022-23, 144 stipends were awarded. The contracted fiscal intermediaries provided stipend recipients job seeking assistance as well as follow up to ensure contractual work service commitment is met; work commitment extensions may be given on a case-by-case basis.

During 2023-24, Psychiatric Technicians will be included as an eligible awardee. DMH will add additional focus as needs are identified.

5. MHSA WET Regional Partnership Match
Pending the availability of additional MHSA WET Regional Partnership funding from the State, the Department may be required to provide a 33% local match to accept and implement recruitment or retention efforts mandated in future Fiscal Years.

D. Mental Health Career Pathway

1. Intensive Mental Health Recovery Specialist Training Program
Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Two Cohorts were delivered during FY 2022-23 with 31 individuals completing the training. At least 50% of enrolled participants are bilingual or bicultural representing unserved and underserved communities. 67% of the participants identified as having lived experience with mental illness/substance abuse. 44% indicated they had a family member with mental illness/substance abuse and 22% indicated as having both lived experience and having a family member with mental illness/substance abuse. Of those who completed the training, 31% have secured employment. All were employed in the mental health field except for two people. No changes are expected through 2023-24. DMH will not continue this program after the current Fiscal Year.

2. Parent Partners Training Program
   This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.

   During FY 2022/2023, the PPTA provided over 418 hours of training for more than 302 Parent Partners.

   The PPTA provides core training to LA County Parent Partners through the 72 hour PPTA Essential Skills training, Continuing Education for all LA County Parent Partners, and also conducts PPTA Certification Exam and PPTA training evaluation.

   The PPTA is an approved SB803 Specialty trainer for Parent, Caregiver, Family Member Peer training and at the time of writing this is in process of being approved as core SB803 training provider.

3. Continuum of Care Reform
   Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. 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, in the prior year the Department utilized MHSA WET to deliver training to these populations. Such training included topics such as introduction to mental health, diagnosis/assessment, and self-care, etc. During FY 2022/2023, these mandated trainings were funded by other available funding. MHSA WET will resume funding training during FY 2023/2024.

4. Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
   The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates and caregivers for employment in the public mental health system. As such, during FY 2022-2023 the Department delivered the following trainings:

   a. Recovery Practices for Organizations
      This 8-hour fun, interactive, and skill-based training is intended for participants to examine how they presently view recovery and resilience and the significance of implementation of such tenets in the work practice. One key objective is to support integration at the organizational level of the practices of recovery and resilience services. Hands-on activities provide opportunities for the application of recovery and resilient understandings and tenets essential to consumer service delivery and relevant to work co-worker relationships. Another key objective is to provide staff with an understanding of the important role of peer support in recovery services and outcomes. Interventions and strategies to sustain recovery and resilient culture and services are included in the training. In FY 2022/2023, one training has been provided to the Peer Support Specialists working in

the LAC DMH PMRT program and a total of 15 Peer Support Specialists have completed this training.

b. Recovery Practices for Leaders
This training is a 2-day dynamic, and experiential training that provides leaders with the principles and practices for creating and sustaining a recovery and resilient-oriented service environment. Participants will gain hands-on experience on how to use several recovery and resilient leadership tools and strategies for leading and coaching peer support specialists as well as every other professional staff member on their entire team. The training also provides leaders with an opportunity to reflect and review personally and confidentially their leadership style. Each leader is to develop a vision statement, a Professional Resilient Employee Plan (PREP), and a Resilient Action Plan to implement recovery and resilient principles transcending to their teams and embedded in resilient leadership practice. In FY 2022/2023, one training has been provided to LACDMH PMRT leadership, and a total of 19 PMRT managers and supervisors have completed this training.

c. The Peer Certification Exam Preparation
This is a virtual online 8 hr. training that reviews core competency topics and applicability to Peer Support Specialist practices covered in the exam. In addition, the training provides test-taking tools, strategies, and materials important for preparing participants for exam taking. As a result, the training is intended to increase Peer confidence, competence, and skills necessary for obtaining the Peer Support Specialist Certification. In FY 2022/2023, three trainings have been provided and a total of 129 Peer Support Specialists have completed this training.

d. Online Law and Ethics for Peer Professionals
This training addresses effective strategies for assisting Peer Support Specialists in navigating legal and ethical issues associated with the delivery of mental health services. The discussion will include ethical decision-making considerations that address common field and service dilemmas that present. A review of standard practices appropriate boundaries and behaviors relevant to working in a treatment team are also covered. Lastly, the training incorporates peer relationship understandings (within legal and ethical contexts) which supports protecting, respecting, and empowering mental health consumers to meet their recovery goals. In FY 2022/2023, three trainings have been provided and a total of 151 Peer Support Specialists have completed this training.

e. Recovery Oriented Tools for Trauma-Informed Services
The best practices for care in the mental health setting should include an awareness of any potential trauma experienced by clients. The use of the recovery model as a foundational standard provides a strength perspective that enhances resiliency. This training will provide a foundation for recognizing trauma and practical examples of incorporating resiliency-based recovery model strategies to avoid re-traumatization. Topics include elements in identifying the intensity of the trauma, principles of the recovery model, and self-help strategies that impact perceptions of trauma. Additionally, this training will discuss how culture, family systems, and

building coping strategies might enhance resiliency in mental health service delivery. In FY 2022/2023, two trainings have been provided and a total of 66 Peer Support Specialists have completed this training.

f. Intentional Peer Support Core Training

It's an innovative practice that has been developed by and for people with shared mental health experiences that focuses on building and growing connected mutual relationships. In this interactive training, participants learn the principles of IPS, examine and challenge assumptions about how we have come to know what we know, and explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices and has been widely used as foundational training for people working in both traditional and alternative mental health settings. In FY 2022/2023, 29 Peer Support Specialists completed the IPS Core Training.

g. Intentional Peer Support (IPS) Advanced Training

This online Advanced Training supports the IPS practice by enacting the principles and tasks using real-life scenarios, heightening self-reflection, enhancing ways of building mutual connections, and sustaining the practice. Participants will learn co-reflection which is a vital practice where people regularly come together to reflect on their relationships using the IPS framework. This includes an opportunity to examine relationships, look at assumptions, and sustain the tasks and principles. This training will also focus on using the crisis to connect, maintain mutuality, and create a culture of healing. Working through challenging situations, participants will explore what it means to be trauma-informed, how to navigate conflict and develop flexible boundaries, and how to implement proactive crisis planning and prepare for evaluation. In FY 2022/2023, 8 Peer Support Specialists completed the IPS Advanced Training.

h. Online Wellness Recovery Action Plan (WRAP)

This training is an introduction to WRAP® and how to use it to increase personal wellness and improve quality of life. The training is highly interactive and encourages participation and sharing from all present. It also lays a broad foundation for building and supporting a skilled peer workforce. Participants will learn to apply the Key Concepts of Recovery and use tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. The history, foundation, and structures of WRAP® will be discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training. During FY 2022/2023, we provided two online WRAP Seminars I. A total of 14 participants have completed this training.

i. Wellness Recovery Action Plan (WRAP) Facilitator Training

This training equips participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provides an experiential learning environment based on mutuality and self-determination. Participants are expected to join in interactive learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants will be able to lead WRAP® groups,

work with others to develop their own WRAP®, and give presentations on mental health recovery-related issues to groups or organizations. Lastly, participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. One WRAP Facilitator Training has been provided in FY 2022/2023 and a total of 12 participants have completed this training. They are now able to facilitate the WRAP groups for the department programs.

j. Question, Persuade, Refer (QPR)
QPR is designed to inform non-clinical professionals to manage situations in which individuals may be at risk of suicide. QPR aims to provide strategies to engage suicidal individuals in distress, provide hope, and refer to those who can formally assess and intervene. This training targets employees providing Peer and parent support services, who are working/in contact with populations at risk for suicide among all age groups. Topics addressed in the training include suicide facts/research data, risk factors/protective factors, and teaching "gatekeepers" interventions using three basic suicide intervention skills: question, persuade, and refer. The training also incorporates a PowerPoint presentation, audio/visual material, and interactive activities which support the enhancement of knowledge and skills important to the work/contact with populations with suicide risks. In FY 2022/2023, three trainings have been provided and a total of 66 Peer Support Specialists have completed this training.

Innovation (INN)

Status	☐ New	☒ Continuing	☐ Modified	☒ Discontinued
Priority Population	☒ Children Ages 0 - 17	☒ Transition Age Youth (TAY) Ages 16 - 24	☒ Adult Ages 24 - 59	☒ Older Adult Ages 60+
Programs for FY 2022-23				
• INN4: Transcranial Magnetic Stimulation (TMS) • INN7: Therapeutic Transportation (TT) • INN8: Early Psychosis Learning Healthcare Network • Hollywood 2.0				
Programs Continuing/Starting in FY 2024-25				
• Hollywood Mental Health Cooperative (formally known as Hollywood 2.0 project) • Children's Community Care Village • Interim Housing Multidisciplinary Assessment & Treatment Teams • INN7: Therapeutic Transportation (TT) • INN8: Early Psychosis Learning Healthcare Network				

FY 2022-23 ■ INNOVATION Data and Outcomes

A. INN 4: TRANSCRANIAL MAGNETIC STIMULATION (TMS)

Table 59. Unique Clients Served and Average Cost per Client

Number of Unique Clients Served for FY 2022-23[1]	Average Cost Per Client
91	$3,575

[1]Cost is based on Mode 15 services, not inclusive of community outreach ser-vices or client supportive services expenditures.

Innovation Project Final Report
Innovation 4: Mobile Transcranial Magnetic Stimulation (TMS)

Brief Summary of the Priority Issue and Design of Project

Los Angeles County Department of Mental Health (LACDMH) implemented Mobile Transcranial Magnetic Stimulation (TMS) as the Innovation 4 project as of May 2019. TMS is FDA approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in clients with depression. The client reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed on the skull directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or

suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the client hears a clicking sound and feels a tapping sensation on the head. The client can go back to their normal activities immediately after treatment. Treatment sessions can last between 3-45 minutes and services are typically administered once per day for 5 consecutive days per week for 4-8 weeks.

In April 2018, LACDMH was approved to implement a Mobile TMS program in a van outfitted with the technology, delivered to fully consenting clients receiving treatment in adult outpatient programs. The target population includes individuals receiving outpatient services that have depression as a major part of their psychiatric symptoms and *one or more of the following*:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or
- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- History of response to TMS in a previous depressive episode; or
- A history of response to ECT in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

Because of the nature of the TMS treatment, individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers) are excluded.

The goals of the INN 4 Mobile TMS Project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Increase the quality of life of clients with histories of poorly treated depression.

Overall, the primary purpose of this Innovation project is to improve the quality of mental health services and achieve greater outcomes by providing new and effective treatment to clients with chronic and severe mental illness. This project seeks to introduce a new approach or an approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

Progress of Implementation over the course of the Project, through June 30, 2023:

Provision of service for this project began on May 30, 2019, after obtaining a mobile TMS unit. The mobile TMS unit consists of a customized van with modifications that allow a small treatment team to deliver TMS services within it. Clients of directly operated LACDMH clinics are referred to the TMS program by their outpatient providers (psychiatrists or clinicians). After receiving referrals, clients have an in-person consultation with the TMS program director (Marc Heiser, MD, PhD)

during which their symptoms, treatment history, and medical history are reviewed, and a safety screening form and initial symptom rating scales are completed. The treatment is explained and demonstrated for the clients and clients are given the opportunity to ask any questions. If they are interested and the treatment is deemed appropriate, an informed consent form is completed, and they are scheduled for their initial treatment.

Until March 13, 2020, clients were being referred and receiving daily (Monday-Friday) treatments within the mobile TMS unit at one location, the Harbor UCLA Outpatient Psychiatry Clinic. While the TMS unit has been at one location, the program has received referrals and treated clients from six LACDMH clinics located throughout LA County (including Service Areas 2, 3, 5 and 8).

INN 4 Mobile TMS services were put on hold as of March 14, 2020, due to the COVID-19 pandemic. Due to the intensive treatment schedule that TMS services require (5 days per week for approximately 4-6 weeks), in general, clients sometimes have difficulty adjusting to the change and experience a sudden worsening of depressive symptoms. Therefore, TMS staff completed phone check-ins with TMS clients as soon as was possible to assess how clients were coping with the transition and continued to conduct phone check-ins 1-2 times per week while clients were not receiving TMS services, to the extent possible. PHQ-9 scores were also completed over the phone weekly with each client while they were not receiving TMS services in order to track depressive symptomology. This information was used to monitor clients and determine the need for a client to return for TMS treatments with a decreased frequency (provided 1-2 times per week) until TMS services were back up to scale.

In November 2020, TMS services restarted once weekly treatment for clients who had been receiving treatment prior to COVID-19 and who were struggling with worsening mood symptoms. By February 2021, TMS services were being provided to current clients 5 days per week and the TMS team began treating new clients. TMS services are currently being provided five days per week. In addition, due to the small size of interior space of the Mobile TMS van and concern for client and staff safety during COVID-19 pandemic, the TMS device was moved from the van into an office space at UCLA Harbor in Torrance in February of 2021. As of June 2023, TMS services continue to be administered 5 days a week and take place inside a designated office space at UCLA Harbor in Torrance.

Number of clients served:

As of **June 30, 2023,** the program had received **195** referrals. Between May 1, 2019, and June 30, 2023, **153** client consultations/initial evaluations were completed. A total of **76** of these clients completed a full TMS treatment course. Common reasons for not completing a full TMS treatment include a disruption due to COIVD-19, medical issues (unrelated to TMS), need for a higher level of care, difficulty with transportation, and perceived lack of efficacy.

Below is a summary of the demographic information on the **76** clients who completed a full treatment course of TMS as of **June 30, 2023**:

- The majority were adults (ages 26-59) 76%, while 19% were older adults (60 years or older) and 5% were transitional age youth (ages 15-25). In this sample, the 4 transitional age youth were over 18 years of age.
- The majority identified as male (55%) and 45% identified as female.
- The majority identified as Non-Hispanic/Latino (51%), while 28% identified as Hispanic/Latino and for 21% of the clients, the ethnicity was unknown.
- 25% of clients identified their race as White and 9% identified as Mexican. Other races included Asian Native (1%), Black/African American (5%), Cambodian (1%), Central/South American (3%), Chinese (1%) Korean (1%), and Vietnamese (1%). 11% of clients were of another race and the race of 42% of clients was unknown.
- The majority of clients stated that their preferred language was English (76%). Other preferred languages included Spanish (12%), Farsi (3%), Cambodian (1%), Vietnamese (1%).

<u>Outcome data collected and analysis of impact</u>

The Overarching Learning Questions for this project include the following:

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

Evaluation methodology:

In order to assess the impact of TMS, depression outcome measures are administered at the beginning of treatment and weekly throughout the course of treatment. Measures include the following: Quick Inventory of Depressive Symptoms (QIDS-SR-16, client rated), the Hamilton Depression Rating Scale (HAMD-17, clinician rated), and the Patient Health Questionnaire (PHQ-9, client rated). Client satisfaction with TMS services is also assessed at the end of each session, utilizing a verbal check in, and using a Client Satisfaction Survey at the end of treatment. Additionally, the providers in the client's treatment team are asked to complete a brief survey to assess their impression on the impact of TMS services in the client's overall recovery and functioning at the end of treatment. These assessment tools enable clinicians to track improvements in depressive symptoms and functional outcomes that, in turn, are used to judge the efficacy of this program.

Summary of Project Outcome data:

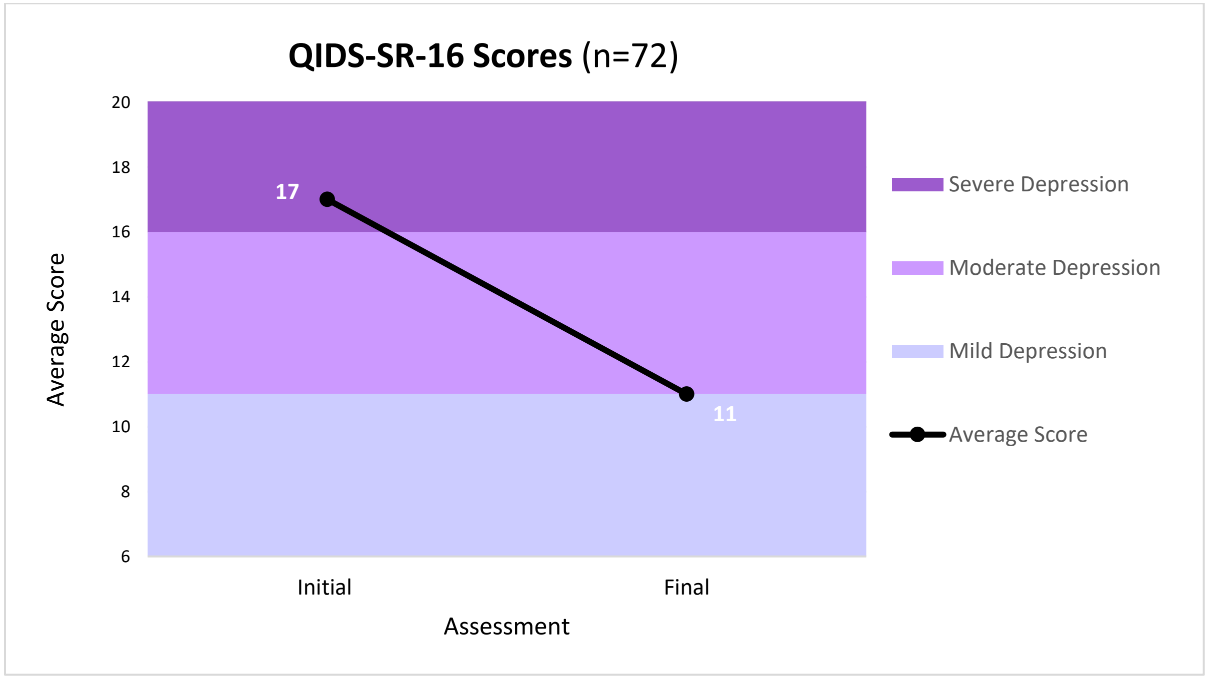
Below are the average initial scores and final scores for each of the three depression measures (QIDS-SR-16, PHQ-9, and HAMD-17) for clients who completed a full TMS treatment course between May 1, 2019, and June 30, 2023. Data included is for clients who received at least two treatments of TMS and completed the respective measure at least twice. There were no variations in outcomes based on demographics of participants.

Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR-16)

The QIDS-SR-16 is a 16-item self-report measure of depressive symptom severity derived from the 30-item Inventory of Depressive Symptomatology (IDS). There are nine depression symptoms measured across the 16 items (sleep, mood, appetite/weight, concentration, view of self, suicidal ideation, interest, fatigue, and psychomotor). Scores 1-5 indicate no depression; scores of 6-10 indicate mild depression; scores of 11-15 indicate moderate depression; scores of 16-20 indicate severe depression; scores 21-27 indicate very severe depression.

For the clients who received TMS treatment during this period:

- The average initial QIDS-SR-16 score was 17, which indicates severe depression. At the end of treatment, the average final QIDS-SR-16 score was 11, which indicates moderate depression. **There was an average change in score of 6 points (35% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 15 clients (**21%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 20 clients had an initial score that indicated very severe depression (score of 21 or more). For **65**% of these clients, depressive symptoms improved (scores of 20 or less) by the end of the course of TMS treatment.



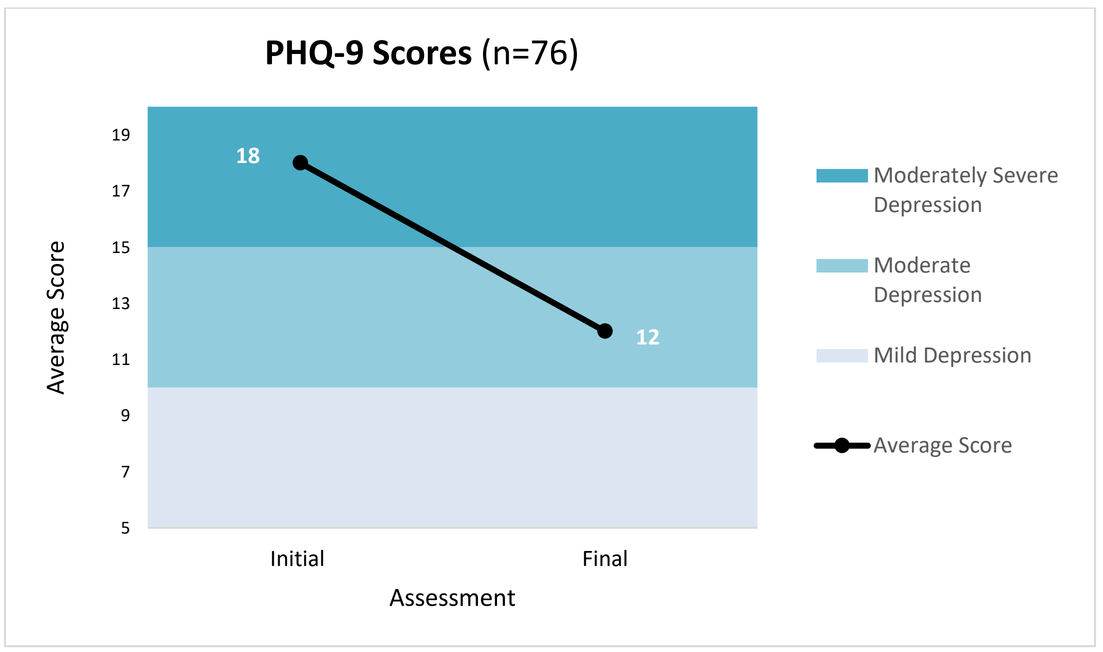
Graph 1. Summary of Average QIDS-SR-16 Scores for Mobile TMS clients.

Patient Health Questionnaire (PHQ-9)

The PHQ-9 is a concise, self-administered screening tool for assessing depression. It incorporates DSM-IV depression criteria with other leading major depressive symptoms into a brief self-report instrument that is commonly used for screening and diagnosis, as well as selecting and monitoring treatment. Scores of 0-4 indicate minimal depression; scores of 5-9 indicate mild depression; scores of 10-14 indicate moderate depression; scores of 15-19 indicate moderately severe depression; and scores 20-27 indicate severe depression.

For the clients who received TMS treatment during this period:

- The average initial PHQ-9 score was 18, which indicates moderately severe depression. At the end of treatment, the average final PHQ-9 score was 12, which indicates moderate depression. **There was an average change in score of 6 points (33% decrease), which indicates that there was an improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 11 clients (**14%**) of clients met criteria for remission (no depressive symptoms) at the end of treatment.
- 36 clients had an initial score that indicated moderately severe depression (score of 20 or above). For **69%** of these clients, depressive symptoms improved (scores less than 20) by the end of the course of TMS treatment.



Graph 2. Summary of Average PHQ-9 Scores for Mobile TMS clients.

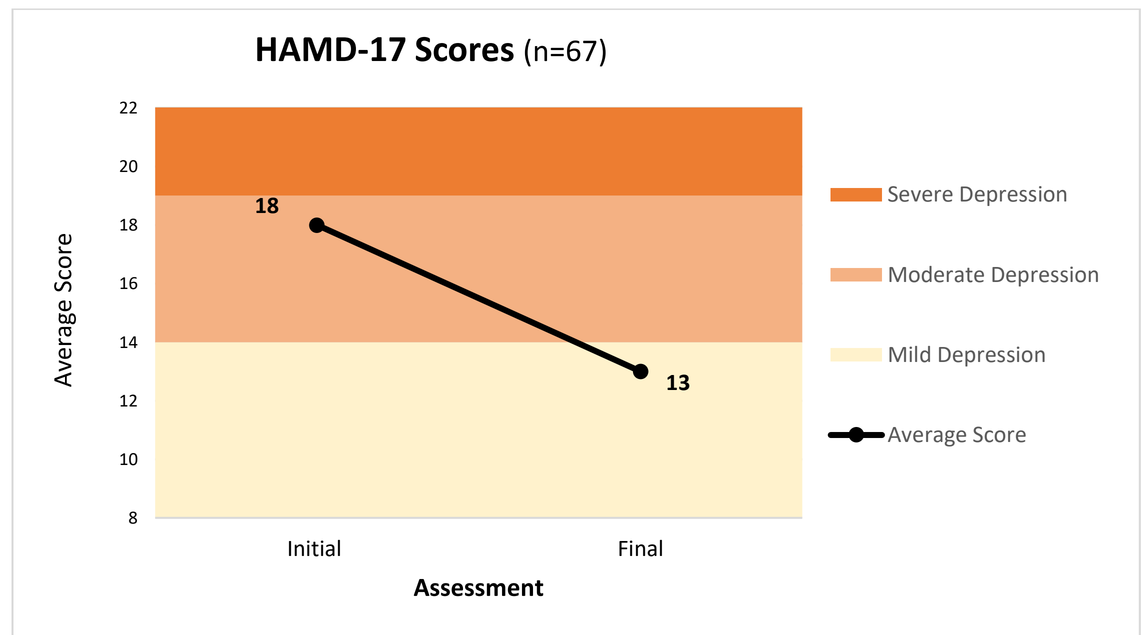
Hamilton Depression Rating Scale (HAMD-17)

The HAMD-17 is one of the longest standing and most widely used measures of depression in research and clinical practice. The HAMD-17 is a clinician completed measure that includes 17-items. Total scores of 0-7 indicate no depression; scores of 8-13 indicate mild depression, scores

of 14-18 indicate moderate depression, scores of 19-22 indicate severe depression, and scores 23-50 indicate very severe depression.

For the clients who received TMS treatment during this period:

- The average initial HAMD-17 score was 18 which indicates moderate depression. At the end of treatment, the average final HAMD-17 score was 13, which indicates mild depression. **There was an average change in score of 5 points (28% decrease), which indicates that there was an overall improvement in depressive symptoms at the end of the course of TMS treatment.**
- Of those who completed a full course of TMS treatment, 17 clients (**26%** of clients) met criteria for remission (no depressive symptoms) at the end of treatment.
- 4 clients had an initial score that indicated severe depression (scores of 25 and above). For **75**% of these clients, depressive symptoms improved (scores of 24 and below) by the end of the course of TMS treatment.



Graph 3. Summary of Average HAMD-17 Scores for Mobile TMS clients.

TMS Client Satisfaction Survey

The TMS Client Satisfaction Survey was developed by LACDMH and was completed by clients who completed a full course of TMS treatment. The Client Satisfaction Survey includes 11 items that assess the client's satisfaction with various aspects of TMS treatment and the client's perceived impact of TMS services on the client's overall well-being and functioning.

Overall Satisfaction [Chart 1]:

- Overall, a majority (**86%**) of clients who completed a CSS were "Very Satisfied" or "Satisfied" with their TMS experience. *Note: Only 2 clients out of 76 were Unsatisfied with their TMS experience, both of whom were non-responsive to treatment.*

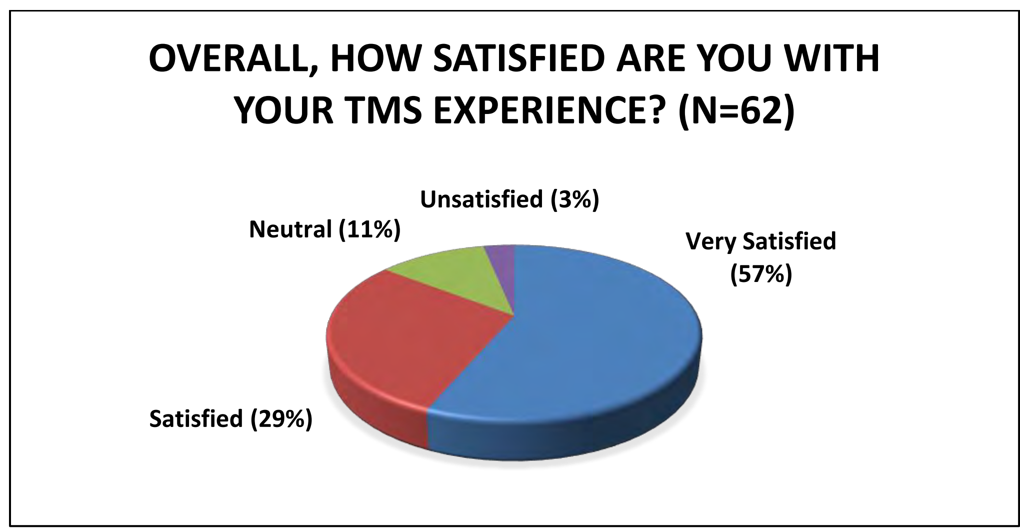


Chart 1. Overall Client Satisfaction with Mobile TMS services

Client TMS Treatment Experience [Chart 2]:

- A majority of clients who completed a CSS (**94%**) “Strongly Agreed” or “Agreed” that they understood what to expect before starting TMS treatment.
- All clients (**98%**) “Strongly Agreed” or “Agreed” that they felt comfortable while receiving TMS services.
- A majority of clients (**83%**) “Strongly Agreed” or “Agreed” that TMS services have been an important part of their treatment and that TMS services have improved their participation in their treatment.
- Finally, a majority of clients (**92%**) “Strongly Agreed” or “Agreed” that they would return for more TMS treatments in the future if recommended by their clinician and would recommend TMS to others if they are experiencing depression.

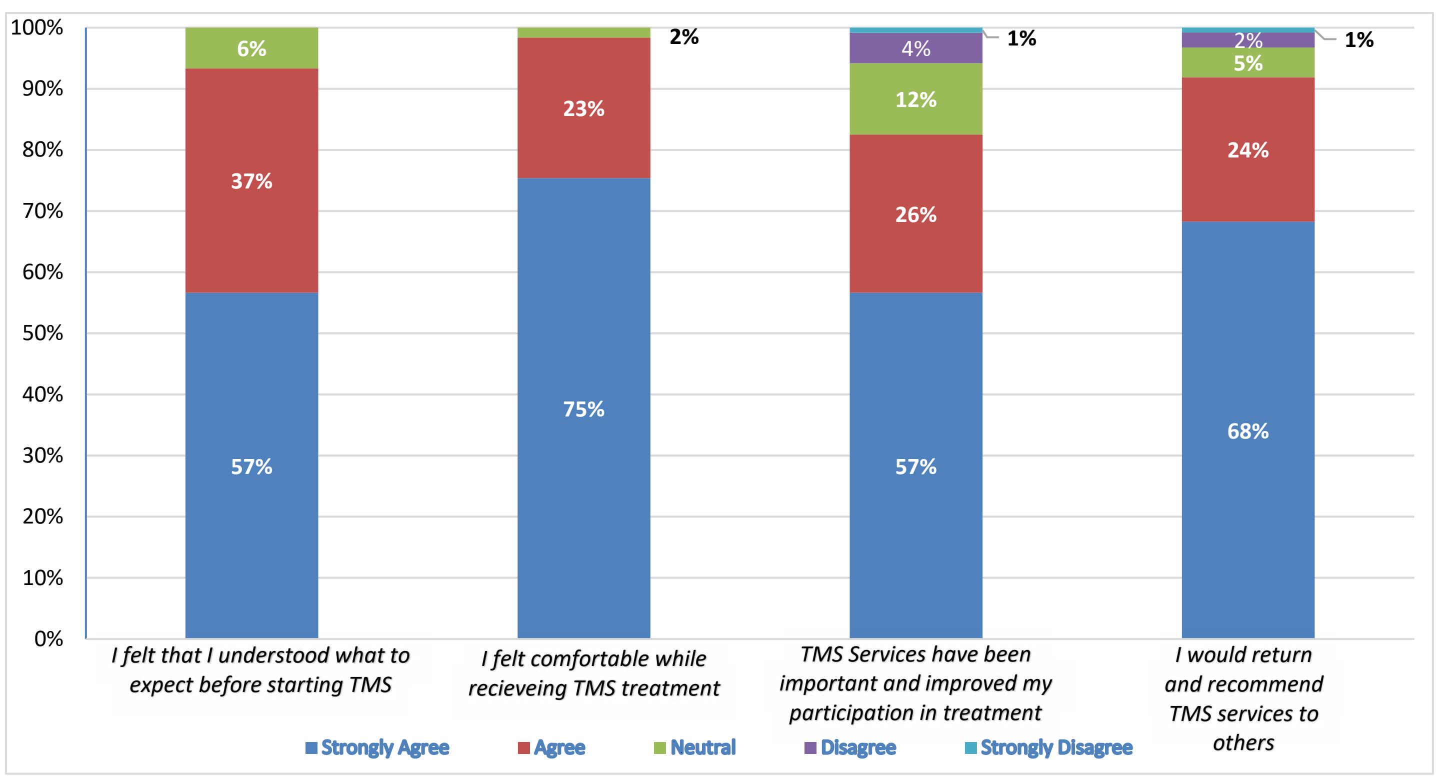


Chart 2. Client Experience with Mobile TMS Treatment Services

Level of Discomfort/Pain during and after TMS Treatment [Chart 3]:

Clients were asked to rate their discomfort/pain during TMS treatments and after TMS treatments on a scale of 1-10, with 1 corresponding to "No Pain" and a score of 10 corresponding to "Very Painful".

- On average, respondents felt mild discomfort/pain during TMS treatments (*2 out of 10*) and less mild discomfort/pain after TMS treatments (*1 out of 10*).
- Clients most often described discomfort/pain as "annoying" and the discomfort usually decreased over the course of treatment and resolved after treatment.

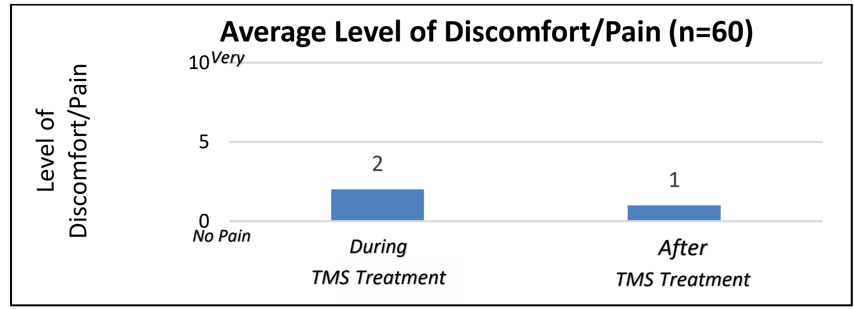


Chart 3. Average Level of Discomfort/Pain During and After Mobile TMS Treatments

Perceived Benefits of TMS Services [Chart 4]:

Clients were asked how they felt they benefitted from participating in TMS services. All answers are listed below and the most endorsed benefits are shown in Chart 4.

- **58%** of clients (a majority of clients) stated that they that they feel happier.
- **48%** of clients stated that they feel less worried/anxious and have more motivation to engage in meaningful activities.
- **47%** of clients stated that they are less frustrated.
- **45%** of clients stated that that that they are able to focus better.
- **43%** of clients stated that they are sleeping better.
- **42%** of clients stated that they feel more relaxed.
- **38%** of clients stated that they have an increased abilty to do the things that they want to do.
- **33%** of clients stated that that they are getting along better with family/friends and that they have more energy.
- **32%** of clients stated that they have more contact with family/friends and that they have more self-confidence.
- **23%** of clients stated that they feel less body pain.
- **20%** of clients stated that they are eating better.
- **15%** of clients stated that they feel more connected to their community.

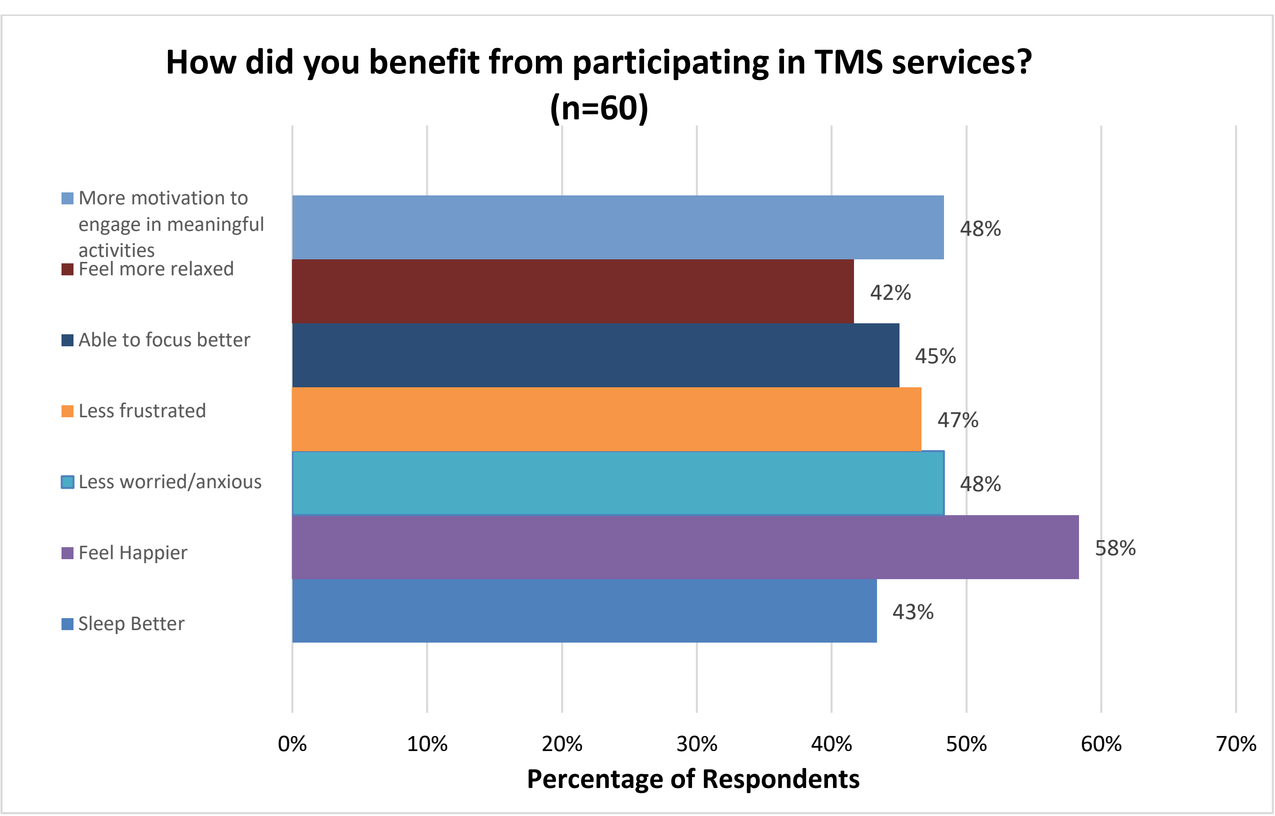


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Chart 4. Most Common Perceived Benefits of TMS Services by Clients After Mobile TMS Treatment.

Client Feedback

Upon treatment completion, clients were asked to share any additional feedback that they may have regarding their experience with TMS services through client exit interviews and on the Client Satisfaction Survey. Some of their feedback is listed below:

General Comments

- “[I] finally feel hope.”
- “I think that TMS helps to reduce my headache. My brain is more clearer [sic] than before. My mood is more happier [sic] because of reducing headache.”
- “TMS was very helpful and the Dr. was caring and attentive, though I may have a little more anxiety, the depression + smeared [sic] thoughts are much better.” (not sure whether to include this)
- "TMS has been extremely beneficial. My depression has at least been cut in half …Thank you so much."
- "[I] have better clarity and less feelings of shame guilt."
- "No longer crying and suicidal"
- "A lot less depressed. Feel more ok."
- "Slightly more conversational. A bit more improvement with depression."
- “Some general improvement in motivation, enthusiasm, not close to remission however”

Client Testimonials

“For over a year I have benefitted from Transcranial Magnetic Therapy at Harbor-UCLA. I suffer from Major Depressive Disorder and have been a county mental health patient for years. Medications have worked intermittently but I have not had a sustained recovery where I can manage my mood consistently. TMS has made things better. Since starting treatment

“I have not had completely immobilizing depression. I have been depressed but I bounce back sooner. I have a more confident outlook. I feel that I have an underlying sense of support. For me, this is big progress. I was fearful of the treatment at first because I was unfamiliar it and it initially hurt. This quickly changed because Dr. Heiser and his team helped me feel calm and safe. Despite the unusual treatment in a van, they made me feel comfortable and I even once fell asleep once during treatment. The opportunity to get this treatment from the county facility was a surprise. I had thought it was only available to wealthy patients. In this way the TMS program works to mitigate health disparities. I hope it can expand.”

“I have been undergoing TMS for several months. It’s been a Godsend me. I had been going through constant suicidel [sic] thoughts for years, if not for the TMS I would have most likely followed through with them. Thanks to the TMS, Dr. Heiser and his team, I am still alive. It has given me hope to keep going. Hopefully this treatment can help other peopol [sic]. To me it is the rock of my treatment. Thank you 😊 ”

“I have had years of therapy and I have tried different medications for depression and they did not work like TMS did. I wish the whole world could get TMS. We would be better to each other if we could. Thank you, Violet, Desta, Desiree, and Dr. Heiser & Thank you to the TMS machine.”

“Before I started I was so depressed to the point of daily suicidal ideation. Felt helpless, worthless, undeserving, and didn't understand why I even existed. It was daily torture to the extreme of suicide attempts and multiple hospitalizations. Now, on this day of leaving final treatment, I feel ALIVE! I feel like living. I'm very seldom depressed and haven't had a suicidal thought in 4 months. That is so new for me. This TMS has helped me more than words can say. Thank you 😌”

"I am extremely thankful for being informed of considered for and accepted as a patient whom can benefit from TMS treatments. I consider myself blessed by the kindness, acceptance, professionalism, care, attention and support that I have received from your wonderful DMH staff.”

"I notice that even when I feel down I am still able to function at a higher level as far as getting tasks done. The initial wave of happiness I felt the first few weeks of treatment has dissipatted [sic] but I still feel it has had a positive effect for the entire treatment."

"I am truly grateful to have been able to have this treatment. While I still have issues with depression, anxiety and pain, the TMS treatment has made a treatment has made a tremendous difference. The physicians and all of the clinicians involved in treatment have been wonderful. Thank you all very much."

Below are comments from clients who were not responsive to TMS treatment (approximately 10% of clients). It is interesting to note that of the clients who did not respond to TMS treatment, most still felt that TMS is a valuable service and that they had a positive experience overall:

- “Although I did not derive perceivable therapeutic benefit from TMS, I am glad I had the opportunity to try the treatment which has helped clarify my future treatment. I am very highly satisfied with the professionalism, helpfulness, and friendly attitude for [the] client.”
- “Although treatment did not work for me, TMS was pretty awesome, and I would consider trying it again if recommended in the future.”
- “…I’ve improved in some ways but I haven’t had the life-altering experience I had some hope for. I’m extremely grated to the county + the team here for giving me the opportunity and I would continue treatment [if] was recommended because I still hold out hope. “
- “I think it’s a really good program. I feel like I didn’t benefit as much as I could have on my part…”
- “Everyone I interacted with was very kind. I am very satisfied with the level of service that I received. The reason for my disagree/neutral answers are because the TMS treatments unfortunately did not help with my depression or my chronic pain.”
- “Because I have been going through some very awful events, my emotions/feelings may be skewed a bit [negatively]. Although still very sad (because of those events) I don’t feel “grey” or have a “hazy” feeling anymore and can experience the actual feeling I’m having.”
- “The treatment experience was great. It had varied effect but was worth it to try.”

- “For me the treatment’s effect were ambiguous…but the overall process was friendly and calm.”

TMS Treatment Team Survey

A survey was provided to each of the client’s treatment team of providers at the end of treatment. The providers were asked to rate their client’s improvement in mood, behavior, overall functioning, and progress made toward treatment goals as a result of TMS services. A total of **44** surveys (for **37** clients) were completed by treatment team staff (27 Psychiatrists/Medical Providers, 7 Therapists, and 4 Case Managers/Community Heatlh Workers).

- A majority (**62%**) of providers “Strongly Agreed” or “Agreed” that their client demonstrated improvements in mood, behavior, and overall functioning (family, community, occupational) as a result of TMS services **[Chart 5].**
- A majority of providers (**56%**) “Strongly Agreed” or “Agreed” that their client made progress towards her/his treatment goals as a result of TMS Services **[Chart 6].**
- A majority (**88%**) of providers “Strongly Agreed” or “Agreed” that they would refer future clients for TMS services. **[Chart 7].** *Note: Not surprisingly, providers whose clients didn’t respond to TMS or relapsed after TMS treatment gave “Neutral”, “Disagree”, or “Strongly Disagree” responses on the survey (This was for about 8 of the 76 clients served). However, it is interesting to note that a majority of those same providers who stated that their clients did not benefit from TMS, still stated that would refer future clients for TMS.*

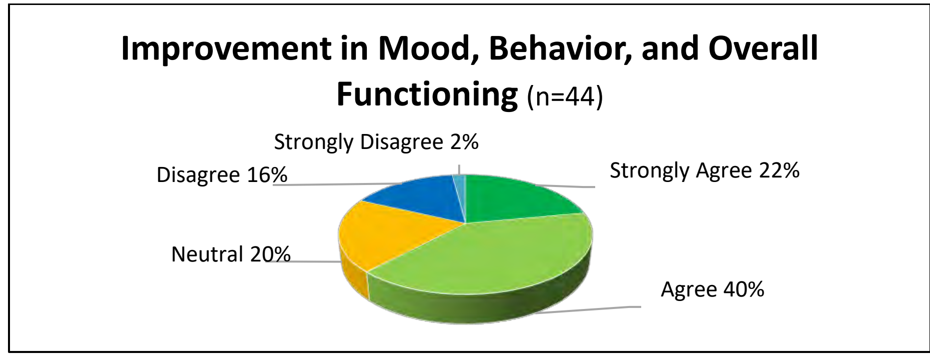


Chart 5. Provider Perception on the Impact of TMS Services on Client’s Mood, Behavior, and Overall Functioning

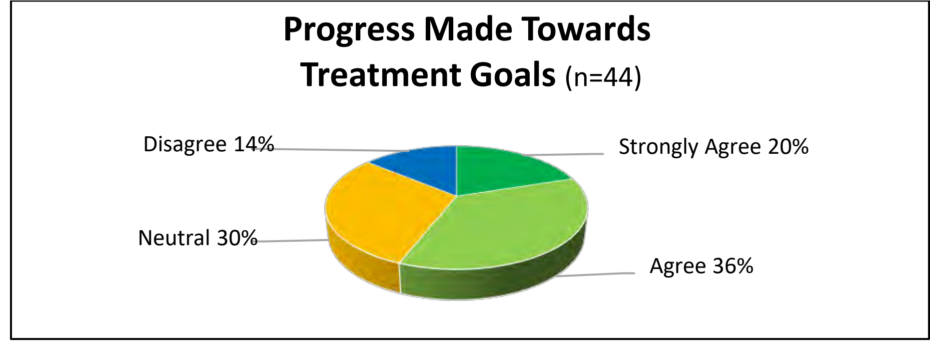


Chart 6. Provider Perception on the Impact of TMS Services on Client’s Progress Toward Treatment Goals

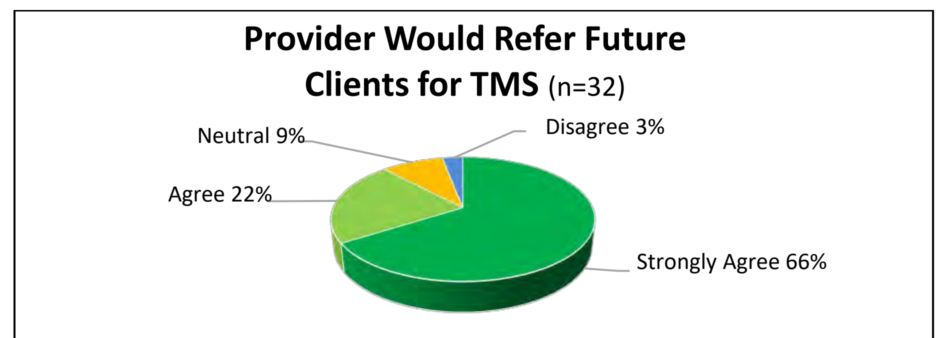


Chart 7. Likelihood of Provider Referral to TMS Services for Future Clients

Additional feedback from TMT treatment team providers:

Impact on their client's mental health symptoms

- "Patient reports that it was beneficial for her mood! That's a big deal for her, as medications have not been particularly helpful for her..." (Psychiatrist)
- "There has been a significant change in her symptoms (particularly her suicidal thought and mood) ..." (Psychiatrist)
- "Client was more open to the therapeutic process after receiving services. Client reported that services were very helpful in being able to lift the feelings of severe depression." (Therapist)
- "Eliminated suicidal ideation. Reduced negative thinking/rumination. Increased hope." (Therapist)
- "Client reported improved mood that she has not experienced in a while." (Case Manager)
- "In addition to improved mood, she showed reduced anxiety and worry related to multiple facets of her life." (Psychiatrist)
- "Client appeared more engaged at his last appointment and... he noted overall improvement with mood and focus." (Nurse)
- "Patient has been significantly less depressed and has been functioning well. He continues to receive medication support services." (Psychiatrist)
- "Client reported improved mood and brighter affect." (Psychiatrist)
- "The patient's anxiety, depression, psychotic symptoms, and concentration improved after the treatment with TMS compared to his baseline. I'm very grateful for your assistance in the patient's care." (Psychiatrist)

Impact on their client's physical health symptoms

- "His headaches and sleep improved significantly." (Psychiatrist)
- "The client had improvement in ability to function despite pain and chronic headaches." (Psychiatrist)

Impact on their client's social functioning

- "After the termination of TMS, client reported regression of his mood. He was able to make it to TMS every day and that was the biggest progress." (Case Manager)
- "I think my patient benefitted by having a routine and a schedule, which forced him to get up in the morning, get out of the house several times per week." (Psychiatrist)

- “The notable change that seems to have remained since TMS treatment is that the client is more socially engaged and involved with community activities.” (Case Manager)
- “Client comes to dance group and MD's appointments regularly. He is noticed to be more interactive and sociable.” (Case Manager)
- “[The client] …was also proud of accomplishment of going to TMS, it was behavioral activation, and it was motivating for her.” (Psychiatrist)
- “The supportive structure and daily visits helped this client through some incredibly stressful times that likely would have resulted in more crises without the daily interventions.” (Therapist)
- “Client was initially very optimistic about TMS services, and his mood seemed to improve. However, over time, he seemed disappointed by the impact of TMS, and his depressive symptoms seemed to regress. The notable change that seems to have remained since TMS treatment is that the client is more socially engaged and involved with community activities.” (Case Manager)

Impact of TMS providers their clients

- “The TMS team is always responsive and gets to know our mutual patients well. The TMS contacted me to indicate that the patient was interested in getting support around the loss of his wife during the pandemic. I was able to refer him to a [sic] Spanish language resources for grief counseling.” (Psychiatrist)
- “Patient was appreciative of the opportunity and enjoyed the experience...” (Psychiatrist)
- “…pt liked the experience of TMS, having a routine, speaking to the friendly nurses every day…” (Psychiatrist)

<u>**Project Summary**</u>

What activities or elements of the Innovative Project contributed to successful outcomes:

- The biggest factor that contributed to successful outcomes for this project is that the TMS machine was moved indoors, from the mobile unit to inside the clinic. This resolved issues related to health safety, space, power, and privacy. Client flow was smoother, and the treatment was better experience for both TMS providers and clients.
- The ability of the TMS treatment team to take time to explain exactly what TMS services are and what to expect seems to have contributed to positive outcomes. Especially since this TMS treatment is new to LACDMH population and there is often misinformation that can be a barrier to access, such as that TMS is the same as ECT. 93% of clients felt that they were clear on what to expect from TMS services, based on the client satisfaction surveys.
- Based on client feedback and client satisfaction surveys, one of the main elements of this Innovative project that contributed to successful outcomes included having knowledgeable, kind, and personable staff who made themselves available to address any questions or concerns about TMS services. It appeared that having the regular, often daily, contact with providers to address concerns and provide support, in and of itself, appears to have made a positive impact on TMS clients and increased treatment adherence.

Cultural Competency of Evaluation:

- There was a need to translate the self-administered measures to meet the linguistic needs of some TMS clients. The QIDS-SR-16 was translated into Spanish, which was the most common preferred language after English by TMS clients. Also, translated versions of the PHQ-9 were made available in all of the LACDMH threshold languages.
- In addition to having Spanish speaking staff, interpreters were utilized to facilitate communication between the client and TMS team when needed.
- The approach to TMS treatment in session was adjusted based on the cultural and familial needs of the clients, in order to create a comfortable and welcoming space, given that this was often an unfamiliar treatment setting for clients. For example, if a client stated that it was important for them that their family members be allowed to stay with them during a treatment, they were allowed to do so.

How stakeholders contributed to the evaluation:

- To help guide program and service implementation decisions, feedback from TMS clients was requested on an ongoing basis. This was done during and after TMS treatment and adjustments were made accordingly in order to improve TMS services throughout the course of the project.
- Stakeholders were also regularly updated on the outcomes and progress of the project via the MSHA Annual reports and given the opportunity to provide feedback during the public comment periods.

Whether and how the County will continue the Innovative Project:

The outcomes of this project have demonstrated that TMS services are effective and able to decrease depressive symptoms for the LACDMH population, when provided in conjunction with psychiatric, therapeutic, and supportive services. Over the course of the project, there has been an increase in demand TMS services, resulting in an increase in referrals and a longer waitlist. Therefore, it is recommended that TMS services continue to be provided to our clients.

Having only one machine has limited the number of clients that could receive services at one time. Also, given that TMS services require daily treatments, the fact that TMS services were only available in one location, transportation was a common barrier to access TMS services for clients. In an effort to make TMS services more accessible, it is important that TMS services be expanded and become available to our clients in every Service Area. To start this expansion, 7 additional TMS machines have been procured by LACDMH and there will be one machine in one Directly Operated clinic in each Service Area.

After the end of this Innovation project, LACDMH will continue providing TMS services on an ongoing basis as part of Client Supportive Services (CSS) services under the MHSA plan. TMS services were not reimbusable by MediCal at the start of this project but as of July 2023, they are reimbursable by MediCal in California. Therefore, LACDMH providers can bill MediCal for TMS services.

Intended outcomes and Lessons Learned:

This project achieved its intended outcomes. The project outcomes over the past three years have consistently shown that TMS services are effective and able to decrease depressive symptoms for the LACDMH population, when provided in conjunction with psychiatric, therpeutic, and supportive services. Some lessons learned are listed below:

- We learned that TMS services need to be provided in a building rather than a mobile unit. TMS requires daily treatments for 4-6 weeks so going to clients' homes to provide TMS services was not logistically feasible. Even with the mobile unit being parked next to a clinic, there were issues with parking, power, privacy, and space that caused a disruption in services at times.
- We learned that LACDMH clients are able and willing to consistently participate in daily TMS treatments as long as transportation is not a barrier. TMS services require daily treatments so it was unclear if LACDMH clients would be able to adhere to the demanding regime initially, given how large LA County is.
- We learned that TMS services need to be better understood by the general public. TMS is often an unfamiliar approach to treatment for LACDMH clients, so time and care was spent by TMS staff to orient and educate patients on the services. While a majority of TMS clients felt that they were clear on what to expect from TMS services, the TMS team did receive feedback that a brochure would be helpful in providing a reference for the future and help with potentially increasing knowledge, awareness, and interest in TMS services.
- We learned that TMS services need to be better understood and utilized by LACMDH providers in order to allow more access to our clients. Dr. Heiser presented at Grand Rounds regularly to familiarize Psychiatrists with TMS services. This increased awareness and resulted in more referrals and interest. In fact, several Resident Psychiatrists were trained so they could oversee/conduct TMS treatments. These efforts to increase familiarity with TMS services for LACDMH providers should continue and be expanded to include the entire treatment team in order to keep our workforce up to date.

How the County disseminated the results of the Innovative Project to Stakeholders:

- Stakeholders were regularly updated on the progress of the project via the MSHA Annual reports and given the opportunity to provide feedback during the public comment periods.

Materials developed to communicate the success of the Innovative Project:

- Attached are the presentations conducted by Marc Heiser M.D., Ph.D., Clinical Lead for the INN 4 Mobile TMS Project. During the course of this 4-year project, Dr. Heiser presented about TMS and its impact at various mental health conferences to increase understanding and visibility of this service to the public, including Stakeholders.

B. INN 7: Therapeutic Transportation (TT)

TT program was partially implemented on January 30, 2022. The overall goals of the Pilot Therapeutic Transportation Project - INN 7 are to: (1) increase access and enhance the quality of mental health services to individual callers in crisis; (2) decompress EDs; (3) reduce the use of Los Angeles Fire Department (LAFD) resources for mental health responses; and (4) leverage partnerships to develop a community-driven approach toward improving outcomes for individuals experiencing a mental health crisis.

LACDMH has developed a collaborative with Los Angeles City (City) LAFD to implement INN 7. The City estimates tens of thousands of emergency calls per year to its police and fire dispatch centers that involve people suffering from a mental health crisis. LAFD Emergency Medical Technicians (EMTs)/paramedics do not have the training or experience to deal with mental health crises and in turn, need the support of LACDMH to provide a mental health field response operation.

Currently, LACDMH triages mental health crises through its ACCESS hotline and deploys the Psychiatric Mobile Emergency Response Team (PMRT). PMRT is staffed with licensed clinicians, who have legal authority per Welfare and Institutions Code Sections 5150 and 5585, to initiate applications for evaluation of involuntary detention of individuals determined to be at risk of harming themselves or others due to a mental health disorder. If transportation is necessary for an individual, PMRT staff utilize the ACCESS hotline to request an ambulance to transport the individual.

The purpose of this report is to provide data on Therapeutic Transportation Program (TTP) incidents from July 1, 2022, through June 30, 2023.

STATION #	SD	IMPLENTATION DATE	HOURS OF OPERATION	ADDRESS
4	1	01/30/22	24/7	450 East Temple Street, Los Angeles CA 90012
59	3	03/06/22	24/7	11505 W. Olympic Boulevard, Los Angeles, CA 90064
77	5	05/16/22	12/7	9224 Sunland Boulevard, Sun Valley, CA 91352
94	2	08/08/22	12/7	4470 Coliseum Street, Los Angeles, CA 90016
40	4	09/26/22	12/7	330 Ferry Street, Los Angeles, CA 90731

During this period, (TTP) responded to N = **2,275** incidents **1,608 (71%)** during the AM shifts (7AM-7:30PM) and **667 (29%)** during the PM shifts (7 PM- 7:30 AM). The table below displays the number of incidents by month and shift. Only station 4, and 94 have both an AM and a PM shift. The remaining stations only have AM shifts due to hiring challenges for this shift. Majority of calls **N = 235 (10.9%)** were during the month of April 2023, followed by June **N = 219 (9.6%)**

YEAR	MONTH	AM	PM	TOTAL	PERCENTAGE
2022	**Jul**	104	54	**158**	**6.9%**
	Aug	98	67	**165**	**7.3%**
	Sep	139	60	**199**	**8.7%**
	Oct	161	60	**221**	**9.7%**
	Nov	136	36	**172**	**7.6%**
	Dec	99	38	**137**	**6.0%**
2023	**Jan**	136	43	**179**	**7.9%**
	Feb	146	50	**196**	**8.6%**
	Mar	148	66	**214**	**9.4%**
	Apr	162	73	**235**	**10.3%**
	May	134	46	**180**	**7.9%**
	Jun	145	74	**219**	**9.6%**
TOTAL		**1,608**	**667**	**2,275**	**100.0%**
PERCENTAGE		**71%**	**29%**		

INCIDENTS BY STATION:

STATION #	INCIDENTS	PERCENTAGE
STATION 4	1,184	**52%**
STATION 40	69	**3%**
STATION 59	265	**12%**
STATION 77	229	**10%**
STATION 94	528	**23%**
TOTAL	**2,275**	**100%**

Station 4 was the busiest station during the reporting period, handling **52**% (N=1,184) of all incidents, followed by station 94 handing **23% (N=528)** of the calls. It may be due to the fact that both these stations have a PM shift.

INCIDENTS BY STATION AND DISPOSITION:

STATION #	5150	6000	CANCELLED IN ROUTE	CANCELLED ON SCENE DUE TO MEDICAL	DID NOT MEET LAFD CHECKLIST REQUIREMENTS	PHONE CONSULT	REFER	REFUSED SERVICES	VOLUNTARY	TOTAL
STATION 4	348	97	469	32	24	2	8	31	173	**1,184**
STATION 40	14	3	25	6	1			3	17	**69**
STATION 59	66	37	126	8	1		3	1	23	**265**
STATION 77	66	19	122	4	3		1	3	11	**229**
STATION 94	188	10	250	13	2			5	60	**528**

STATION #	5150	6000	CANCELLED IN ROUTE	CANCELLED ON SCENE DUE TO MEDICAL	DID NOT MEET LAFD CHECKLIST REQUIREMENTS	PHONE CONSULT	REFER	REFUSED SERVICES	VOLUNTARY	TOTAL
TOTAL	682	166	992	63	31	2	12	43	284	2,275
% DISPOSITION	30%	7%	44%	3%	1%	0%	1%	2%	12%	100%

30% (N=682) of all incidents were placed on an involuntary hold while **12% (N=284)** voluntarily were held and **7% (N= 166)** were 6000.

INCIDENTS BY STATION AND DESTINATION:

STATION #	UCC	HOSPITAL	CLINIC	EMERGENCY DEPARTMENT	OTHER FACILITY	LPS FACILITY	TOTAL
STATION 4	206	178	139	59	22	4	608
STATION 40	8	9	13	2	2		34
STATION 59	10	52	27	18	12	3	122
STATION 77	48	3	6	31	2	3	93
STATION 94	135	40	41	33	3		252
TOTAL	407	282	226	143	41	10	1,109
% DESTINATION	37%	25%	20%	13%	4%	1%	

37% (N = 407) of all incidents were transported to an urgent care center and **25% (N = 282)** were transported to a Hospital. 20% (N = 226) went to a clinic.

INCIDENTS BY STATION AND FACE TO FACE CONTACT:

STATION #	NO FACE TO FACE	FACE TO FACE	TOTAL	% FACE TO FACE
STATION 4	507	677	1,184	57%
STATION 40	28	41	69	59%
STATION 59	130	135	265	51%
STATION 77	124	105	229	46%
STATION 94	254	274	528	52%
TOTAL	1,043	1,232	2,275	54%
% FACE TO FACE	46%	54%	100%	

54% (N=1,232) of incidents that TT responded to have had a face-to-face contact. Station 40 had the most face-to-face contacts with **59%** of their total incidents followed by station 4 which had **57%.** TT had no face-to-face contact with **46% (N = 1,043)** of all calls. Of these incidents, **33% (N = 339)** had no face-to-face contact because the calls were cancelled in route.

INCIDENTS BY STATION AND TT TRANSPORT SERVICES:

STATION #	NOT TRANSPORTED	TRANSPORTED BY TT	TOTAL	% TRANSPORTED
STATION 4	586	600	1,184	**51%**
STATION 40	35	34	69	**49%**
STATION 59	144	121	265	**46%**
STATION 77	137	92	229	**40%**
STATION 94	280	248	528	**47%**
TOTAL	**1,182**	**1,095**	**2,275**	**48%**
% TRANSPORTED?	**52%**	**48%**	**100%**	

TT transported **48% (N=1,093)** of all the incidents they responded to. Station 4 transported **51%** of their incidents followed by station 40 at **49%**.

INCIDENTS BY STATION AND REASON IF NO TRANSPORT:

STATION #	# OF INCIDENTS	PERCENTAGE
TRANSPORTED BY TT	1,095	**48.1%**
CALL CANCELLED	1,049	**46.1%**
CLIENT REFUSED	49	**2.2%**
TRANSPORTED VIA AMBULANCE	44	**1.9%**
ON-SCENE TREATMENT/RESOLUTION	16	**0.7%**
OTHER	13	**0.6%**
CLIENT AWOLED	4	**0.2%**
LAW ENFORCEMENT DISENGAGED	4	**0.2%**
LEFT IN EMERGENCY DEPARTMENT	1	**0.0%**
TOTAL	**2,275**	**100%**

The table above displays the reasons TT incidents did not result in a transport.

This program has expanded to include the city of Santa Monica.

C. INN 8: EARLY PSYCHOSIS LEARNING HEALTHCARE NETWORK

The Department received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for this multi-county 5-year project on December 17, 2018 and DMH entered a contract with UC Davis to execute this project as of July 1, 2020 after initial approval by the Human Subjects Research Committee on April 23, 2020. The Early Psychosis Learning Healthcare Network (LHCN) allows counties who use a variety of Coordinated Specialty Care models to treat early psychosis to collect common outcome data. They can then use this outcome data to inform treatment and engage in cross-county learning.

Participation in this learning collaborative connects California counties with a national effort to promote evidence-based Coordinated Specialty Care models to effectively treat first episode

psychosis and to collect common outcome data. It is a unique California effort to join a national movement to reduce the duration of untreated psychosis and improve the outcomes and lives of individuals experiencing a first psychotic break. Los Angeles County has expanded its population to also include those who are identified as at clinical high risk for experiencing a first psychotic episode.

Beehive is a tablet- and web-based application developed by the UC Davis-led Learning Healthcare Network that is being used by programs to collect client and clinician-reported outcome data and help clinicians, clinic management and County administration visualize client outcome data to help inform treatment and track clinic and Countywide program outcomes. The goals of the Statewide Early Psychosis Evaluation and LHCN are to increase the quality of mental health services including measurable outcomes, and to introduce a mental health practice or approach that is new to the overall mental health system.

Additional funding by the National Institutes of Health (NIH) obtained by UC Davis has allowed the project to further expand to add additional sites across the State. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now "EPI-CAL." In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).
The Department's early psychosis coordinated specialty care model is the Portland Identification and Early Referral (PIER) program to identify and comprehensively treat individuals ages 12-25 who are at clinical high risk for psychosis (i.e., prodromal) or have experienced their first psychotic episode. Five (5) contractor teams have been trained in the PIER Model as of December 2019 and began community outreach and direct service in January 2020. As of October 2023, there are 94 clients enrolled at five (5) clinics across Los Angeles County.

Status of Implementation as of June 30, 2023:

Stakeholder Advisory Committee and Multi-County Quarterly Leadership Meetings
The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative from each participating EP program, and consumers and family members who have been, or are being served, by EP programs. Attendees receive updates and provide feedback on project elements biannually and collaborate on issues around Early Psychosis. Advisory Committee meetings during this reporting period were held on November 29, 2022, and June 6, 2023.

Key updates from the November 29, 2022, meeting were updates on current Beehive enrollment numbers and a presentation on Beehive clinical utility. Aggregate data was presented about Urgent Clinical Issues indicated in Beehive. There was study description of the Duration of Untreated Psychosis (DUP) and opportunities for future research opportunities through the larger nationwide EPINET. The June 6, 2023, meeting provided updates on Beehive and the DUP project. Discussion of EPI-CAL feasibility and preliminary results was made. There was a presentation on High Adverse Childhood Events (ACEs) in youth with early psychosis associated with housing instability and suicidal ideation. Additionally, there was a presentation on the importance of lived and living experience integration in early psychosis coordinated specialty care to foster a climate of recovery.

EP Program Fidelity Assessments
Each early psychosis clinic underwent a fidelity assessment using the First Episode Psychosis Services Fidelity Scale (FEPS-FS) in order to evaluate program fidelity to the Coordinated Specialty Care model. The FEPS-FS represents a standardized measure of fidelity to EP program best practice and was recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. However, most programs within EPI-CAL, including Los Angeles County, also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in several respects. To

provide a program assessment that most accurately represents the care delivered, alongside the FEP-FS, research team will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-PS-FS.

Fidelity Assessments were conducted at all five Los Angeles County EP programs. Assessments were completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff for UC Davis and its subcontractors.

Table 1. Fidelity Assessments of Los Angeles County Early Psychosis Programs by EPI-CAL staff

Site	Review Dates	Date of Report to agency	Date reported to County	FEPS-FS or CHR-PS-FS?
The Help Group	12/13/2022 - 12/14/23	8/30/2023	8/30/2023	Both
IMCES West Covina	12/14/2022	7/20/2023	8/28/2023	FEPS-FS
IMCES Koreatown	12/14/2022 - 12/16/2022	8/30/2023	8/30/2023	FEPS-FS
SFVCMHC	8/2/2022 - 8/3/2022	10/10/2022	8/28/2023	CHR-PS-FS
The Whole Child	12/12/2022 - 12/16/2022	5/11/2023	8/28/2023	Both

Each EP program participated in an assessment of EP program components using the revised FEPS-FS and/or CHRPS-FS, which was completed via web-based teleconference. Three programs were evaluated using only one of the two fidelity review tools because they did not have the minimum number of clients identified as CHR or FEP who were open for more than a year needed to use the review tool.

For sites completing the FEP-FS, the average item score range was 3.46-3.94, with the range of percentage of items at "good" and "high" fidelity from 59.5% - 72.70%. For sites completing the CHRPS-FS, the average item score range was 3.78 - 4.29, with the range of percentage of items at "good" and "high" fidelity from 65.63% - 78.00%. The goal average score is 4.0 on both measures, so all sites are near or at this goal.

The fidelity review staff identified several strengths across LACDMH programs. Identified strengths in most LACDMH programs were flexibility of staff to meet clients in the field or via telehealth, weekly integrated treatment team meetings where client treatment plans are discussed, and the availability of several evidence-based treatment components and appropriate staff to provide these services. Areas of growth identified were having a dedicated Peer Support Specialist on each team to provide Peer services, having clear messaging about the length of treatment when client enroll in services and having appropriate psychiatric services for Clinical High Risk clients that follow evidence-based prescribing goals.

EPI-CAL staff has shared findings with program management for three out of five clinics and are pending to present County-wide findings with County leadership. Individual site visits by DMH staff are planned in the coming fiscal year to incorporate findings from these fidelity reviews to further support program improvement.

Updates to Beehive Dashboard

Over the last project period, several changes and improvements to Beehive were made based on feedback from programs and community partners. Annual penetration testing ("pentesting") was conducted in June 2022, which was part of LACDMH requirements. Results from this testing also triggered changes to Beehive (release date of 8/25/2022) to maintain compliance with

increasing security standards. The abridged list below are changes made to Beehive over the last six months are in part from requests directly from Los Angeles County Beehive users:

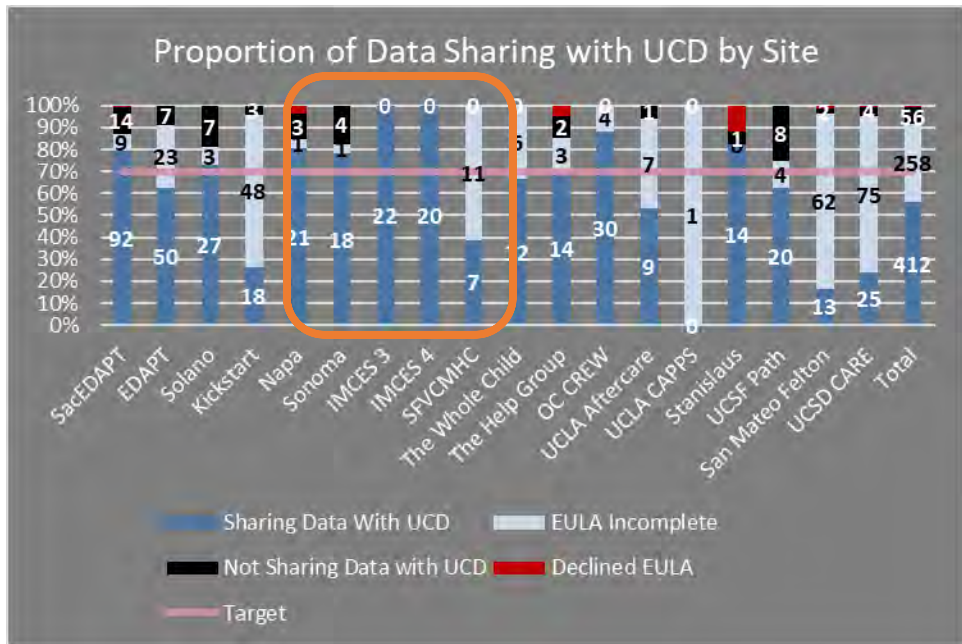
- **Multiple performance updates (e.g. increased efficiency in application to reduce loading times) at login, during survey completion, on survey results and client data view page and in other places throughout the application.**
- **Added email and in-App notifications for urgent clinical issues. Urgent clinical issues are when clients endorse issues around harm to self or others, plans to stop taking medication, and being at risk of homelessness through questionnaire responses. By improving notification to clinical staff and supervisors, they can more immediately respond to these issues. Also, two additional response options are available when clinical staff mark when and how an urgent clinical issue has been resolved.**
- **Improved issues around passwords, including updating password policy (does not apply to SSO-users), adding the ability to change password, adding Added One-Time Password timeouts for multiple login attempts, and an OTP cool down to prevent users from requesting a new OTP before the first OTP has had time to arrive**
- **Improved workflow for editing client data (e.g. summary page shows all registration information, user can jump to sections for editing purposes, user may save and close at any screen of client's profile when editing registration information)**
- **Update to client registration feature: allowing users to save registration before it is completed to finish later.**

Updates to Beehive Training and Enrollment

The Epi-Cal team continued to provide multicounty core trainings and refresher trainings about the Beehive application for newly hired Los Angeles County EP staff. Refresher trainings were also provided to current staff at two EP programs per program request.

During this fiscal year, LACDMH was able to increase Beehive enrollment of clients, and client completion of EULAs from the previous fiscal year. As of June 30, 2023, 98 LACDMH clients were registered in the Beehive application. Seventy-five clients agreed to share their data with EPI-CAL researchers, two clients agreed to utilize the Beehive application but declined to share their data with EPI-CAL researchers and one client declined to participate with the Beehive application. Twenty clients had not yet completed the End User Licensing Agreement (EULA). Three out of five LACDMH clinics nearly met or met Beehive data sharing goals. Two clinics that were unable to meet the target of goal to have 70% of consumers agree to share their data with UC Davis and the National Institute of Health cited difficulty in integrating Beehive enrollment procedures into their intake workflow, struggles with engaging clients to interact with Beehive due to discomfort with sharing private information outside of their clinic, and challenges brought about by staff turnover in their EP program.

Figure 1. Proportion of Data Sharing with EPI-CAL Researchers at UC Davis by Site



EPI-CAL staff met with DMH and EP program teams to discuss issues around enrollment and EULA completion after initial trainings and Beehive launch in Los Angeles County. EPI-CAL held 19 meetings during this fiscal year to support LACDMH EP programs with Beehive enrollment.

Additionally, DMH staff met with individual EP program leadership three times each from July 2022 to November 2022 to troubleshoot issues and set goals for enrollment and EULA completion per EPI-CAL request.

The Epi-Cal team continued to provide multicounty core trainings and refresher trainings about the Beehive application for newly hired Los Angeles County EP staff. Refresher trainings were also provided to current staff at two EP programs per program request.

Identification of County-level available data and data transfer methods, and statistical analysis methods selected for integrated county-level data evaluation.
One component of the EPI-CAL project is to identify and describe the services and related costs for individuals served by the EP programs in each county. EPI-CAL staff will also examine services and costs associated with similar individuals served elsewhere in each county. EPI-CAL staff will harmonize and integrate data across all LHCN counties in order to perform these analyses.

Specifically, in each county EPI-CAL staff identified an early psychosis (EP) group consisting of individuals served by an early psychosis program. EPI-CAL staff also identified a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who entered standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, Lake, and Solano counties. Inclusion of Kern County is pending an executed contract. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1st, 2017 – December 31st, 2019) to harmonize data across counties and to account for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1st, 2020 – June 30th, 2022). For Los Angeles County, historical EP group data was taken from three programs that had provided Early Psychosis services using the Center for the Assessment and Prevention of Prodromal States (CAPPS) model of treatment during the time period. This was due to the fact that the current Early Psychosis program using the PIER model did not start until January 2020.

For each county, the LHCN data team held meetings with the EP program managers and the county data analysts. For Los Angeles County, DMH located previous and current program managers and obtained information about services provided by the EP program, description of clients served, staffing specifics and billing codes for each service. This information was then reported to LHCN staff. A follow-up meeting was held with each county to review details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of clients (i.e., foster care). Meetings were held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next deliverable period. Meetings with Los Angeles County Outcomes and Informatics team staff were held on 7/18.22, 8/22/22 and 11/4/22. The discussion included time-periods for which the LHCN team will request data, description of the clients from EP programs and how similar clients served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP clients (i.e., hospitalization, crisis stabilization, substance use treatment), and data transfer methods.

Finalize methods of multi-county-integrated evaluation costs and utilization data
The following describes the data extraction and analysis plan for the first time period, January 1, 2017 – December 31, 2019.

Early Psychosis (EP) sample
First, all individuals who entered the EP programs January 1st, 2017 – December 31st, 2019 were identified using County Electronic Health Record (EHR) data, then limited to clients who received treatment versus assessed and referred out. EPI-CAL staff further restricted the comparison to individuals diagnosed with first-episode psychosis (FEP) and did not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.

Comparator Group (CG) sample
EPI-CAL staff compared the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who did not receive care in the EP program during the same timeframe in the same County.

Service Utilization
Next, data was requested from the County EHR on all services received by individuals in the EP programs and all services for members of both groups including 1) any non-EP outpatient services; 2) inpatient services and 3) crisis/Emergency Department services. As possible, EPI-CAL staff also worked with other systems identified by EP programs as having service use data not otherwise captured in the County EHR (e.g., databases of other EP program services; private inpatient hospitalizations not billed to the County; non-billable services, etc.).

Costs
Costs per unit of service were assigned to each type of service. EPI-CAL staff worked with county staff to identify the most accurate source of cost data. For Los Angeles County, DMH provided costs attached to the outpatient services and a daily rate sheet for the different types of 24-hour inpatient services the county offers. EPI-CAL staff then determined whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific depending on the information they received from a county. They included billable and non-billable services. Outcomes were calculated per month to account for varying lengths of time receiving services during the active study period. Additional details on outcomes and cost data sources are described in Table 2 below.

Table 2. Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per client • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per client	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits, per client • Duration of each visit (hours) • Total duration (hours) of all visits, per client	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County *Examples:* • Assessment • Case management • Group Rehab • Group Therapy • Individual Rehab • Individual Therapy • Family Therapy • Plan Development • Medication management • Collateral Services • Crisis Intervention	• Service type • Number of service units (minutes)	• Contract service unit rates

Statistical Methods to be Applied

Multi-County Analysis
The data will be harmonized on demographics, diagnoses, and service types across all participating LHCN counties, for EP and CG groups, then merged into a single dataset for our primary analyses. This combined, multi-county dataset will provide increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests will be used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the EP and CG groups. Both unadjusted and adjusted analyses will be used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data

All service data outcomes will be analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. EPI-CAL staff will use all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors will be always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and EPI-CAL staff are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services), and time per month will be analyzed by estimating the empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage will be examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) will be analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) will be analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) will be analyzed by estimating the empirical equation described above with linear regression. These various methods will allow us to determine whether each respective outcome differed between the EP and CG samples.

Data transfer methods

All information was de-identified and provided with a unique numeric ID by DMH Informatics staff before being submitted to the UCD evaluation team. Data is shared through an encrypted and password protected GoAnywhere MFT software, which will populate data to UCD secure servers. Counties will not have access to any identifiable data from the other counties. Each county is given a unique, secure login into the GoAnywhere portal and upload their data directly to the UCD servers. Once the EPI-CAL team receive data, they confirm with the county that all the information was received.

Next Steps

In the final fiscal year of this project, EPI-CAL staff will meet with county and the rest of EP program leadership to provide detailed feedback on fidelity results. EPI-CAL staff will also continue to provide training as needed to new EP program staff. As implementation of Beehive continues, EPI-CAL staff will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. The goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. EPI-CAL staff are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice. EPI-CAL staff are collecting informal data on these factors via regular check-in meetings with programs, as well as through a qualitative research approach by examining barriers and facilitators to Beehive implementation through interviews with EP program participants.

Regarding data analysis, EPI-CAL staff expects to receive and review data for both EP program and CG clients and their service utilization data from Napa and Stanislaus counties for the retrospective data period January 1st, 2017 – December 31st, 2019. Upon receiving the data, EPI-CAL staff will

review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental health services received by EP program clients, which may need to be retrieved from different sources. They will harmonize these data with the prior counties' and integrate them into the final dataset using the analysis described above. The EPI-CAL staff will submit final reports that detail all program- and County-level data collected as well as a final report evaluating the impact of the Learning Health care network on Early Psychosis services at DMH.

Niendam et al., 2022. Deliverable 3.1: Summary Report of the Activities of the LHCN. Final version submitted December 22nd, 2022. Prepared by UC Davis, San Francisco and San Diego.

Niendam et al., 2023. Deliverable 2 for FY22/23: Summary Report of the Activities of the LHCN. Final version submitted June 20, 2023. Prepared by UC Davis, San Francisco and San Diego.

Niendam et al., 2023. LHCN Enrollment and Survey Completion in All EP Programs. Final version submitted June 30, 2023. Prepared by UC Davis, San Francisco and San Diego.

D. INN-HWD-SERVICES, HOLLYWOOD 2.0 PROJECT

The Los Angeles County Department of Mental Health (DMH) was approved to receive a Mental Health Services Act (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 and experiencing chronic homelessness, incarceration and or repeated hospital use, as a result. The Hollywood 2.0 Pilot Project is a modification of the MHSA Innovations project (originally Trieste) approved by the MHSOC in May of 2019 before the pandemic. The project is based on the context of our 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 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. 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 will enhance the client's abilities to lead fulfilling lives and feel connected to their surrounding neighborhood. 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 that a client's ability to manage their life successfully is a key element of recovery.

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 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 strengthen the clients' ties to the Hollywood community.

Service Delivery

The new Hollywood Mental Health Cooperative field teams began delivering services to clients at the beginning of January 2023. The teams have since received 100 referrals. The teams are currently serving 73 active clients, some of which have already begun to benefit from the new housing components of Hollywood 2.0. The teams have housed 10 clients in our partered interim housing site- Mark Twain and 17 clients in our partnered board and care A New Dawn.

The Hollywood Mental Health Cooperative

The Hollywood Mental Health Cooperative is an innovate treatment team approach combining outpatient and intensive field services, in partnership with the community, that centers around an individual's needs. New clinic space has been identified to house both of these teams in Spring 2024. Hiring and training for both clinic and field-based staff is underway in addition to involvement in various community events.

Housing

A variety of housing options have been identified to address the various needs of individuals living with SMI. LACDMH is partnering with SSG as the onsite provider at a 56-bed interim housing site located in the center of Hollywood called the Mark Twain. LACDMH is also partnering with The Hollywood Walk of Fame Hotel for an additional 20 interim beds. LACDMH is partnering with A New Dawn. A 94-bed board and care facility that is already serving Hollywood Mental Health Cooperative clients. Enriched services are provided on site from the Hollywood Mental Health Cooperative's field based Wellness teams. A Request for Information (RFI) has been released for the Highly Enriched Residential Site to gather interest from additional board and care sites and providers to expand the network of sites offering these services.

UCC/24 Peer Respite

The Hollywood Respite and Recovery Center is an innovative housing model that includes UCC services and 24-hour peer respite in one location. The current Hollywood Mental Health Clinic space will house this program once the Hollywood Mental Health Cooperative moves to their new location. A solication is currently being drafted and reviewed by legal counsel and will be publicly posted for agencies to bid.

Clubhouse

LACDMH has been approved to sole source with Fountain House for the Hollywood Clubhouse. Contract negotiations are underway. Fountain House has identified a "pop up" space and has started meeting weekly with a group of inaugural members that have been identified to serve as the steering committee for the Hollywood Clubhouse.

Employment/Education

LACDMH is currently developing the SOW for the supported employment contract. This agency will work collaboratively with the Hollywood Mental Health Cooperative to support individuals with SMI wanting to enter or renter the workplace. The Clubhouse will also provide employment and education services through their transitional employment program as well as providing members

with assistance developing and pursuing individualized education goals. They will provide information and linkage to educational opportunities that range from adult basic education to graduate school, and educational supports, such as reasonable accommodations in educational settings and financial aid.

Educational/PR Campaign

The support and involvement of the larger (i.e., non-mental health) community is essential to this endeavor. LACDM is currently developing the SOW for the Hollywood 2.0 media campaign that will inform the Hollywood community on current mental health services, guidance on access, and ways in which the Hollywood community can get involved.

Academic Partner

LACDMH has been approved to sole source with RAND as the pilot's academic evaluator. LACDMH is currently developing the Statement of Work for the evaluator to independently assess and report on the outcomes of the project. The assessment includes comparing the results and outcomes achieved with the target population in the Hollywood region with a demographically and fiscally similar comparison region and population within Los Angeles area.

The goal of this innovation project is:

1. Are the lives of the people served by the Innovation pilot significantly improved over time across the variety of measures and indicators?
2. Are the outcomes within the pilot population significantly better or worse than the outcomes in the comparison population?
3. Are the costs of providing services to the pilot population greater or less than the cost of services provided to the comparison population?

Metrics for each of these items are outlined in the initial Trieste Proposal.

Activities to Date

Task	Date
DMH contracted with Hollywood 4WRD as our stakeholder engagement partner for Hollywood 2.0	07/01/22
Launch of the community workgroups to engage the Hollywood community in planning process. The workgroups are facilitated by Hollywood 4WRD but led by DMH staff with expertise in the areas of interest.	08/01/22
Development of logistics of implementing the project, which includes developing an organizational chart, duty statements for staff, and a proposed budget.	5/1/22-11/15/22
Community and stakeholder event held to identify key priorities and proposals to be implemented in H20 Pilot Program.	02/10/23
DMH has been approved to sole source with Fountain House for a Clubhouse. DMH and Fountain House are working towards finalizing contract.	7/2/23
Request for Information (RFI) released for the Hollywood Respite and Recovery Center	5/30/23

Task	Date
DMH and H4WRD hosted their first local community event. DMH and H4WRD are prioritizing local community member engagement for the current fiscal year.	8/1/23
RFI released for the Highly Enriched Residential Care Setting	8/28/23
40 of the 54 approved vacancies DMH have been hired	8/31/23
DMH has identified provider Special Services for Groups (SSG) as an interim housing provider for this project. 52 of the 56 beds are currently filled.	9/6/23
DMH was approved to sole source with RAND	10/20/23
DMH is partnering with the Hollywood Walk of Fame Hotel for an additional 20 interim beds. 19 of the 20 beds have been filled since it opened on 11/20/23	11/20/23

E. INTERIM HOUSING MULTIDISCIPLINARY ASSESSMENT & TREATMENT TEAMS

This Innovation project will begin during Fiscal Year 2023-24.

This Innovation project seeks to create new regional, field-based, multidisciplinary teams dedicated to serving people experiencing homelessness (PEH) who are living in interim housing. The project is designed to address current gaps in behavioral health and physical health services, support interim housing stability, facilitate transition to permanent housing and prevent a return to homelessness.

The Interim Housing Multidisciplinary Assessment and Treatment Teams will serve all eight Service Areas in Los Angeles County and will be comprised of staff from DMH, DPH-SAPC and DHS-HFH in an effort to ensure the full spectrum of client needs can be addressed. Teams will be assigned to support interim housing sites.

The current interim housing inventory in Los Angeles County is approximately 220 sites and 14,376 beds. The additional 11 interim housing sites in the pipeline provide an additional 1,037 beds to support PEH.

The key elements that make this project innovative are:

- The implementation of dedicated field-based multidisciplinary teams that are specifically outreaching, engaging and providing direct mental health, physical health and substance use services to clients in interim housing at their interim housing location, which is an entirely new service setting. This includes 24/7 crisis response.
- The partnership with the managed care organizations that will allow the County to leverage private resources from local health plans to support interim housing client needs.

By implementing this innovative project, LACDMH intends to learn if having dedicated field-based, multidisciplinary teams serving interim housing sites result in the following:

- Increased access to mental health services and co-occurring SUD services by interim housing residents?
- Increased exits to permanent housing?
- Decreased exits to homelessness?
- Interim housing provider staff increasing their knowledge and skills when serving individuals with severe mental illness and feeling more confident in being able to serve this population in their interim housing sites?

F. CHILDREN'S COMMUNITY CARE VILLAGE (CCCV)

This Innovation project was approved by the MHSA Oversight and Accountability Commission on November 17, 2023. The duration of the project is five (5) years. The project is scheduled to launch in FY 2024-25.

The proposed project will provide a continuum of mental health services and resources to help improve the health, wellbeing, and social value indices of the children and families in SA 6 by creating new mental health programs that do not currently exist in Los Angeles County and co-locating them with enhanced existing programs all in one location.

The LACDMH provides specialty mental health services for children through a network of directly operated and contracted community outpatient clinics across the County. LACDMH has identified a community-based non-profit organization, Kedren Health, Inc. (Kedren), a Community Mental Health Center, to partner with for this Innovation proposal because of its long and deep ties to the local community as well as their experience with the array of mental health services for children.

The CCCV will demonstrate the first of its kind, best practice "village" concept dedicated to children and families that will include the delivery of the new services listed below and include the existing children and youth services at Kedren (i.e., acute inpatient, FQHC and outpatient programs). These services/programs will be integrated into new programs to ensure a full continuum of care is available to provide our clients with the right care at the right time and right place. New services include:

- Intensive Case Management with an assigned care coordinator for each family as part of a Continuity of Care and Treatment Team to coordinate care among the continuum and ensure child and family voice and access to the most appropriate level of care.
- A full spectrum of children and youth mental health outpatient services including outpatient care and Integrated Comprehensive and Intensive Care for children.
- A children and youth crisis residential treatment program (The first and only CRTP in LA County dedicated to children and youth).
- A children and youth crisis stabilization unit.
- On-site transitional housing for children and families in crisis to include units for parent-child interactive therapy.

These new services will integrate and augment with the existing services on the same campus and surrounding network of services that are not funded with MHSA which includes but is not limited to:

- An inpatient acute psychiatric hospital,
- Federally Qualified Healthcare Center (FQHC) for primary and specialty care,
- Inpatient and outpatient pharmacy,
- Social services linkages,
- Community integration and reintegration programs,
- Parental supports and treatment for mental health and substance use,
- Transitional housing for families experiencing homelessness, and

- Work and life skill development programs.

Collectively, these services are designed to increase access to care, minimize disruption in the life of the child, youth, and family, and directly address some of the needs outlined in this proposal:

- Improve access to health and mental health resources.
- Address the needs of children, youth, and families with limited access to transportation.
- Reduce homelessness.
- Improved success in school.
- Reduce incidence of neglect and abuse by assuring timely access to care in times of crisis.

For a full copy of the proposal, please the DMH website, MHSA announcement page: MHSA Announcements - Department of Mental Health (lacounty.gov)

Capital Facilities and Technological Needs (CFTN)

Status	☒ New	☒ Continuing	☐ Modified	☐ Discontinued

CAPITAL FACILITIES

Projects – Fiscal Year 2022-23

The County transferred funds from its CSS account into the CFTN account to fund the following capital facilities projects:

Capital Project – Tenant Improvement/New Facilities

Capital facilities projects encompasses several key stages, each of which plays a crucial role in the successful development and implementation of a facility project. During FY 2022-23, the following facilities have incurred either design fees, project management fees, construction fees and/or plan checks:

- LAC+USC Crisis Residential Treatment Programs (CRTPs)
- Rancho Los Amigos Crisis Residential Treatment Programs (CRTPs)
- Olive View Crisis Residential Treatment Programs (CRTPs)
- Olive View Urgent Care Center
- Capital Facility Project: Pool dollars/Unanticipated projects

Upcoming Projects – Fiscal Year 2024-25

The County will transfer funds from its CSS account into the CFTN account to fund the following capital facilities projects:

- Tenant Improvement/New Facilities: funds will be utilized to increase and improve existing capital facilities infrastructure to accommodate the needs of current and expanded MHSA programs which includes the purchasing of equipment and furniture.
- Crocker Street Project: Alongside the Los Angeles County Department of Health Services, DMH and the Department of Public Health will collaborate to develop the Crocker Campus in Los Angeles' Skid Row area, which includes 250 new, Behavioral Health Bridge Housing (BHBH)-funded interim housing beds. These beds are included in the Skid Row Action Plan (SRAP) to transition Skid Row into a safe and healthy community: developed as a result of a June 2022 motion passed by the Los Angeles County Board of Supervisors. The centralized and coordinated services to be delivered by the Crocker Campus are planned to include an outdoor, safe services space, a 24/7 urgent care clinic, a Safe Landing model for 24/7 access to interim housing beds, and a Harm Reduction Health Center. DMH will invest BHBH capital funding to be used to purchase and renovate an existing 80,000 sq. foot warehouse for this transformational project.
- Exodus
- Children's Community Care Village: this capital facilities project will support the construction of facilities that will house a full spectrum of children and youth mental art, up to date facilities that will house a full spectrum of children and youth mental outpatient services, including a 23-hour urgent care crisis stabilization unit (UCC/CSU), an integrated "step-down" sub-acute crisis residential treatment program (CRTP), an outpatient pharmacy, and space for partner organizations and complementary services to engage with children and their families.

Upcoming Projects – Fiscal Year 2025-26

The County will transfer funds from its CSS account into the CFTN account to fund the following capital facilities projects:

- Capital Project – Tenant Improvement/New Facilities
- Exodus
- Children's Community Care Village
- Crocker Street Project

TECHNOLOGICAL NEEDS

Projects – Fiscal Year 2022-23

The County transferred funds from its CSS account into the CFTN account to fund the following technological needs projects:

ACCESS Call Center Modernization Project

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.

The Call Center will continue in Fiscal Year 2024-25.

Upcoming Projects – Fiscal Year 2024-25

The County will transfer funds from its CSS account into the CFTN account to fund new technology projects and expand existing ones, Digital Workplace Wi-Fi at Clinics and Integrated Behavioral Health Information System.

Upcoming Projects – Fiscal Year 2025-26

The County will transfer funds from its CSS account into the CFTN account to fund the following: Modern Call Center, Digital Workplace: WiFi at Clinics, Integrated Behavioral Health Information System and Technological Improvement.

EXHIBITS

EXHIBIT A – BUDGET

FY 2024-25 Mental Health Services Act Annual Update
Funding Summary

County: Los Angeles | Date: 3/27/24

	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Total
A. Estimated FY 2024-25 Funding						
1. Estimated Unspent Fund	597,200,000	199,000,000	240,600,000	20,200,000	95,500,000	1,152,500,000
2. Prudent Reserve	123,500,000	24,000,000				147,500,000
3. Estimated New FY2024/25 Funding	561,100,000	140,700,000	40,700,000	800,000	1,000,000	745,300,000
4. Transfer in FY2024/25 Annual Update	(56,000,000)			25,000,000	31,000,000	-
5. Estimated Available Funding for FY2024/25	1,226,800,000	363,700,000	281,300,000	46,000,000	127,500,000	2,045,300,000
B. Estimated FY2024/25 MHSA Expenditures	757,400,000	271,500,000	56,100,000	20,300,000	76,600,000	1,181,900,000
C. Estimated FY2024/25 Unspent Fund Balance	469,400,000	92,200,000	225,200,000	25,700,000	50,900,000	863,400,000

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	491,365,744	154,653,725	254,505,127		68,782,008	13,424,884
2. Outpatient Care Services	789,925,664	242,909,633	424,232,616		91,875,364	30,908,052
3. Alternative Crisis Services	195,801,296	136,203,755	51,555,933		3,309,849	4,731,759
4. Planning Outreach & Engagement	20,607,485	20,004,023	74,267			529,195
5. Linkage Services	74,787,121	54,732,599	17,667,853		152,144	2,234,524
6. Housing	90,011,960	85,890,437	3,919,530		7,018	194,975
CSS Administration	63,005,828	63,005,828				-
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	1,725,505,098	757,400,000	751,955,326	-	164,126,384	52,023,388

	Fiscal Year 2024-25					
	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	4,660,239	4,660,239				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	20,598,713	20,598,713				
3. PREVENTION	147,709,309	147,709,309				
4 EARLY INTERVENTION	772,118,503	73,849,920	432,718,657		240,425,151	25,124,775
PEI Administration	24,681,818	24,681,818				
Total PEI Program Estimated Expenditures	969,768,583	271,500,000	432,718,657	-	240,425,151	25,124,775

	Fiscal Year 2024/25					
	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. TTA	5,870,508	5,870,508				
2. MHCPATHWAY	2,633,867	2,633,867				
3. Residency	2,344,799	2,344,799				
4. Financial Incentive	7,931,023	7,931,023				
WET Administration	1,519,803	1,519,803				
Total WET Program Estimated Expenditures	20,300,000	20,300,000	-	-	-	-

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Project -Tenant Improvement/New Facilities	7,291,442	7,291,442				
2. Exodus	25,000,000	25,000,000				
3. Children's Community Care Village	10,000,000	10,000,000				
4. Crocker Street Project	10,000,000	10,000,000				
CFTN Programs - Technological Needs Projects	-					
5. Modern Call Center	2,008,616	2,008,616				
6. Digital Workplace: WIFI at Clinics	114,778	114,778				
7. Integrated Behavioral Health Information System	6,312,793	6,312,793				
8. Technological Improvement	10,172,206	10,172,206				
CFTN Administration	5,700,165	5,700,165				
Total CFTN Program Estimated Expenditures	76,600,000	76,600,000	-	-	-	-

	Fiscal Year 2024/25					
	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. Innovation 7 - Therapeutic Transportation	4,948,220	4,948,220	-		-	-
2. Innovation 8 - Early Psychosis Learning Health Care Network	187,866	187,866				
3. Hollywood Mental Health Cooperative (formally known Hollywood 2.0 project)	20,251,787	20,251,787	-		-	
4. Interim Housing Multidisciplinary Assessment & Treatment Teams	29,329,817	20,406,031	8,584,787		-	339,000
5. Children's Community Care Village	5,206,096	5,206,096				
INN Administration	5,100,000	5,100,000				
Total INN Program Estimated Expenditures	65,023,787	56,100,000	8,584,787	-	-	339,000

FY 2025-26 Mental Health Services Act Annual Update
Funding Summary

County: Los Angeles Date: 3/27/25

	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Total
A. Estimated FY 2025-26 Funding						
1. Estimated Unspent Funds	345,900,000	68,200,000	225,200,000	25,700,000	50,900,000	715,900,000
2. Prudent Reserve	123,500,000	24,000,000				147,500,000
3. Estimated New FY2025/26 Funding	460,800,000	115,500,000	34,100,000	1,000,000	500,000	611,900,000
4. Transfer in FY2025/26 Annual Update	(45,000,000)			25,000,000	20,000,000	-
5. Estimated Available Funding for FY2025/26	885,200,000	207,700,000	259,300,000	51,700,000	71,400,000	1,475,300,000
B. Estimated FY2025/26 MHSA Expenditures	767,400,000	207,700,000	66,300,000	20,300,000	41,600,000	1,103,300,000
C. Estimated FY2025/26 Unspent Fund Balance	117,800,000		193,000,000	31,400,000	29,800,000	372,000,000

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CSS Programs						
1. Full Service Partnerships	493,407,647	156,695,628	254,505,127		68,782,008	13,424,884
2. Outpatient Care Services	793,132,816	246,116,784	424,232,616		91,875,364	30,908,052
3. Alternative Crisis Services	197,599,602	138,002,062	51,555,933		3,309,849	4,731,759
4. Planning Outreach & Engagement	20,871,599	20,268,137	74,267			529,195
5. Linkage Services	75,509,759	55,455,237	17,667,853		152,144	2,234,524
6. Housing	91,145,977	87,024,454	3,919,530		7,018	194,975
CSS Administration	63,837,698	63,837,698				-
Total CSS Program Estimated Expenditures	1,735,505,098	767,400,000	751,955,326	-	164,126,384	52,023,388

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs						
1. SUICIDE PREVENTION	3,565,126	3,565,126				
2. STIGMA DISCRIMINATION REDUCTION PROGRAM	15,758,205	15,758,205				
3. PREVENTION	112,998,982	112,998,982				
4 EARLY INTERVENTION	754,764,452	56,495,869	432,718,657		240,425,151	25,124,775
PEI Administration	18,881,818	18,881,818				
Total PEI Program Estimated Expenditures	905,968,583	207,700,000	432,718,657	-	240,425,151	25,124,775

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. TTA	5,870,508	5,870,508				
2. MHCPATHWAY	2,633,867	2,633,867				
3. Residency	2,344,799	2,344,799				
4. Financial Incentive	7,931,023	7,931,023				
WET Administration	1,519,803	1,519,803				
Total WET Program Estimated Expenditures	20,300,000	20,300,000	-	-	-	-

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Capital Project -Tenant Improvement/New Facilities	2,627,188	2,627,188				
2. Exodus	9,518,797	9,518,797				
3. Children's Community Care Village	9,518,797	9,518,797				
4. Crocker Street Project	3,807,519	3,807,519				
CFTN Programs - Technological Needs Projects						
5. Modern Call Center	1,332,632	1,332,632				
6. Digital Workplace: WIFI at Clinics	76,150	76,150				
7. Integrated Behavioral Health Information System	4,188,271	4,188,271				
8. Technological Improvement	6,748,827	6,748,827				
CFTN Administration	3,781,818	3,781,818				
Total CFTN Program Estimated Expenditures	41,600,000	41,600,000	-	-	-	-

	Fiscal Year 2025-26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Innovation 7 - Therapeutic Transportation	5,722,224	5,722,224	-		-	-
2. Innovation 8 - Early Psychosis Learning Health Care Network	217,252	217,252				
3. Hollywood Mental Health Cooperative (formally known Hollywood 2.0 project)	23,419,581	23,419,581	-		-	
4. Interim Housing Multidisciplinary Assessment & Treatment Teams	34,671,898	24,893,235	9,439,663		-	339,000
5. Children's Community Care Village	6,020,436	6,020,436				
INN Administration	6,027,273	6,027,273				
Total INN Program Estimated Expenditures	76,078,663	66,300,000	9,439,663	-	-	339,000

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: 2023-24

Local Mental Health Director

Name: Lisa H. Wong, Psy.D.

Telephone: (213) 947-6670

Email: LWong@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).

Lisa H. Wong, Psy.D.	Connie D. Draxler	5/2/24
Local Mental Health Director (PRINT NAME)	Signature	Date

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

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT PRUDENT RESERVE FUNDING LEVEL CALCULATION for FY 2023-24

Prudent Reserve Calculation:

		C	D=C*76%	E	F=D+E	G=F/5	H=G*33%
Fiscal Year	Check Issue Date	State Allocation	CSS Allocation	Reallocated CSS	CSS Total	CSS Average	Max Prudent Reserve Level
2018-19	07/15/18 thru 06/15/19	$ 555,104,318.81	$ 421,879,282.30				
2019-20	07/15/19 thru 06/15/20	$ 515,636,475.39	$ 391,883,721.30	$ -			
2020-21	07/15/20 thru 06/15/21	$ 781,747,657.28	$ 594,128,219.53				
2021-22	07/15/21 thru 06/15/22	$ 873,104,922.37	$ 663,559,741.00				
2022-23	07/15/22 thru 06/15/23	$ 571,915,115.70	$ 434,655,487.93	$ -			
		$ 3,297,508,489.55	$ 2,506,106,452.06	$ -	$ 2,506,106,452.06	$ 501,221,290.41	$ 165,403,025.84

CURRENT PRUDENT RESERVCE	$ 116,483,541.70
TRANSFER FY 2023-24	$ 31,000,000.00
PRUDENT RESERVE BALANCE	$ 147,483,541.70

Per WIC 5847(b)(7), counties are required to establish and maintain a prudent reserve (PR) to ensure children, adults, and seniors can continue receiving services at current levels in the event of an economic downturn. The Prudent Reserve is funded with monies allocated to the Community Services and Supports component and cannot exceed 33% of a county's average distribution for the previous five years.

Per 5892 (b)(7), counties are required to assess and certify their local prudent reserve every 5 years, beginning in FY 17-18.

Per the California Code of Regulations (CCR) 3420.30 (f) counties may reassess the Prudent Reserve funding level more frequently at the county level, which may allow for a new Prudent Reserve maximum level, based on the most recent assessment. Counties choosing to reassess the prudent reserve funding level must submit a DHCS 1819: PR Certification Form.

EXHIBIT C – MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

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

Local Mental Health Director	County Auditor-Controller
Name: Lisa H. Wong, Psy.D.	Name: Oscar Valdez
Telephone Number: (213) 974-6670	Telephone Number: (213) 974-8302
E-mail: LWong@dmh.lacounty.gov	E-mail: OValdez@auditor.lacounty.gov
Local Mental Health Mailing Address: County of Los Angeles - Department of Mental Health 510 S. Vermont Avenue, 22nd floor Los Angeles, CA 90020	

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

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

Lisa H. Wong, Psy.D.
Local Mental Health Director

Signature   Date 3/26/2024

I hereby certify that for the fiscal year ended June 30, 2023, 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 12/8/23 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2023, 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.

Oscar Valdez
County Auditor Controller (PRINT)

Signature   Date 4/1/2024

[1]Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)
Three-Year Program and Expenditure Plan, Annual Update County/City Certification

EXHIBIT D – MENTAL HEALTH COMMISSION (MHC) LETTER

Los Angeles County

Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

First District	Second District	Third District	Fourth District	Fifth District
Susan Friedman	Kathleen Austria	Stacy Dalgleish	Victor Manalo	Judy Cooperberg
Bennett W. Root, Jr.	Reba Stevens	Thomas Roache	Michael Molina	Lawrence Schallert
Imelda Padilla-Frausto	Vacant	Jaqueline Sandoval-Valenzuela	Marilyn Sanabria	Brittney Weissman

Member from LAC Board of Supervisors: Supervisor Kathryn Barger, Represented by Anders Corey

April 22, 2024

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

Lisa H. Wong, Psy.D.
Director, Department of Mental Health
510 S. Vermont Ave
Los Angeles, California 90020

Dear Supervisors and Director Wong:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING:
TWO YEAR PROGRAM AND EXPENDITURE PLAN 2024-25 THROUGH 2025-26

On March 28, 2024, the Los Angeles County Mental Health Commission (Commission) held a Public Hearing relative to the Mental Health Services Act (MHSA) Two Year Program and Expenditure Plan for the years 2024-2025 and 2025-2026. The Department of Mental Health submitted the Plan on February 28, 2024, for a 30-day Comment Period. A total of 56 members of the public participated March 28th Hearing (both in-person and via online) and 22 persons provided Public Comment. This letter provides a summary of the comments received by members of the public and by the Commission.

Public Outreach

The leadership of the Department of Mental Health (LADMH) is to be commended for its tremendous efforts to engage stakeholders through a robust nine-month Community Planning Process. Community and institutional partners were invited to participate in this process and in the development of recommendations. Workgroups were established among the participants to identify priority areas and changes to the plan were proposed.

Several members of the public commented on their satisfaction for being part of the process. Levels of engagement by stakeholders was noticeably improved. Some commented, including members of the Commission, that despite the efforts to engage a cross-section of participants that level was never fully achieved.

Commissioners' comments also described the lack of easy access to information on the LADMH website of the process.

The value of LADMH's programs and activities rests on its ability to ensure the delivery of quality services to those most in need. A key component of the delivery process is communication. We must ensure pan-programmatic commitment that any and all programs, initiatives, and products be able to be accessed, utilized, and understood by members of the disabled and/or refugee communities residing in the County. That list of communities should explicitly include but not be limited to deaf, hard of hearing, deaf-blind, and deaf-disabled, as well as those immigrating from regions such as Eastern Europe, the Middle East, Asia, Pacific Islanders, Africa and Latin America.

Recommendation

LADMH staff is encouraged to find ways to further enhance the Community Planning Process by securing the participation of more stakeholders, particularly from underserved communities and our ethnic groups. Staff is further encouraged to utilize the LADMH website as a tool for education, outreach and communication by improving its landing page with clear methods for gaining information. The website should be enhanced to clearly provide performance metrics indicating the number of persons served in various service categories.

Staff is urged to review communication efforts to include the above-mentioned communities through all aspects of its public outreach and information shared.

Staff is also requested to review programs, initiatives, and products to ensure that communication can be accessed, utilized and understood by the communities described above. This review should include any and all publicity or outreach efforts and associated materials and centralized information resources meant to be accessed by the public (pubic databases, websites, etc.).

Community Planning Team Recommendations

The document provides a list of Recommendations, by component, for funding consideration. In the Public Hearing, questions were asked relative to the process by which institutions applied for possible funding. Was the process seamless? One organization, Parents Anonymous, was not approved for funding despite their participation in previous years. Their representatives actively participated in the Public Hearing and commissioners asked whether institutions understood the method of applying.

Recommendation

LADMH staff is encouraged to review the process to ensure that institutions and community groups fully understand the application process and the method by which recommendations are made. Additionally, staff is requested to dialogue with Parents Anonymous to resolve their questions and concerns.

Address: 510 South Vermont Ave., Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website**: https://dmh.lacounty.gov/about/mental-health-commission/

Demographics of Clients Served

The document identifies population served using several categories: by age group, ethnic groups and by service area. Since the Commission is appointed by the Board of Supervisors, it is important for the Commission to also be given the demographic of clients served by Supervisorial District.

Recommendation
LADMH staff is asked to include in the Plan the County populations served by Supervisorial District.

Future Impact of Proposition 1

Last month's election resulted in the passage of Proposition 1 which will significantly reshape the Mental Health Services Act of 2004. While LADMH leadership and the Commission have already addressed its potential impact several times, we must be vigilant in our efforts to properly prepare for the changes to come.

Recommendation
LADMH staff is requested to collaborate with the Commission and pertinent County personnel as we prepare for the 2026 implementation of Proposition 1.

The release of the MHSA Two Year Program and Expenditure Plan for the years 2024-2025 and 2025-2026 is the culmination of a detailed and exhaustive process. We commend our LADMH staff for completing this process. The Commission remains committed to working with staff and all stakeholders towards successful achievements in the next two years.

Sincerely,

Michael Molina, Chair
Los Angeles County Mental Health Commission

Address: 510 South Vermont Ave., Los Angeles, CA 90020
E-mail: MHCommission@dmh.lacounty.gov **Website:** https://dmh.lacounty.gov/about/mental-health-commission

EXHIBIT E – LACDMH RESPONSE TO MHC LETTER

DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LISA H. WONG, Psy.D.
Director

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

Connie D. Draxler, M.P.A.
Acting Chief Deputy Director

April 25, 2024

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

Michael Molina
Chair, Mental Health Commission
510 South Vermont Avenue
Los Angeles, California 90020

Dear Supervisors and Commissioner Molina:

RESPONSE TO MENTAL HEALTH COMMISSION INQUIRIES ON THE PUBLIC HEARING FOR THE MENTAL HEALTH SERVICES ACT TWO YEAR PROGRAM AND EXPENDITURE PLAN, FISCAL YEARS 2024-25 THROUGH 2025-26

On April 22, 2024, the Los Angeles County Mental Health Commission (Commission) submitted a letter reflecting their comments and inquiries to the Los Angeles County Board of Supervisors (Board) and the Los Angeles County Department of Mental Health (LACDMH) pertaining to the March 28, 2024, public hearing on Mental Health Services Act (MHSA) Two Year Program and Expenditure Plan, Fiscal Years (FY) 2024-25 through 2025-26.

The Commission also provided recommendations centering on the following four broad themes:

1. Public Outreach
2. Community Planning Team Recommendations
3. Demographics of Clients Served
4. Future Impact of Proposition 1

510 S. VERMONT AVENUE, LOS ANGELES, CA 90020 | HTTPS://DMH.LACOUNTY.GOV | (800) 854-7771

The following are LACDMH's responses to the Commission's recommendations:

Public Outreach

The Commission commended the Department for its efforts to engage stakeholders through a nine-month Community Planning Process (CPP) inclusive of community and institutional partners and the use of workgroups to solicit community feedback. In addition, the Commission recommended LACDMH find ways to enhance the CPP by securing the participation of more stakeholders and improve ease of access to information on the LACDMH website to ensure all underserved racial and ethnic communities, and individuals with disabilities can utilize information and participate in the process.

LACDMH appreciates the acknowledgement of efforts to date and the significant improvement over years past. Increasing engagement in person and online is a priority for the LACDMH MHSA Administration team. Work to increase engagement will continue in May as we utilize our community Take Action events in each Service Area to engage community members in the process. The LACDMH MHSA Administration team is also working with Service Area Leadership Teams (SALTs) to facilitate planning and implementation of events that educate the community about resources and encourages involvement in the planning process. While we have ensured all stakeholder materials are available online in English and Spanish, LACDMH MHSA Administration will work closely with the Communications Manager to ensure, as practical, all materials are easily accessible from the LACDMH and MHSA home pages.

Community Planning Team Recommendations

The Commission made note of the CPP identifying recommendations made by the Community Planning Team (CPT) and recommended we meet with a provider who spoke at the Commission hearing regarding the outcome of the process and their proposal. For clarification, the planning process was not to identify and fund individual providers, but rather to identify concepts for development and subsequent solicitation. LACDMH must abide by County guidelines and processes to fund any individual provider. LACDMH acknowledges the concerns brought forth and will strive to ensure the process and documents are clear to participating members and the public at large. LACDMH met with the provider referenced on April 11, 2024, and clarified the rating process to address the provider's concerns.

Demographics of Clients Served

The Commission recommends that data on populations served are available by Supervisorial District in addition to Service Area. Currently, this data is available by Supervisorial District and by Service Area on the LACDMH website: https://dmh.lacounty.gov/dashboards. The LACDMH MHSA Administration team will

ensure the Annual update and following plans will include data broken out by Supervisorial District.

Future Impact of Proposition 1

The Commission recommends that LACDMH staff collaborate with the Commission and pertinent County personnel as the County prepares for the 2026 implementation of Proposition 1, specifically the Behavioral Health Services Act (BHSA). LACDMH acknowledges the significant impact that implementation of the BHSA will have on services, the community, and the Commission, and is committed to working closely with stakeholders including providers, clients, community agencies, and the Commission to ensure the community remains informed and has opportunity for input and collaboration.

I would like to thank the Commission for its commendation on completing this year's planning process as well as its collaboration, support, and engagement during this planning period. Recommendations listed by the Commission will be referenced and utilized as LACDMH begins its planning process for the FY 2025-2026 Annual Update. The LACDMH MHSA Administration leadership will be available to provide ongoing updates to these recommendations and on implementation plans for the BHSA.

I look forward to working with stakeholders, partners, and the Commission to ensure our MHSA resources help those most in need live healthy, independent, and meaningful lives.

If there are any questions, you may contact me at lwong@dmh.lacounty.gov or Kalene Gilbert, MHSA Services Coordinator at kgilbert@dmh.lacounty.gov.

Respectfully submitted,

Lisa H. Wong, Psy.D.
Director

APPENDICES

Appendix A – Stakeholder Meeting Announcements

MHSA ANNOUNCEMENTS (TAKEN FROM: [MHSA Announcements - Department of Mental Health (lacounty.gov)]

See below for this year's MHSA-related announcements and postings; previous years' announcements are accessible through our MHSA archive page.

MHSA Community Planning Process Survey Due by Tuesday, February 20, 2024, 5 p.m. Pacific Time

At the Community Planning Team meeting on February 6, 2024, you requested additional time to review key materials before completing a survey to close this segment of the MHSA community planning process.

Attached you will find the requested materials to help you complete the survey.

1. *LACDMH List of Recommendations Final:* This document provides background information for those who missed the last meeting, including instructions on how to fill out the survey and the materials you requested that show how DMH's recommendations aligning with your recommendations.
2. *Total CPT & Workgroup Recommendations:* This document contains all the CPT Recommendations and the consensus recommendations for each Workgroup.

After reviewing these documents, please fill out the survey using the following link: https://forms.office.com/g/biyhSB0i36?origin=lprLink

Surveys are due by 5 PM on Tuesday, February 20, 2024.

If you have any questions about how to fill out this survey, please email us at communitystakeholder@dmh.lacounty.gov.

We will provide you a summary of the results on Friday, February 23, 2024, at our next CPT meeting, which will be held virtually. We will send a notice early next week with more details.

- Total CPT & WG Recommendations_FINAL_ENG.pdf
- DMH_List of Recommendations_FINAL_SPNks.pdf
- DMH_List of Recommendations_FINAL.pdf
- Total CPT & WG Recommendations_FINAL_Spanish.pdf

Enlace a la Encuesta – Lista de Recomendaciones del DMH – Responda Antes de las 5 p.m. del Martes 20 de Febrero

En la reunión del Equipo de Planificación Comunitaria el 6 de febrero de 2024, ustedes solicitaron tiempo adicional para revisar los materiales clave antes de completar una encuesta para cerrar este segmento del proceso de planificación comunitaria de MHSA.

Adjunto encontrarán materiales para ayudarles a completar la encuesta.

1. *Lista de Recomendaciones Final del LACDMH:* Este documento proporciona información de antecedentes para aquellos que se perdieron la última reunión, incluidas instrucciones sobre cómo completar la encuesta y los materiales que solicitó que muestran cómo las recomendaciones del DMH se ajustan a sus recomendaciones.
2. *Total de recomendaciones del CPT y de los Grupos de Trabajo:* Este documento contiene todas las recomendaciones del CPT y las recomendaciones de consenso para cada grupo de trabajo.

Después de revisar estos documentos, completen la encuesta utilizando el siguiente enlace: https://forms.office.com/g/Qp874TUYLA?origin=lprLink

Las encuestas deben entregarse antes de las 5 p.m. del martes 20 de febrero de 2024.

Si tiene alguna pregunta sobre cómo completar esta encuesta, envíenos un correo electrónico a communitystakeholder@dmh.lacounty.gov.
Les proporcionaremos un resumen de los resultados el viernes 23 de febrero de 2024 en nuestra próxima reunión del CPT, que se llevará a cabo virtualmente. Enviaremos un aviso a principios de la próxima semana con más detalles.

- Total CPT & WG Recommendations_FINAL_ENG.pdf
- DMH_List of Recommendations_FINAL_SPNks.pdf
- DMH_List of Recommendations_FINAL.pdf
- Total CPT & WG Recommendations_FINAL_Spanish.pdf

In-Person MHSA Stakeholder Meeting on Tuesday, February 6 from 9:30a-12:30p

DEAR MHSA STAKEHOLDERS,

We look forward to seeing you in-person this upcoming Tuesday, February 6, 2024, from 9:30-12:30 at St. Anne's Conference Center, 155 N. Occidental Blvd, Los Angeles, CA 90026.

The upcoming CPT meeting has a two-fold purpose.

The first is to close the MHSA stakeholder input segment for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26.
Over the course of the community planning process, DMH Leads have been listening closely to your ideas and recommendations through the Workgroup sessions. Following the Workgroup consensus (January 16 & 26) on new programs, services, or interventions (PSIs) for one-time funding, DMH Leads have been developing a list PSIs for consideration for one-time MHSA funds. This list attempts to balance MHSA stakeholder recommendations, the Board of Supervisors' priorities (i.e., homelessness and prevention services), the Department's obligations, and other key factors (e.g., the likelihood of Proposition 1 passing).

On Tuesday, DMH will review this proposed list of PSIs and field any questions from MHSA stakeholders. They will take this feedback into consideration as they prepare the draft plan that will be available for the public to review during a 30-Day Public Posting Period. Community stakeholders will have additional opportunities to provide feedback at the Public Hearing held by the Los Angeles County Mental Health Commission and then the Board of Supervisors' meeting to review and approve the plan.

The second purpose is to provide an MHSA Annual Update and an MHSA Mid-Year Adjustment Update.

As explained at the CPT meetings October 3 and December 15, 2023, MHSA planning entails four overlapping processes:

1. MHSA Mid-Year Adjustment (current fiscal year);
2. MHSA Annual Update (next fiscal year);
3. MHSA Three-Year Plan (three fiscal years); and
4. Ongoing Requests for Changes and Funds (requests at any time during the fiscal year)

Given the aforementioned items, Tuesday's session has three objectives:

1. Provide an MHSA Annual Update and an MHSA Mid-Year Adjustment Update and obtain stakeholder feedback.
2. Provide an overview of the recommendations from the CPT Workgroups and DMH's list of recommended new programs, services, and interventions for MHSA one-time funding consideration.
3. Clarify the next steps in the approval process for the MHSA Three-Year Plan and implementation monitoring.
4.

For those who cannot attend in person but would like to listen to discussions, please use the following link:

Click here to join the meeting, Meeting ID: 232 671 873 129 | Passcode: S9qXPa
Or call in (audio only): +1 323-776-6996,,851803068#
Phone Conference ID: 851 803 068#
We hope you will continue to participate actively during the two-year implementation phase that begins on July 1, 2024. Your participation and insights will help guide the implementation phase. Please reserve the follow dates on your calendar for CPT meetings.

COMMUNITY PLANNING TEAM SESSIONS
February-June 2024

DATE	TIME	MODE	MEETING TYPE
February 23	9:30-12:30 PM	Online	CPT – Workgroups
March 19	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
April 2	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
April 26	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT – Workgroups
May 7	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
May 24	9:30-12:30 PM	Online	CPT – Workgroups
June 4	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
June 28	9:30-12:30 PM	Online	CPT – Workgroups

Lastly, if you are a CPT member and unable to attend the upcoming meeting, please contact us by 5 PM on Monday, February 5th at communitystakeholder@dmh.lacounty.gov and provide us the name of your

alternate. If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov.
Meeting materials

- DMH_Recommendation List_ 2024-25_FINAL_ENG.pdf
- MHSA Two Year Program and Expenditure Plan FY 24-25 through 25-26_FINAL_ENG.pdf
- CPT_PEI RECS_FINAL_ENG.pdf
- CPT_CSC RECS_FINAL_ENG.pdf
- CPT_HSHR RECS_FINAL_ENG.pdf
- CPT_WET RECS_FINAL_ENG.pdf
- CPT_Session 15_FINAL_ENG.pdf

RECORDATORIO AMISTOSO – Reunión en persona de las partes interesadas de MHSA el martes 6 de febrero de 9:30 a 12:30
ESTIMADOS GRUPOS DE INTERÉS DE MHSA,
Esperamos verlo en persona el próximo martes 6 de febrero de 2024, de 9:30 a 12:30 en el Centro de Conferencias de St. Anne, 155 N. Occidental Blvd., Los Ángeles, CA 90026.

La próxima reunión del CPT tiene un doble propósito.

El primero es cerrar el segmento de aportes de las partes interesadas de MHSA para el *Plan Trienal de MHSA* para los años fiscales 2024-25 y 2025-26.
En el transcurso del proceso de planificación de la comunidad, los líderes de DMH han estado escuchando atentamente sus ideas y recomendaciones a través de las sesiones del Grupo de Trabajo. Después del consenso del Grupo de Trabajo (16 y 26 de enero) sobre nuevos programas, servicios o intervenciones (PSI, por sus siglas en inglés) para financiamiento único, los líderes del DMH han estado desarrollando una lista de PSI para su consideración para fondos únicos de MHSA. Esta lista intenta equilibrar las recomendaciones de las partes interesadas de la MHSA, las prioridades de la Junta de Supervisores (es decir, los servicios de prevención y personas sin hogar), las obligaciones del Departamento y otros factores clave (por ejemplo, la probabilidad de que se apruebe la Proposición 1).

Este martes, DMH revisará esta lista propuesta de PSI y responderá cualquier pregunta de las partes interesadas de MHSA. Tendrán en cuenta estos comentarios a medida que preparen el borrador del plan que estará disponible para que el público lo revise durante un período de publicación pública de 30 días. Las partes interesadas de la comunidad tendrán oportunidades adicionales para proporcionar comentarios en la Audiencia Pública celebrada por la Comisión de Salud Mental del Condado de Los Ángeles y luego en la reunión de la Junta de Supervisores para revisar y aprobar el plan.

El segundo propósito es proporcionar una actualización anual de la MHSA y una actualización de ajuste de mitad de año de la MHSA.

Como se explicó en las reuniones del CPT del 3 de octubre y el 15 de diciembre de 2023, la planificación de MHSA implica cuatro procesos superpuestos:

1. Ajuste de mitad de año de MHSA (año fiscal en curso);
2. Actualización Anual de MHSA (próximo año fiscal);
3. Plan Trienal de la MHSA (tres ejercicios fiscales); y
4. Solicitudes continuas de cambios y fondos (solicitudes en cualquier momento durante el año fiscal)

Teniendo en cuenta los puntos mencionados, la sesión de este martes tiene tres objetivos:

1. Proporcione una actualización anual de MHSA y una actualización de ajuste de mitad de año de MHSA y obtenga comentarios de las partes interesadas.
2. Proporcionar una descripción general de las recomendaciones de los Grupos de Trabajo de CPT y la lista del DMH de nuevos programas, servicios e intervenciones recomendados para la consideración de financiamiento único de MHSA.
3. Aclarar los próximos pasos en el proceso de aprobación del Plan Trienal de MHSA y el monitoreo de la implementación.

Para aquellos que no puedan asistir en persona pero deseen escuchar las discusiones, por favor utilicen el siguiente enlace:

Haga clic aquí para unirse a la reunión, ID de reunión: 232 671 873 129 | Código de acceso: S9qXPa
O llame (solo audio): +1 323-776-6996,,851803068#
ID de la conferencia telefónica: 851 803 068#
Esperamos que continúen participando activamente durante la fase de implementación de dos años que comienza el 1 de julio de 2024. Su participación y conocimientos ayudarán a guiar la fase de implementación. Por favor, reserve las siguientes fechas en su calendario para las reuniones de CPT.

SESIONES DEL EQUIPO DE PLANIFICACIÓN COMUNITARIA

Febrero-Junio 2024

FECHA	HORA	MODO	TIPO DE REUNIÓN
23 de febrero	21:30-12:30	En línea	CPT – Grupos de trabajo
19 de marzo	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
2 de abril	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
26 de abril	21:30-12:30	En persona: Centro de Conferencias de St. Anne	CPT – Grupos de trabajo
7 de mayo	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
24 de mayo	21:30-12:30	En línea	CPT – Grupos de trabajo
4 de junio	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP

FECHA	HORA	MODO	TIPO DE REUNIÓN
28 de junio	21:30-12:30	En línea	CPT – Grupos de trabajo

Por último, si usted es miembro de CPT y no puede asistir a la próxima reunión, comuníquese con nosotros antes de las 5 p.m. del lunes 5 de febrero a las communitystakeholder@dmh.lacounty.gov y proporciónenos el nombre de su suplente. Si tiene alguna pregunta sobre este mensaje, póngase en contacto con nosotros en communitystakeholder@dmh.lacounty.gov.
Materiales de reunión

- DMH_Recommendation List_ 2024-25_FINAL_SPAN.pdf
- MHSA Two Year Program and Expenditure Plan FY 24-25 through 25-26_FINAL_SPAN.pdf
- CPT_CSC RECS_FINAL_SPN.pdf
- CPT_HSHR RECS_FINAL_SPN.pdf
- CPT_PEI RECS_FINAL_SPN (1).pdf
- CPT_Session 15_2.6.24_FINAL_SPN (1).pdf
- CPT_WET RECS_FINAL_SPN.pdf

Mid-Year Adjustment to the MHSA FY 2023–24 Annual Update
Public Review and Comment Period: February 1 through March 1, 2024

- FY 23-24 MHSA Mid-Year Adjustment
- Feedback by email
- Online Feedback Survey

MHSA Community Planning Team (CPT) Meeting – January 26, 2024
Este mensaje se presenta en español al final.
Thank you for being such active participants in the community planning process (CPP) for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26. We are nearing the end of the CPP, with two more Community Planning Team (CPT) meetings remaining: Friday, January 26, 2024, and Tuesday, February 6, 2024. We look forward to seeing you in-person this Friday, January 26, 2024, from 9:30-12:30 at St. Anne's Conference Center, 155 N Occidental Blvd, Los Angeles, CA 90026.
The primary purpose of this Friday's session is to discuss how DMH will use the Workgroup consensus recommendations, Board priorities, and other factors to guide the preparation of the draft *MHSA Three-Year Plan*, including the budget.
Last week, on Tuesday, January 16th, three CPT Workgroups were able to achieve consensus on their recommendations: Community Supports Continuum (CSC); Prevention and Early Intervention (PEI); and Workforce Education and Training (WET). However, the Homeless Services and Housing Resources (HSHR) Workgroup still needs a little bit more time to finish.

With this in mind, Friday's session focuses on three objectives:

1. Complete the consensus-building process with the HSHR Workgroup.
2. Discuss how DMH is using the Workgroup consensus recommendations to prepare the draft *MHSA Three-Year Plan*, including the budget.
3. Clarify the final steps to close the community planning process.

Please read remaining part of this message closely as it explains two important points for this Friday's session and beyond.

1. The HSHR Workgroup will meet from 9:30-10:45 AM to complete its consensus building task.
   i. Only HSHR Workgroup members should attend this part of the session.
   ii. This session will be held in the classroom upstairs.
   iii. We have 1 hour and 15 minutes for this segment.
   iv. As an HSHR Workgroup member, please closely review the HSHR Workgroup recommendations that were pulled for discussion and come prepared with your questions and/or suggestions.
2. The CPT meeting will be held from 11:00 AM-12:30 PM.
   i. This session will be held in the Foundation Room downstairs.
   ii. We have 1.5 hours for this process.

After the January 26 session, you will receive a link to access all the final CPT Workgroup recommendations to prepare for the February 6th session. This will be the last session for the Community Planning Process, but please remember that you still have additional opportunities to provide input during the 30-Day Posting Period, the Los Angeles County Mental Health Commission's Public Hearing, and the Board of Supervisor's meeting to review and approve the plan.

For those who cannot attend in person but would like to listen to discussions, please use the following links:

TIMES	WORKGROUPS & LINKS
9:30-10:45	**HOUSING SERVICES & HOUSING SUPPORTS (HSHR)** Click here to join the meeting Meeting ID: 221 991 271 321 Passcode: KTUQMC **Or call in (audio only)** +1 323-776-6996,,348493574# Phone Conference ID: 348 493 574#
11:00-12:30	**COMMUNITY PLANNING TEAM** Click here to join the meeting Meeting ID: 274 381 988 660 Passcode: 8ftw9S Download Teams | Join on the web **Or call in (audio only)** +1 323-776-6996,,774128689# Phone Conference ID: 774 128 689#

We hope you will continue to participate actively during the two-year implementation phase that begins on July 1, 2024. Your participation and insights will help guide the implementation phase. Please reserve the follow dates on your calendar for CPT meetings. Please see the calendar on the next page.

Lastly, if you are a CPT member and unable to attend the upcoming meeting, please contact us by 5 PM on Thursday, January 25th at communitystakeholder@dmh.lacounty.gov and provide us the name of your alternate. If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov

COMMUNITY PLANNING TEAM SESSIONS

January-June 2024

DATE	TIME	MODE	MEETING TYPE
January 26	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
February 6	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
February 23	9:30-12:30 PM	Online	CPT – Workgroups
March 19	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
April 2	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
April 26	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT – Workgroups
May 7	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
May 24	9:30-12:30 PM	Online	CPT – Workgroups
June 4	9:30-12:30 PM	In-person: St. Anne's Conference Center	CPT Meeting
June 28	9:30-12:30 PM	Online	CPT – Workgroups

Meeting Materials:
Agenda (English/Spanish)
Next Steps Presentation (English/Spanish)

HSHR Workgroup Recommendations (English/Spanish)
Workgroup Update (English/Spanish)
RECORDATORIO AMISTOSO – Reunión presencial de MHSA CPT el viernes 26 de enero de 9:30 a 12:30 en el Centro de Conferencias de St. Anne
Gracias por ser participantes activos en el proceso de planificación comunitaria (CPP, por sus siglas en inglés) para el *Plan Trienal de MHSA* para los años fiscales 2024-25 y 2025-26. Nos acercamos al final del CPP y quedan dos reuniones más del Equipo de Planificación Comunitaria (CPT, por sus siglas en inglés): el viernes 26 de enero de 2024 y el martes 6 de febrero de 2024. Esperamos verlo en persona este viernes 26 de enero de 2024, de 9:30 a 12:30 en el Centro de Conferencias de St. Anne, 155 N Occidental Blvd, Los Ángeles, CA 90026.
El propósito principal de la sesión de este viernes es discutir cómo el DMH utilizará las recomendaciones consensuadas de los Grupos de Trabajo, las prioridades de la Junta de Supervisores y otros factores para guiar la preparación del borrador del *Plan Trienal de MHSA*, incluido el presupuesto.
La semana pasada, el martes 16 de enero, tres Grupos de Trabajo del CPT lograron consenso sobre sus recomendaciones: Community Supports Continuum (CSC); Prevención e Intervención Temprana (PEI); y Educación y Capacitación de la Fuerza Laboral (WET, por sus siglas en inglés). Sin embargo, el Grupo de Trabajo de Servicios para Personas sin Hogar y Recursos de Vivienda (HSHR, por sus siglas en inglés) todavía necesita un poco más de tiempo para terminar.

Con esto en mente, la sesión del viernes se centra en tres objetivos:

1. Completar el proceso de creación de consenso con el Grupo de Trabajo de HSHR.
2. Discutir cómo el DMH utilizará las recomendaciones de consenso de los Grupos de Trabajo para preparar el borrador del *Plan Trienal de MHSA*, incluido el presupuesto.
3. Aclarar los pasos finales para cerrar el proceso de planificación comunitaria.

Por favor, lea atentamente el resto de este mensaje, ya que explica dos puntos importantes para la sesión de este viernes y más allá.

1. El Grupo de Trabajo de HSHR se reunirá de 9:30 a 10:45 a.m. para completar su tarea de creación de consenso.
   i. Solo los miembros del Grupo de Trabajo de HSHR deben asistir a esta parte de la sesión.
   ii. Esta sesión se llevará a cabo en el aula de arriba.
   iii. Tenemos 1 hora y 15 minutos para este segmento.
   iv. Como miembro del Grupo de Trabajo de HSHR, revise detalladamente las recomendaciones del Grupo de Trabajo de HSHR que se extrajeron para su discusión y venga preparado con sus preguntas y/o sugerencias.
1. La reunión del CPT se llevará a cabo de 11:00 a.m. 12:30 p.m.
   i. Esta sesión se llevará a cabo en la Sala de la Fundación en la planta baja.
   ii. Tenemos 1 hora y 30 minutos para este segmento.
1.

Después de la sesión del 26 de enero, recibirá un enlace para acceder a todas las recomendaciones finales de los Grupos de Trabajo y un borrador del *Plan Trienal de MHSA* para prepararse para la sesión del 6 de febrero. Esta será la última sesión para el Proceso de Planificación Comunitaria, pero recuerde que aún tiene oportunidades adicionales para proporcionar información durante el Período de Publicación de 30 Días, la Audiencia Pública de la Comisión de Salud Mental del Condado de Los Ángeles y la reunión de la Junta de Supervisores para revisar y aprobar el plan.
Para aquellos que no puedan asistir en persona pero deseen escuchar las discusiones, por favor utilicen los siguientes enlaces:

VECES	GRUPOS DE TRABAJO Y ENLACES
9:30-10:45	**SERVICIOS DE VIVIENDA Y APOYOS A LA VIVIENDA (HSHR)** Haga clic aquí para unirse a la reunión ID de reunión: 221 991 271 321 Código de acceso: KTUQMC **O llame (solo audio)** +1 323-776-6996,,348493574# ID de la conferencia telefónica: 348 493 574#
11:00-12:30	**EQUIPO DE PLANIFICACIÓN COMUNITARIA** Haga clic aquí para unirse a la reunión ID de reunión: 274 381 988 660 Código de acceso: 8ftw9S Descargar Teams | Únete en la web **O llame (solo audio)** +1 323-776-6996,,774128689# ID de la conferencia telefónica: 774 128 689#

Esperamos que continúen participando activamente durante la fase de implementación de dos años que comienza el 1 de julio de 2024. Su participación y conocimientos ayudarán a guiar la fase de implementación. Por favor, reserve las siguientes fechas en su calendario para las reuniones del CPT. Por favor, vea el calendario en la siguiente página.

Por último, si usted es miembro de ECAP y no puede asistir a la próxima reunión, comuníquese con nosotros antes de las 5 p.m. del jueves 25 de enero a las communitystakeholder@dmh.lacounty.gov y proporciónenos el nombre de su suplente. Si tiene alguna pregunta sobre este mensaje, póngase en contacto con nosotros en communitystakeholder@dmh.lacounty.gov

SESIONES DEL EQUIPO DE PLANIFICACIÓN COMUNITARIA
Enero-Junio 2024

FECHA	HORA	MODO	TIPO DE REUNIÓN
26 de enero	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
6 de febrero	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
23 de febrero	21:30-12:30	En línea	CPT – Grupos de trabajo
19 de marzo	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
2 de abril	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
26 de abril	21:30-12:30	En persona: Centro de Conferencias de St. Anne	CPT – Grupos de trabajo

7 de mayo	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
24 de mayo	21:30-12:30	En línea	CPT – Grupos de trabajo
4 de junio	21:30-12:30	En persona: Centro de Conferencias de St. Anne	Reunión de ECAP
28 de junio	21:30-12:30	En línea	CPT – Grupos de trabajo

Meeting Materials:
Agenda (English/Spanish)
Next Steps Presentation (English/Spanish)
HSHR Workgroup Recommendations (English/Spanish)
Workgroup Update (English/Spanish)

Innovation Project: Children's Community Care Village (CCCV)
Approved by the MHSA Oversight and Accountability Commission on November 17, 2023

MHSA Community Planning Team (CPT) Meeting – January 16, 2024
Este mensaje se presenta en español al final.
This is a friendly reminder of our upcoming **in-person-only** Community Planning Team (CPT) session on Tuesday, January 16, 2024, from 9:30a-12:30p, at St. Anne's Conference Center, located at 155 N. Occidental Blvd, Los Angeles, CA 90026.
The primary purpose of this session is to build consensus among Workgroup participants in terms of their recommendations and proposals for the *MHSA Three-Year Plan*. We want to focus on three objectives:

1. Review the consensus-building method.
2. Review the survey results for the recommendations and proposals that DMH requested more feedback on.
3. Use the consensus-building method to find agreement on all the Workgroup's recommendations and proposals.

Please use the following links for the Workgroup session you want to listen to.

TIMES	WORKGROUPS & LINKS	
9:30-11:00	**COMMUNITY SUPPORTS CONTINUUM (CSC)** Click here to join the meeting Meeting ID: 232 834 950 947 Passcode: vuXVw7 **Or call in (audio only)**	**PREVENTION & EARLY INTERVENTION (PEI)** Click here to join the meeting Meeting ID: 245 532 642 564 Passcode: 6Tc4zd **Or call in (audio only)** +1 323-776-6996,,226367885#

	+1 323-776-6996,,260618578# Phone Conference ID: 260 618 578#	Phone Conference ID: 226 367 885#
11:00- 12:30	**HOUSING SERVICES & HOUSING SUPPORTS (HSHR)** Click here to join the meeting Meeting ID: 232 834 950 947 Passcode: vuXVw7 **Or call in (audio only)** +1 323-776-6996,,260618578# Phone Conference ID: 260 618 578#	**WORKFORCE EDUCATION & TRAINING (WET)** Click here to join the meeting Meeting ID: 245 532 642 564 Passcode: 6Tc4zd **Or call in (audio only)** +1 323-776-6996,,226367885# Phone Conference ID: 226 367 885#

The Workgroup's recommendations will be presented to the CPT members on Friday, January 26, 2024, to build consensus. The draft *MHSA Three-Year Plan* will be posted in February, which you will be able to present to your communities and obtain additional feedback. In March, we anticipate that the Los Angeles County Mental Health Commission will host a public hearing on the draft *MHSA Three-Year Plan*. After that hearing, the draft plan will go to the Los Angeles County Board of Supervisors for a final hearing and then sent to the state for final approval.

We hope you will continue to participate actively during the two-year implementation phase that begins on July 1, 2024. Your participation and insights will help guide the implementation phase. Please reserve the follow dates on your calendar for CPT meetings. Given how long it takes to reserve ASL, language interpreters, and CART services, we scheduled online sessions for Workgroups in case these are needed.

Date	Time	Mode	Meeting Type
January 26, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting
February 6, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting
February 23, 2024	9:30 AM – 12:30 PM	Online	MHSA CPT – Workgroups
March 19, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting

Date	Time	Mode	Meeting Type
April 2, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting
April 26, 2024	9:30 AM – 12:30 PM	Online	MHSA CPT – Workgroups
May 7, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting
May 24, 2024	9:30 AM – 12:30 PM	Online	MHSA CPT – Workgroups
June 4, 2024	9:30 AM – 12:30 PM	In-person St. Anne's Conference Center 155 N Occidental Blvd, Los Angeles, CA 90026	MHSA CPT Meeting
June 28, 2024	9:00 AM – 1:00 PM	Online	MHSA CPT – Workgroups

If you are a CPT member and unable to attend the upcoming meeting, please contact us by 5 PM on Monday, January 15th at communitystakeholder@dmh.lacounty.gov and provide us the name of your alternate. If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov

Meeting Materials:
Agenda (English/Spanish)
CSC (English/Spanish)
HSHR (English/Spanish)
PEI (English/Spanish)
WET (English/Spanish)

RECORDATORIO AMISTOSO – Reunión presencial de MHSA CPT el martes 16 de enero de 9:30 a 12:30 en el Centro de Conferencias de St. Anne

Este es un recordatorio amistoso de nuestra **próxima sesión presencial** del Equipo de Planificación Comunitaria (CPT, por sus siglas en inglés) el martes 16 de enero de 2024, de 9:30 a 12:30, en el Centro de Conferencias de St. Anne, ubicado en 155 N. Occidental Blvd, Los Ángeles, CA 90026.

El objetivo principal de esta sesión es crear consenso entre los participantes de los Grupos de Trabajo en torno a sus recomendaciones y propuestas para el *Plan Trienal de MHSA*. Queremos centrarnos en tres objetivos:

1. Revisar el método de creación de consenso.
2. Revisar los resultados de la encuesta en torno a las recomendaciones y propuestas sobre las que el DMH solicitó más comentarios.

3. Utilizar el método de creación de consenso para llegar a un acuerdo sobre todas las recomendaciones y propuestas del Grupo de Trabajo.

Utilice los siguientes enlaces la sesión del Grupo de Trabajo que quiera usted escuchar.

VECES	GRUPOS DE TRABAJO Y ENLACES	
9:30-11:00	**GAMA DE APOYOS COMUNITARIOS (CSC)** Haga clic aquí para unirse a la reunión ID de reunión: 232 834 950 947 Código de acceso: vuXVw7 **O llame (solo audio)** +1 323-776-6996,,260618578# ID de conferencia telefónica: 260 618 578#	**PREVENCIÓN E INTERVENCIÓN TEMPRANA (PEI)** Haga clic aquí para unirse a la reunión ID de reunión: 245 532 642 564 Código de acceso: 6Tc4zd **O llame (solo audio)** +1 323-776-6996,,226367885# ID de conferencia telefónica: 226 367 885#
11:00-12:30	**SERVICIOS DE VIVIENDA Y RECURSOS DE VIVIENDA (HSHR)** Haga clic aquí para unirse a la reunión ID de reunión: 232 834 950 947 Código de acceso: vuXVw7 **O llame (solo audio)** +1 323-776-6996,,260618578# ID de conferencia telefónica: 260 618 578#	**EDUCACIÓN Y CAPACITACIÓN DE LA FUERZA LABO** Haga clic aquí para unirse a la reunión ID de reunión: 245 532 642 564 Código de acceso: 6Tc4zd **O llame (solo audio)** +1 323-776-6996,,226367885# ID de conferencia telefónica: 226 367 885#

Las recomendaciones del Grupo de Trabajo se presentarán a los miembros del CPT el viernes 26 de enero de 2024 para generar consenso. El borrador *del Plan Trienal de MHSA* se publicará en febrero, el cual podrá presentar a sus comunidades y obtener comentarios adicionales. En marzo, anticipamos que la Comisión de Salud Mental del Condado de Los Ángeles organizará una audiencia pública sobre el borrador del *Plan Trienal de MHSA*. Después de esa audiencia, el borrador del plan irá a la Junta de Supervisores del Condado de Los Ángeles para una audiencia final y luego se enviará al estado para su aprobación final.

Esperamos que continúe participando activamente durante la fase de implementación de dos años que comienza el 1 de julio de 2024. Su participación y sus conocimientos ayudarán a guiar la fase de implementación. Reserve las siguientes fechas en su calendario para las reuniones del CPT. Dado el tiempo que lleva reservar ASL, intérpretes de idiomas y servicios CART, programamos sesiones en línea para grupos de trabajo en caso de que sean necesarias.

Fecha	Hora	Modo	Tipo de reunión
26 de enero de 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
6 de febrero de 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
23 de febrero de 2024	9:30 – 12:30	En línea	Reunión MHSA CPT – Comité
19 de marzo de 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
2 de abril de 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
26 de abril de 2024	9:30 – 12:30	En línea	Reunión MHSA CPT – Comité
7 de mayo de 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
24 de mayo de 2024	9:30 – 12:30	En línea	Reunión MHSA CPT – Comité
4 de junio, 2024	9:30 – 12:30	Presencial Centro de Conferencias St. Anne's 155 N Occidental Blvd, Los Ángeles, CA 90026	Reunión de MHSA CPT
28 de junio de 2024	9:00 – 13:00	En línea	Reunión MHSA CPT – Comité

Si usted es miembro del CPT y no puede asistir a la próxima reunión, comuníquese con nosotros antes de las 5 p.m. del lunes 15 de enero a las communitystakeholder@dmh.lacounty.gov y proporciónenos el nombre de su suplente. Si tiene alguna pregunta sobre este mensaje, póngase en contacto con nosotros en communitystakeholder@dmh.lacounty.gov.

Meeting Materials:
Agenda (English/Spanish)
CSC (English/Spanish)
HSHR (English/Spanish)
PEI (English/Spanish)
WET (English/Spanish)

MHSA Workgroup Surveys (Open Through January 5, 2024)
This message is for individuals who participated in at least one MHSA Workgroup meeting from October 27th through December 5th, 2023, either in-person or online as a listener.
If you did not attend an MHSA Workgroup meeting on October 27, November 7 and 17, and December 5, please disregard this message.
If you did attend at least one Workgroup meeting from October 27th to December 5th, we thank in advance for taking the time to score the MHSA recommendations for the Workgroup(s) you attended. **Please do not score recommendations for Workgroups you did not attend.**
Over the course of the Workgroup sessions, you have developed a deeper understanding of the overall critical issues (unmet needs and service gaps) and more specific equity concerns of underserved populations and/or geographies pertaining to your Workgroup's topic.

The following links give you access to the recommendations and the rubric for each of the Workgroups. **Again, only score the recommendations for the Workgroup you attended.**

Workgroup	Survey Link (English & Spanish)
Community Supports Continuum (CSC)	English: https://forms.office.com/g/39FFHCikbk Spanish: https://forms.office.com/g/JTs2rRQN4N
Homeless Services & Housing Resources (HSHR)	English: https://forms.office.com/g/JFhLiLrHWB Spanish: https://forms.office.com/g/YuKd5ufqt2
Prevention & Early Intervention (PEI)	English: https://forms.office.com/g/aRUShqSvRu Spanish: https://forms.office.com/g/zRpijg7diZ
Workforce Education & Training (WET)	English: https://forms.office.com/g/r7xSAxvkZh Spanish: https://forms.office.com/g/nFc1NcpUAs

We attached recommendations and rubric for each Workgroup in case you want to review the recommendations and score them before uploading your scores to the online survey.

Scores are due by 5 PM on Friday, January 5, 2024.

If you have any questions about how to score the recommendations, please contact the MHSA Division staff at communitystakeholder@dmh.lacounty.gov. Staff will be available from January 2 to 5, 2024, to respond to your questions.

Este mensaje está dirigido a las personas que participaron en al menos una reunión de los Grupos de Trabajo de MHSA del 27 de octubre al 5 de diciembre de 2023, ya sea en persona o en línea como oyente.
Si no asistió a una reunión de los Grupo de Trabajo de MHSA el 27 de octubre, el 7 y 17 de noviembre y el 5 de diciembre, ignore este mensaje.
Si asistió al menos a una de las reuniones de los Grupos de Trabajo del 27 de octubre al 5 de diciembre, le agradecemos de antemano que se haya tomado el tiempo de calificar las recomendaciones de MHSA para los Grupos de Trabajo a los que asistió. Por favor, sólamente califique las recomendaciones de los Grupos de Trabajo a los que no asistió.

En el transcurso de las sesiones de los Grupos de Trabajo, usted ha desarrollado una comprensión más profunda de los problemas críticos generales (necesidades insatisfechas y brechas de servicio) y preocupaciones de equidad más específicas de las poblaciones y/o geografías desatendidas relacionadas con el tema de su Grupo de Trabajo.

Los siguientes enlaces le dan acceso a las recomendaciones y a la rúbrica de cada uno de los Grupos de Trabajo. De nuevo, solo califique las recomendaciones para el grupo de trabajo al que asistió.

Grupo de trabajo	Enlace de la encuesta (inglés y español)
Continuum de Apoyos Comunitarios (CSC)	Inglés: https://forms.office.com/g/39FFHCikbk Español: https://forms.office.com/g/JTs2rRQN4N
Servicios para Personas sin Hogar y Recursos de Vivienda (HSHR, por sus siglas en inglés)	Inglés: https://forms.office.com/g/JFhLiLrHWB Español: https://forms.office.com/g/YuKd5ufqt2
Prevención e Intervención Temprana (PEI)	Inglés: https://forms.office.com/g/aRUShqSvRu Español: https://forms.office.com/g/zRpijg7diZ
Educación y Capacitación de la Fuerza Laboral (WET)	Inglés: https://forms.office.com/g/r7xSAxvkZh Español: https://forms.office.com/g/nFc1NcpUAs

Adjunto encontrarán las recomendaciones y la rúbrica de los diferentes Grupos de Trabajo en caso de que desee revisarlas y calificarlas antes de cargar sus puntajes en la encuesta en línea.

Los puntajes deben entregarse antes de las *5 p.m. del viernes 5 de enero de 2024.*
Si tiene alguna pregunta sobre cómo calificar las recomendaciones, comuníquese con el personal de la División MHSA en communitystakeholder@dmh.lacounty.gov.
El personal estará disponible del 2 al 5 de enero de 2024 para responder a sus preguntas.

MHSA Stakeholders Community Planning Team (CPT) Meeting – December 15, 2023

This is a friendly reminder of our upcoming in-person-only Community Planning Team (CPT) session on Friday, December 15, 2023, 9:30a-12:30p, at St. Anne's Conference Center, located at 155 N. Occidental Blvd, Los Angeles, CA 90026. Here is the MS Teams link if you want to listen to the session:
Click here to join the meeting
Meeting ID: 238 297 755 846
Passcode: PmTQ9e
Download Teams | Join on the web
Or call in (audio only)
+1 323-776-6996,,187170619#
Phone Conference ID: 187 170 619#
Meeting Materials:

- Agenda (English/Spanish)
- Presentation Slides (English/Spanish)

The primary purpose of this session is to update the CPT members and other MHSA stakeholders on the final steps to complete the community planning process for the *MHSA Three-Year Plan*.
Since the December 5th meeting, DMH Workgroup Leads have focused on two core tasks:

- Sorting through all the CPT recommendations to determine which ones are ready to go forward, which CPT recommendations cannot be funded due to MHSA regulations (or other reasons), and which ones require additional feedback from CPT members and stakeholders.
- Conducting an internal review of more than 130 funding proposals that came through the MHSA portal to determine which ones to present to the CPT members and stakeholders for additional feedback.

At the December 15th meeting, we want to focus on three objectives:

1. Describe the process, criteria, and rationale used for the aforementioned tasks.
2. Review the steps through the end of January 2024 to build consensus among CPT members.
3. Discuss how to pivot the CPT's role from 'planning' to 'monitoring' the implementation of the MHSA Three-Year Plan.

As described in the December 5th communication, our intention is to close the planning process on January 26, 2024, and using the month of February to present the draft plan to your constituents and obtain additional feedback.

In March, we anticipate that the Los Angeles County Mental Health Commission will host a public hearing on the proposed plan. After that hearing, the proposed plan will go to the Los Angeles County Board of Supervisors for a final hearing and then sent to the state for final approval.

To continue to stay connected with each other as the proposed plan moves from approval to implementation, we have reserved St. Anne's Conference Center for in-person meetings on the following Fridays (from 9:30-12:30): February 23, March 22, April 26, May 24, and June 28.

We sincerely hope that you will continue to participate actively during the two-year implementation phase that begins on July 1, 2024. Your participation and insights will help guide the implementation phase.

If you are a CPT member and unable to attend the upcoming meeting, please contact us by 5 PM on Thursday, December 14th at communitystakeholder@dmh.lacounty.gov and provide us the name of your alternate.
If you have any questions about this message, please contact us at communitystakeholder@dmh.lacounty.gov

REORDATORIO AMISTOSO – Reunión en persona de MHSA CPT el viernes 15 de diciembre de 9:30 a 12:30 en el Centro de Conferencias de St. Anne
ESTIMADOS GRUPOS DE INTERÉS DE MHSA,
Este es un recordatorio amistoso de nuestra próxima sesión presencial del Equipo de Planificación Comunitaria (CPT, por sus siglas en inglés) el viernes 15 de diciembre de 2023, de 9:30a a 12:30p, en el Centro de Conferencias de St. Anne, ubicado en 155 N. Occidental Blvd, Los Ángeles, CA 90026. Aquí está el enlace de MS Teams si desea escuchar la sesión:
CPT Español
Call in (audio only)
+1 323-776-6996,,241199544#
Phone Conference ID: 241 199 544#
Meeting Materials:

- Agenda (English/Spanish)
- Presentation Slides (English/Spanish)

El propósito principal de esta sesión es actualizar a los miembros del CPT y otros grupos interesados sobre los pasos finales para completar el proceso de planificación comunitaria para el *Plan de Tres Años de MHSA*.
Desde la reunión del 5 de diciembre, los líderes del grupo de trabajo del DMH se han centrado en dos tareas principales:

- Clasificar todas las recomendaciones del CPT para determinar cuáles están listas para seguir adelante, qué recomendaciones del CPT no pueden financiarse debido a las regulaciones de MHSA (u otras razones) y cuáles requieren comentarios adicionales de los miembros del CPT y los grupos interesados.
- Llevar a cabo una revisión interna de más de 130 propuestas de financiamiento que llegaron a través del portal de MHSA para determinar cuáles presentar a los miembros de CPT y a los grupos interesados para obtener comentarios adicionales.

En la reunión del 15 de diciembre, queremos centrarnos en tres objetivos:

1. Describir el proceso, los criterios y la justificación utilizados para las tareas antes mencionadas.
2. Revisar los pasos hasta finales de enero de 2024 para crear consenso entre los miembros del CPT.
3. Discuta cómo cambiar el papel del CPT de “planificación” a “monitoreo” de la implementación del Plan Trienal de MHSA.

Como se describe en la comunicación del 5 de diciembre, nuestra intención es cerrar el proceso de planificación el 26 de enero del 2024 y utilizar el mes de febrero para presentar el borrador del plan a sus grupos y obtener comentarios adicionales.

En marzo, anticipamos que la Comisión de Salud Mental del Condado de Los Ángeles organizará una audiencia pública sobre el plan propuesto. Después de esa audiencia, el plan propuesto irá a la Junta de Supervisores del Condado de Los Ángeles para una audiencia final y luego se enviará al estado para su aprobación final.

Para continuar conectados entre sí a medida que el plan propuesto pasa de la aprobación a la implementación, hemos reservado el Centro de Conferencias de St. Anne para reuniones en persona los siguientes viernes (de 9:30 a 12:30): 23 de febrero, 22 de marzo, 26 de abril, 24 de mayo y 28 de junio.

Esperamos sinceramente que continúe participando activamente durante la fase de implementación de dos años que comienza el 1 de julio de 2024. Su participación y conocimientos ayudarán a guiar la fase de implementación.

Si usted es miembro de ECAP y no puede asistir a la próxima reunión, comuníquese con nosotros antes de las 5 p.m. del jueves 14 de diciembre a las communitystakeholder@dmh.lacounty.gov y proporciónenos el nombre de su suplente.
Si tiene alguna pregunta sobre este mensaje, póngase en contacto con nosotros en communitystakeholder@dmh.lacounty.gov

MHSA Stakeholders Community Planning Team (CPT) Meeting – December 5, 2023
We look forward to seeing you at the upcoming in-person-only Community Planning Team (CPT) meeting on **Tuesday, December 5, 2023, from 9:30 a.m. – 12:30 p.m.** to continue our planning efforts for the *MHSA Three-Year Plan for fiscal years 2024-25 and 2025-26.*
The meeting will be held at St. Anne's Conference Center, 155 N. Occidental Blvd., Los Angeles, CA, 90026. Although Friday's session will be **in-person only**, you can follow the session virtually using the following links:
For those who want to listen to the Housing Workgroup 9:30-12:30 session, here's the MS Teams link:
Click here to join the meeting
Meeting ID: 256 624 233 396
Passcode: srmPzB
Download Teams | Join on the web
Or call in (audio only)
+1 323-776-6996,,545663717# United States, Los Angeles
Phone Conference ID: 545 663 717#
For those who want to listen to the PEI Workgroup 930-11:00 session, here's the MS Teams link:
Click here to join the meeting
Meeting ID: 219 361 210 108
Passcode: TQcQzm
Download Teams | Join on the web
Call in (audio only)
+1 323-776-6996,,52166974#
Phone Conference ID: 521 669 74#
For those who want to listen to the WET Workgroup 11:00-12:30 session, here's the MS Teams link:
Click here to join the meeting
Meeting ID: 219 361 210 108
Passcode: TQcQzm
Download Teams | Join on the web
Call in (audio only)
+1 323-776-6996,,52166974#
Phone Conference ID: 521 669 74#
Meeting Materials:

- CPT Session Worksheet (English/Spanish)
- PEI Category 1 (English/Spanish)
- PEI Category 2 (English/Spanish)
- PEI Category 3 (English/Spanish)
- HSHR Categories 1-5 (English/Spanish)
- WET Categories 1 & 4 (English/Spanish)
- WET Categories 2 & 3 (English/Spanish)

As a reminder, we have one remaining session in December.

DATES	GROUP	MODE	LOCATION
December 15	CPT	In-Person Only	St. Anne's Conference Center

Should you wish to join our mailing list, please subscribe at:
https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952

Reunión del equipo de planificación comunitaria de MHSA – Martes 5 de Diciembre 2023, de 9:30 a.m. a 12:30 p.m. en el Centro de Conferencias de St. Anne's

Esperamos verlos en la próxima reunión presencial del Equipo de Planificación Comunitaria (CPT) el **martes 5 de Diciembre del 2023, de 9:30 a.m. a 12:30 p.m.** para continuar nuestros esfuerzos de planificación para el *Plan Trienal de la MHSA para los años fiscales 2024-25 y 2025-26.*

La reunión se llevará a cabo en el Centro de Conferencias St. Anne's, 155 N. Occidental Blvd., Los Ángeles, CA, 90026. Aunque la sesión del martes será solo en persona, puede seguir la sesión virtualmente utilizando el siguiente enlaces:

Para aquellos que quieran escuchar la sesión del grupo de trabajo Housing 9:30-12:30, aquí está el enlace de MS Teams:
Click here to join the meeting
Identificación de reunión: 256 624 233 396
Clave: srmPzB
Llamada (solo audio)
+1 323-776-6996,,845543743#
Identificación de llamada de conferencia: 845 543 743#

Para aquellos que quieran escuchar la sesión del grupo de trabajo PEI 9:30-11:00, aquí está el enlace de MS Teams:
Click here to join the meeting
Identificación de reunión: 219 361 210 108
Clave: TQcQzm
Llamada (solo audio)
+1 323-776-6996,,212103868#
Identificación de llamada de conferencia: 212 103 868#

Para aquellos que quieran escuchar la sesión del grupo de trabajo WET 11:00-12:30, aquí está el enlace de MS Teams:
Click here to join the meeting
Identificación de reunión: 219 361 210 108
Clave: TQcQzm
Llamada (solo audio)
+1 323-776-6996,,212103868#
Identificación de llamada de conferencia: 212 103 868#

Meeting Materials:

- CPT Session Worksheet (English/Spanish)
- PEI Category 1 (English/Spanish)
- PEI Category 2 (English/Spanish)
- PEI Category 3 (English/Spanish)
- HSHR Categories 1-5 (English/Spanish)
- WET Categories 1 & 4 (English/Spanish)
- WET Categories 2 & 3 (English/Spanish)

A modo de recordatorio, nos quedan uno mas session en Diciembre.

FECHAS	GRUPO	MODO	UBICACIÓN
15 de diciembre	CPT	Solo en persona	St. Anne's Conference Center

Si desea unirse a nuestra lista de correo, suscríbase en: https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952
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MHSA Stakeholders Community Planning Team (CPT) Meeting – November 17, 2023
We look forward to seeing you at the upcoming *in-person-only* Community Planning Team (CPT) meeting on **Friday, November 17, 2023, from 9:30 a.m. – 12:30 p.m.** to continue our planning efforts for the *MHSA Three-Year Plan for fiscal years 2024-25 and 2025-26.*
The meeting will be held at St. Anne's Conference Center, 155 N. Occidental Blvd., Los Angeles, CA, 90026. Although Friday's session will be **in-person only**, you can follow the session virtually using the following links:
For those who want to listen to the PEI Workgroup session, here's the MS Teams link: Click here to join the meeting
Or call in (audio only) +1 323-776-6996,,236195697#
Phone Conference ID: 236 195 697#
For those who want to listen to the CSC Workgroup session, here's the MS Teams link: Click here to join the meeting
Or call in (audio only) +1 323-776-6996,,568511692#
Phone Conference ID: 568 511 692#
Meeting Materials:

CPT Session Agenda (English/Spanish)
PEI Programs (English/Spanish)
PEI Category 2 (English/Spanish)
PEI Category 3 (English/Spanish)
CSC Recommendations (English/Spanish)
As a reminder, we have two remaining sessions.

DATES	GROUP	MODE	LOCATION
December 5	CPT	In-Person Only	St. Anne's Conference Center
December 15	CPT	In-Person Only	St. Anne's Conference Center

Should you wish to join our mailing list, please subscribe at:
https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952

Reunión del equipo de planificación comunitaria de MHSA – Viernes 17 de Noviembre 2023, de 9:30 a.m. a 12:30 p.m. en el Centro de Conferencias de St. Anne's
Esperamos verlos en la próxima reunión presencial del Equipo de Planificación Comunitaria (CPT) el **viernes 17 de Noviembre del 2023, de 9:30 a.m. a 12:30 p.m.** para continuar nuestros esfuerzos de planificación para el *Plan Trienal de la MHSA para los años fiscales 2024-25 y 2025-26.*
La reunión se llevará a cabo en el Centro de Conferencias St. Anne's, 155 N. Occidental Blvd., Los Ángeles, CA, 90026. Aunque la sesión del martes será solo en persona, puede seguir la sesión virtualmente utilizando el siguiente enlaces:

Para aquellos que quieran escuchar la sesión del grupo de trabajo PEI, aquí está el enlace de MS Teams: Click here to join the meeting
Llamada (solo audio) +1 323-776-6996,,236195697#
Identificación de llamada de conferencia: 236 195 697#
Para aquellos que quieran escuchar la sesión del grupo de trabajo CSC, aquí está el enlace de MS Teams: Click here to join the meeting
Llamada (solo audio) +1 323-776-6996,,568511692#
Identificación de llamada de conferencia: : 568 511 692#
Meeting Materials:

CPT Session Agenda (English/Spanish)
PEI Programs (English/Spanish)
PEI Category 3 (English/Spanish)
CSC Recommendations (English/Spanish)
A modo de recordatorio, nos quedan dos sesiones.

FECHAS	GRUPO	MODO	UBICACIÓN
5 de diciembre	CPT	Solo en persona	St. Anne's Conference Center
15 de diciembre	CPT	Solo en persona	St. Anne's Conference Center

Requests for Proposals (RFPs) Application Being Accepted for 2024 Take Action LA Community Grants Program (NEW)
LACDMH and CalMHSA are seeking mission-driven partners for May 2024 to enhance mental health awareness and well-being in the community. Grants will support diverse and innovative organizations in organizing events that align with LACDMH's Take Action LA for Mental Health campaign. These grants, ranging from $25,000 to $150,000, aim to promote mental health awareness, community connections, and a theme of taking action for oneself, others, and the community.

Everything your organization needs to apply is in the Bonfire procurement portal: https://calmhsa.bonfirehub.com/.

- The Bidder's Conference was recorded and has been posted in Bonfire.
- The deadline to submit questions was **extended** to November 14, 2023 at 5 p.m. PST. Remember, all questions must be submitted through Bonfire.
- Questions will now be answered and posted by November 20, 2023 at 5pm PST.
- The application deadline has been **extended** to December 1, 2023 at 5 p.m. PST. Submit your completed application form through Bonfire.
- The grant period (dates events can be held) must take place from May 1 to May 31, 2024.

MHSA Stakeholders Community Planning Team (CPT) Meeting – November 7, 2023
We look forward to seeing you at the upcoming in-person-only Community Planning Team (CPT) meeting on **Tuesday, November 7, 2023, from 9:30 a.m. – 12:30 p.m.** to continue our planning efforts for the *MHSA Three-Year Plan for fiscal years 2024-25 and 2025-26.*
The meeting will be held at St. Anne's Conference Center, 155 N. Occidental Blvd., Los Angeles, CA, 90026. Although Tuesday's session will be **in-person only**, you can follow the session virtually using the link here.
Click to view **9:30 – 11:00 a.m. CPT PEI and CSC Workgroup** meeting links.
Click to view **11:00 a.m. – 12:00 p.m. CPT WET and Housing Workgroup** meeting links.
Click to view CPT documents:

- CPT Planning Session 9 – English

- CPT Three Year Plan – CSC – English
- CPT Three Year Plan – HSHR – English
- CPT Three Year Plan – PEI – English
- CPT Three Year Plan – WET – English

Below is a calendar of the remaining sessions:

DATES	GROUP	WAY	LOCATION
November 7	CPT	Only in person	St. Anne's Conference Center
November 17	Workgroups	Only in person	St. Anne's Conference Center
December 5	CPT	Only in person	St. Anne's Conference Center
December 15	CPT	Only in person	St. Anne's Conference Center

Should you wish to join our mailing list, please subscribe at:
https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952

Reunión del equipo de planificación comunitaria de MHSA – Martes 7 de Noviembre 2023, de 9:30 a.m. a 12:30 p.m. en el Centro de Conferencias de St. Anne's

Esperamos verlos en la próxima reunión presencial del Equipo de Planificación Comunitaria (CPT) el **Martes 7 de Noviembre del 2023, de 9:30 a.m. a 12:30 p.m.** para continuar nuestros esfuerzos de planificación para el *Plan Trienal de la MHSA para los años fiscales 2024-25 y 2025-26.*

La reunión se llevará a cabo en el Centro de Conferencias St. Anne's, 155 N. Occidental Blvd., Los Ángeles, CA, 90026. Aunque la sesión del martes será solo en persona, puede seguir la sesión virtualmente utilizando el siguiente enlace aquí.

Haga clic para ver los enlaces de las reuniones **del grupo de trabajo CPT PEI y CSC de 9:30 a 11:00 a. m.**

Haga clic para ver 11:00 a. m. – 12:00 p. m. Enlaces a las reuniones **del CPT WET y sobre Vivienda.**

Click to view CPT documents:

- CPT Sesión 9 – Español
- CPT El Plan Trienal – CSC – Español
- CPT El Plan Trienal – HSHR – Español
- CPT El Plan Trienal – PEI – Español
- CPT El Plan Trienal – WET – Español

A continuación se muestra un calendario de las sesiones restantes:

FECHAS	GRUPO	MODO	UBICACIÓN
7 de Noviembre	CPT	Solo en persona	St. Anne's Conference Center
17 de Noviembre	Grupos de trabajo	Solo en persona	St. Anne's Conference Center

FECHAS	GRUPO	MODO	UBICACIÓN
5 de Diciembre	CPT	Solo en persona	St. Anne's Conference Center
15 de Diciembre	CPT	Solo en persona	St. Anne's Conference Center

Si desea unirse a nuestra lista de correo, suscríbase en: https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952
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MHSA Stakeholders Community Planning Team (CPT) Meeting – October 27, 2023
We look forward to seeing you at the upcoming virtual Community Planning Team (CPT) workgroups meeting on **Friday, October 27, 2023, from 9:30 a.m. – 12:30 p.m.** to continue our planning efforts for the *MHSA Three-Year Plan for fiscal years 2024-25 and 2025-26.*
The meeting will be held **ONLINE ONLY.** Please use the following links to log on to the MHSA workgroup of your choice:

Prevention / Early Intervention (PEI) Workgroup
9:30 – 11:00 a.m. Click here to join the meeting
Meeting ID: 236 391 692 272
Passcode: SAWU3z **Or call in (audio only)**
+1 323-776-6996,,166413205#
Phone Conference ID: 166 413 205#

Community Services Support Continuum (CSC) Workgroup
9:30 – 11:00 a.m. Click here to join the meeting
Meeting ID: 294 467 060 793
Passcode: xaYja3 **Or call in (audio only)**
+1 323-776-6996,,233507836#
Phone Conference ID: 233 507 836#

Housing Workgroup
11:00 a.m. – 12:30 p.m. Click here to join the meeting
Meeting ID: 287 883 383 378
Passcode: pzjrs9 **Or call in (audio only)**
+1 323-776-6996,,689988842#
Phone Conference ID: 689 988 842#

Workforce Education & Training (WET) Workgroup
11:00 a.m. – 12:30 p.m. Click here to join the meeting
Meeting ID: 248 314 222 782
Passcode: rK37md **Or call in (audio only)**
+1 323-776-6996,,644506425#
Phone Conference ID: 644 506 425#

Below is a calendar of the remaining sessions:

DATES	GROUP	METHOD	TIME	LOCATION
October 27	Workgroups	Online only	9:30 a.m. – 12:30 p.m.	N/A
November 7	CPT	Only in person	9:30 a.m. – 12:30 p.m.	St. Anne's Conference Center

DATES	GROUP	METHOD	TIME	LOCATION
November 17	Workgroups	Only in person	9:30 a.m. – 12:30 p.m.	St. Anne's Conference Center
December 5	CPT	Only in person	9:30 a.m. – 12:30 p.m.	St. Anne's Conference Center
December 15	CPT	Only in person	9:30 a.m. – 12:30 p.m.	St. Anne's Conference Center

Click to view CPT documents:

- CSC (English / Spanish)
- HSHR (English / Spanish)
- PEI (English / Spanish)
- WET (English / Spanish)

Should you wish to join our mailing list, please subscribe at:
https://public.govdelivery.com/accounts/CALACOUNTY/subscriber/new?topic_id=CALACOUNTY_2952

Mid-Year Adjustment to the MHSA FY 2023–24 Annual Update
Public Review and Comment Period: October 4 through November 2, 2023

- FY 23-24 MHSA Mid-Year Adjustment
- Feedback by email
- Online Feedback Survey

MHSA Stakeholders Community Planning Team (CPT) Meeting – October 3, 2023
We look forward to seeing you at the upcoming in-person-only Community Planning Team (CPT) meeting on **Tuesday, October 3, 2023, from 9 a.m. – 12 p.m.** to continue our planning efforts for the *MHSA Three-Year Plan for fiscal years 2024-25 and 2025-26.*
The meeting will be held at St. Anne's Conference Center, located at 155 N. Occidental Blvd, Los Angeles, CA, 90026. Although Tuesday's session will be **in person only**, you can follow the session virtually using the link below:
Click here to join the meeting
Meeting ID: 252 223 201 332 | Passcode: fSjebg
Or call (audio only): +1 323-776-6996,,720310501#
Phone Conference ID: 720 310 501#
Below is a calendar of the remaining sessions.

DATES	GROUP	WAY	LOCATION
October 27	Workgroups	Online only	N/A
November 7	CPT	Only in person	St. Anne's Conference Center
November 17	Workgroups	Only in person	St. Anne's Conference Center
December 5	CPT	Only in person	St. Anne's Conference Center
December 15	CPT	Only in person	St. Anne's Conference Center

If you are a CPT member and are unable to attend, please contact us by Monday, October 2 at communitystakeholder@dmh.lacounty.gov and provide us with the name of your alternate. Please use the same email to contact us with any questions about this message.
Meeting Agenda (English / Spanish)
Meeting Presentation (English / Spanish)
CPT Critical Issues (English / Spanish)

Reunión del equipo de planificación comunitaria de MHSA – 3 de octubre de 2023, de 9 a.m. a 12 p.m. en el Centro de Conferencias de St. Anne's
Esperamos verlos en la próxima reunión presencial del Equipo de Planificación Comunitaria (CPT) el **martes 3 de octubre del 2023, de 9 a.m. a 12 p.m.** para continuar nuestros esfuerzos de planificación para el *Plan Trienal de la MHSA para los años fiscales 2024-25 y 2025-26.*
La reunión se llevará a cabo en el Centro de Conferencias St. Anne's, ubicado en 155 N. Occidental Blvd, Los Ángeles, CA, 90026. Aunque la sesión del martes será solo en persona, puede seguir la sesión virtualmente utilizando el siguiente enlace:

Haga clic aquí para unirse a la reunión
ID de reunión: 252 223 201 332 | Código de acceso: fSjebg
O llame (solo audio)
+1 323-776-6996,,720310501# Estados Unidos, Los Ángeles
Teléfono ID de conferencia: 720 310 501#
A continuación se muestra un calendario de las sesiones restantes.

FECHAS	GRUPO	MODO	UBICACIÓN
27 de octubre	Grupos de trabajo	Solo en línea	N/A
7 de noviembre	CPT	Solo en persona	St. Anne's Conference Center
17 de noviembre	Grupos de trabajo	Solo en persona	St. Anne's Conference Center

FECHAS	GRUPO	MODO	UBICACIÓN
5 de diciembre	CPT	Solo en persona	St. Anne's Conference Center
15 de diciembre	CPT	Solo en persona	St. Anne's Conference Center

Si es miembro del CPT y no puede asistir, comuníquese con nosotros el lunes 2 de octubre a mas tardar al communitystakeholder@dmh.lacounty.gov y proporciónenos el nombre de su suplente. Utilice el mismo correo electrónico para contactarnos si tiene alguna pregunta sobre este mensaje.
Meeting Agenda (English / Spanish)
Meeting Presentation (English / Spanish)

MHSA Stakeholders Community Planning Team (CPT) Meeting – September 22, 2023
We look forward to seeing you at the upcoming online-only Workgroup meeting on **Friday, September 22, 2023**, to continue our planning efforts for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26. The Workgroups will meet at the following times:

TIME	WORKGROUPS	
9:00a-10:30a	Prevention & Early Intervention (PEI)	Community Supports Continuum (CSC)
10:30a-12:00p	Workforce Education & Training (WET)	Homeless Services & Housing Resources (HSHR)

Again, the upcoming session will be online only using the following link:
Click here to join the meeting, Meeting ID: 254 498 173 837 | Passcode: hSeNV8
Or call in (audio only) at 323-776-6996, Phone Conference ID: 461 656 780#
Meeting documents are available here. If you have any questions about this message, please reach out to at MHSAAdmin@dmh.lacounty.gov.
If you are unable to attend, please contact us by this Wednesday, September 20, at communitystakeholder@dmh.lacounty.gov to provide us the name of your alternate. Please review the materials in these attachments. Below is a calendar of the remaining sessions. All sessions are from 9 AM-12 PM.

DATES	GROUP	MODE	LOCATION
October 3	CPT	In Person Only	St. Anne's Conference Center
October 27	Workgroups	Online Only	N/A
November 7	CPT	In Person Only	St. Anne's Conference Center
November 17	Workgroups	In Person Only	St. Anne's Conference Center

DATES	GROUP	MODE	LOCATION
December 5	CPT	In Person Only	St. Anne's Conference Center
December 15	CPT	In Person Only	St. Anne's Conference Center

RECORDATORIO AMISTOSO – Reuniones solo en línea del grupo de trabajo de MHSA – Viernes 22 de septiembre de 9 a.m. a 12 p.m.
Esperamos verlas y verlos en la próxima reunión de los grupos de trabajo el viernes 22 de septiembre de 2023, para continuar nuestros esfuerzos de planificación para el *Plan trienal de MHSA para los años fiscales 2024-25 y 2025-26.* Los grupos de trabajo se reunirán en los siguientes horarios:

HORA	GRUPOS DE TRABAJO	
9:00-10:30	PEI	CSC
10:30-12:00	MOJADO	HSHR

Una vez más, la próxima sesión será en línea solamented utilizando el siguiente enlace:
Haga clic aquí para unirse a la reunión, ID de reunión: 254 498 173 837 | Código de acceso: hSeNV8
O llame (solo audio) al 323-776-6996, ID de conferencia telefónica: 461 656 780#
Los documentos de la reunión están disponibles aquí. Si tiene alguna pregunta sobre este mensaje, comuníquese con nosotros asl communitystakeholder@dmh.lacounty.gov.
Si no puede asistir, contáctenos a mas tardar este miércoles 20 de septiembre a communitystakeholder@dmh.lacounty.gov para proporcionarnos el nombre de su suplente. Por favor revise los materiales en estos archivos adjuntos. A continuación se muestra un calendario de las sesiones restantes. Todas las sesiones son de 9 AM a 12 PM.

FECHAS	GRUPO	MODO	UBICACIÓN
3 de octubre	CPT	Solo en persona	Centro de Conferencias St. Anne's
27 de octubre	Grupos de trabajo	Solo en línea	N/A
7 de noviembre	CPT	Solo en persona	Centro de Conferencias St. Anne's
17 de noviembre	Grupos de trabajo	Solo en persona	Centro de Conferencias St. Anne's
5 de diciembre	CPT	Solo en persona	Centro de Conferencias St. Anne's
15 de diciembre	CPT	Solo en persona	Centro de Conferencias St. Anne's

Client Activity Fund (CAF) Orientation Meeting – September 8, 2023, 1 p.m. to 3:30 p.m.
Please refer to the below materials for this meeting:

- CAF Participant Onboarding Protocol (English/Spanish/Korean)
- CAF Application (English/Spanish/Korean)
- W9 Form (English/Spanish/Korean)
- CAF Claim Form (English/Spanish/Korean)
- CAF Attestation (English/Spanish/Korean)

The meeting link and Spanish and Korean Language line numbers are listed below. CART and ASL services will be available and the links to those services will be dropped in the Chat at the beginning of the meeting.

Join on your computer, mobile app or room device
Click here to join the Microsoft Teams meeting
Meeting ID: 227 609 944 487
Passcode: t8JdK7
Download Teams | Join on the web
Call in (audio only)
+1 323-776-6996,,928584589#
Phone Conference ID: 928 584 589#
Spanish Language Line; Call in (audio only)
+1 323-776-6996,,52701870#
Phone Conference ID: 527 018 70#
Korean Language Line; Call in (audio only)
+1 323-776-6996,,342673466#
Phone Conference ID: 342 673 466#

MHSA Community Planning Team Meeting – September 5, 2023, 9 a.m. to noon
We look forward to seeing you at the upcoming Community Planning Team (CPT) meeting on **Tuesday, September 5, 2023**, to continue our planning efforts for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26.
The upcoming session will be in-person only. If you are unable to attend, please contact us by this Thursday, August 31st at communitystakeholder@dmh.lacounty.gov to provide us the name of your alternate. You can also observe the session virtually via the following link:
Click here to join the meeting
Meeting ID: 245 923 839 837 | Passcode: uWctrb
Or call in (audio only): +1 323-776-6996,,865836491#
Phone Conference ID: 865 836 491#
(Anyone can view the session, but only people attending the session in-person will be able to participate in the discussions.)

To recap, the July and August sessions focused on three foundational topics to onboard CPT members:

- The structure of the community planning process for the MHSA Three-Year Plan for FY 2024-25 and 2025-26;

- The MHSA components (Prevention and Early Intervention; Community Supports and Services; Workforce Education and Training; Innovations; and Information Technology/Capital Facilities); and
- Population and client data pertaining to DMH and MHSA.

The purpose of the two September sessions is to obtain and analyze community stakeholder input for each of the workgroup areas:

- *Prevention and Early Intervention (PEI)*: Focuses on building protective factors, preventing trauma, eliminating mental health stigma, and intervening at the early onset of mental health challenges. Strategies include prevention, suicide prevention, early intervention, stigma and discrimination reduction, and outreach to increase recognition of early signs of mental illness.
- *Community Supports Continuum (CSC)*: Promotes recovery, hope, and well-being for individuals experiencing serious mental health challenges through a continuum of community supports that includes the following: urgent/emergency services; intensive services; outpatient care services; and access points.
- *Homeless Services and Housing Resources (HSHR)*: Provides mental health services and housing resources for individuals experiencing serious mental health challenges through Homeless Services (i.e., outreach and treatment; and housing supports) and Housing Resources (i.e., short-term interim housing; and long-term permanent supportive housing).
- *Workforce Education and Training (WET)*: Focuses on recruiting and sustaining a highly qualified and talented workforce for the public mental health system in order to deliver culturally competent, congruent, and effective services for linguistically and culturally diverse mental health consumers who meet Specialty Mental Health service criteria.

We encourage all CPT members to consult their constituencies in September to develop a clear list of their community's needs with regards to each of the aforementioned areas (i.e., PEI, CSC, HSHR, and WET). At the beginning of the September 5th session, community stakeholders will be asked to share their community's specific needs within each area. There will be additional opportunities in future sessions to provide more input. Below is a calendar of the remaining sessions. All sessions are from 9AM-12 PM. The in-person session will all be held at St. Anne's Conference Center.

DATES	GROUP	MODE
September 5	CPT	In Person Only
September 22	Workgroups	Online Only
October 3	CPT	In Person Only
October 27	Workgroups	Online Only
November 7	CPT	In Person Only
November 17	Workgroups	In Person Only
December 5	CPT	In Person Only
December 15	CPT	In Person Only

The Workgroups will meet at the following times:

TIME	WORKGROUPS	
9:00-10:30	PEI	CSC
10:30-12:00	WET	HSHR

Please review the below material in preparation for this meeting. If you have any questions about this message, please reach out to at MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda (English/Spanish)
- Meeting Slides (English/Spanish)

Reunión presencial del CPT – Martes 5 de septiembre de 9 a 12 p.m.
Esperamos verlos en la próxima reunión del Equipo de Planificación Comunitaria (CPT, siglas en inglés) el **martes 5 de septiembre de 2023**, para continuar nuestros esfuerzos de planificación para el Plan Trienal de MHSA *para los años fiscales 2024-25 y 2025-26.*
La próxima sesión será solo en persona. Si no puede asistir, contáctenos este jueves 31 de agosto a communitystakeholder@dmh.lacounty.gov para proporcionarnos el nombre de su suplente. También puede observar la sesión virtualmente a través del siguiente enlace:
Haga clic aquí para unirse a la reunión
ID de reunión: 245 923 839 837 | Código de acceso: uWctrb
O llame (solo audio): +1 323-776-6996,,865836491#
ID de conferencia telefónica: 865 836 491#
(Cualquiera puede ver la sesión, pero solo las personas que asistan a la sesión en persona podrán participar en las discusiones).

Para recapitular, las sesiones de julio y agosto se centraron en tres temas fundamentales para incorporar a los miembros del CPT:

- La estructura del proceso de planificación comunitaria para el Plan Trienal de MHSA para los años fiscales 2024-25 y 2025-26;
- Los componentes de MHSA (Prevención e Intervención Temprana; Apoyos y Servicios Comunitarios; Educación y Capacitación de la Fuerza Laboral; Innovaciones; y Tecnología de la Información/Instalaciones de Inmobiliario); y
- Datos de población y clientes relacionados con DMH y MHSA.

El propósito de las dos sesiones de septiembre es obtener y analizar los aportes de las partes interesadas de la comunidad para cada una de las áreas de los equipos de trabajo:

- *Prevención e intervención temprana (PEI)*: Se enfoca en desarrollar factores de protección, prevenir traumas, eliminar el estigma de salud mental e intervenir en el inicio temprano de los desafíos de salud mental. Las estrategias incluyen prevención, prevención del suicidio, intervención temprana, reducción del estigma y la discriminación, y divulgación para aumentar el reconocimiento de los signos tempranos de enfermedad mental.
- *Continuo de apoyos comunitario (CSC):* Promueve la recuperación, la esperanza y el bienestar de las personas que experimentan serios desafíos de salud mental a través de un continuo de apoyos comunitarios que incluye lo siguiente: servicios de urgencia / emergencia; servicios intensivos; servicios de atención ambulatoria; y puntos de acceso.
- *Servicios para personas sin hogar y recursos de vivienda (HSHR):* Proporciona servicios de salud mental y recursos de vivienda para personas que experimentan serios problemas de salud mental a través de Servicios para personas sin hogar (es decir, alcance y tratamiento; y apoyos de

vivienda) y Recursos de vivienda (es decir, vivienda provisional a corto plazo; y vivienda de apoyo permanente a largo plazo).

- *Educación y capacitación de la fuerza laboral (WET):* Se enfoca en reclutar y mantener una fuerza laboral altamente calificada y talentosa para el sistema público de salud mental con el fin de brindar servicios culturalmente competentes, congruentes y efectivos para consumidores de salud mental lingüística y culturalmente diversos que cumplen con los criterios de servicios especializados de salud mental.

Alentamos a todos los miembros del CPT a consultar a sus comunidades en septiembre para desarrollar una lista clara de las necesidades de su comunidad con respecto a cada una de las áreas mencionadas (es decir, PEI, CSC, HSHR y WET). Al comienzo de la sesión del 5 de septiembre, se pedirá a las partes interesadas de la comunidad que compartan las necesidades específicas de su comunidad dentro de cada área. Habrá oportunidades adicionales en futuras sesiones para hacer más aportaciones. A continuación se muestra un calendario de las sesiones restantes. Todas las sesiones son de 9 AM a 12 PM. La sesión en persona se llevará a cabo en el Centro de Conferencias de St. Anne's.

FECHAS	GRUPO	MODO
5 de septiembre	CPT	Solo en persona
22 de septiembre	Grupos de trabajo	Solo en línea
3 de octubre	CPT	Solo en persona
27 de octubre	Grupos de trabajo	Solo en línea
7 de noviembre	CPT	Solo en persona
17 de noviembre	Grupos de trabajo	Solo en persona
5 de diciembre	CPT	Solo en persona
15 de diciembre	CPT	Solo en persona

Los Grupos de Trabajo se reunirán en los siguientes horarios:

HORA	GRUPOS DE TRABAJO	
9:00-10:30	PEI	CSC
10:30-12:00	WET	HSHR

Sírvase revisar el material adjunto en preparación para esta reunión. Si tiene alguna pregunta sobre este mensaje, comuníquese con al MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda (English/Spanish)
- Meeting Slides (English/Spanish)

MHSA Community Planning Team Meeting – August 25, 2023, 9 a.m. to noon
We look forward to seeing you at the upcoming Community Planning Team (CPT) meeting on **Friday, August 25, 2023** from 9 a.m. -12 p.m. to continue our planning efforts for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26.
Next Friday's session will be **all online** using the following link:
Click here to join the meeting
Meeting ID: 237 000 518 286 | Passcode: 9Ya2xn
Audio only: +1 323-776-6996,,899355861#
Phone Conference ID: 899 355 861#
(We will **not** be meeting in person on August 25 at St. Anne's.)
The primary goal of the August 25th session is to build a common understanding of the clients served by DMH based on the MHSA program, differentiated by age group, fiscal year, unique or new clients, average cost, and/or Service Area. Please see attached documents, which can also be found on our website at: https://dmh.lacounty.gov/about/mhsa/announcements/.
Our hope is that this foundational information will trigger questions that will help us generate more specific and helpful data for September and October.

Additionally, for CPT members, we also want to request that you fill out the new CPT Diversity Survey by Friday, August 25th using the following link: https://forms.office.com/g/FeWS5FQ0uR. We know some of you already filled out a prior version. We would really appreciate it if you could please do so one more time.
Please review the attached material in preparation for this meeting. If you have any questions about this message, please reach out to at MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda (English / Spanish)
- Meeting Slides (English / Spanish)
- MHSA Data Presentation

Reunión del equipo de planificación comunitaria de la MHSA, 25 de agosto de 9 a 12
Esperamos verlos en la próxima reunión del Equipo de Planificación Comunitaria (Community Planning Team, CPT) el viernes 25 de agosto de 2023 de 9 a.m. a 12 p.m. para continuar con nuestros esfuerzos de planificación para el Plan de tres años de la MHSA para los años fiscales 2024-25 y 2025-26.

La sesión del próximo viernes se llevará acabo **sólamente en línea** a través del siguiente enlace:
Click here to join the meeting
Identificación de reunión: 237 000 518 286 | Clave: 9Ya2xn
Llamada (solo audio): +1 323-776-6996,,899355861#
Identificacion de conferencia telefónica: 899 355 861#
(**No** habrá reunión en persona el 25 de agosto en St. Anne's.)
El objetivo principal de la sesión del 25 de agosto es generar un entendimiento común sobre los clientes atendidos por DMH según el programa de MHSA, diferenciado por grupos de edad, años fiscales, clientes únicos o nuevos, costo promedio y/o área de servicio. Consulte los documentos adjuntos, que también se encontran en nuestro: https://dmh.lacounty.gov/about/mhsa/announcements/.
Por favor revise el material adjunto en preparación para esta reunión. Si tiene alguna pregunta sobre este mensaje, comuníquese con nosotros: MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda (English / Spanish)
- Meeting Slides (English / Spanish)
- MHSA Data Presentation

MHSA Community Planning Team Meeting – August 8, 2023, 9 a.m. to noon
We look forward to seeing you at the upcoming Community Planning Team (CPT) meeting on Tuesday, August 8, 2023, to continue our planning efforts for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26.
Next Tuesday's session will be in-person at St. Anne's Conference Center, located at 155 N. Occidental Blvd, Los Angeles, CA 90026. We encourage everyone to be physically present so that you get to meet your fellow CPT members. For those who cannot attend the session in person, please use the following link.

Click here to join the meeting
Meeting ID: 251 467 052 844 | Passcode: iHLd6R
Call in (audio only): +1 323-776-6996,,513117112#
Phone Conference ID: 513 117 112#
The primary goal of the August 8th session is to build a common understanding of the County's population, the Medi-Cal-eligible population, and the demographics of clients served by DMH. Our hope is that this foundational information will trigger questions from that will help us generate more specific and helpful data for September and October. In addition, we will provide updates on the Community Planning Team (CPT) Diversity Survey, CPT recruitment efforts, and the deadline for the proposals.

Please review the attached material in preparation for this meeting. If you have any questions about this message, please reach out to at MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda
- Community Planning Team Representatives
- MHSA Community Planning Process – Initial Planning Data
- L.A. County Population Data (English / Spanish)
- MHSA Clients Served by Service Area and Specific Racial/Ethnic Groups (English / Spanish)
- LACDMH Clients Served by Service Area and Specific Racial/Ethnic Groups (English / Spanish)
- 2021 Foster Youth Placement & Removal Rate
- 2022 Homeless Count and Justice Equity Need Rank
- 2022 Justice Equity Need Rank

Reunión del equipo de planificación comunitaria de la MHSA, 8 de agosto de 9 a 12
Esperamos verlo en la próxima reunión del Equipo de Planificación Comunitaria (Community Planning Team, CPT) el martes 8 de agosto de 2023 para continuar con nuestros esfuerzos de planificación para el Plan de tres años de la MHSA para los años fiscales 2024-25 y 2025-26.

La sesión del próximo martes será en persona en el Centro de Conferencias de St. Anne, ubicado en 155 N. Occidental Blvd, Los Ángeles, CA 90026. Alentamos a todos a estar físicamente presentes para que puedan conocer a sus compañeros miembros de CPT. Para aquellos que no puedan asistir a la sesión en persona, utilicen el siguiente enlace.

Click here to join the meeting
Identificación de reunión: 251 467 052 844 | Clave: iHLd6R
Llamada (solo audio): +1 323-776-6996,,513117112#
Identificacion de conferencia telefónica: : 513 117 112#
El objetivo principal de la sesión del 8 de agosto es generar un entendimiento común de la población del condado, la población elegible para Medi-Cal y la demografía de los clientes atendidos por el DMH. Ojalá esta información genere preguntas que nos ayuden a generar datos más específicos y útiles para septiembre y octubre. Además, proporcionaremos actualizaciones sobre la Encuesta de Diversidad del Equipo de Planificación Comunitaria (CPT), los esfuerzos de reclutamiento de CPT y la fecha límite para las propuestas.

Por favor revise el material adjunto en preparación para esta reunión. Si tiene alguna pregunta sobre este mensaje, comuníquese con nosotros a MHSAAdmin@dmh.lacounty.gov.

- Meeting Agenda
- Community Planning Team Representatives
- MHSA Community Planning Process – Initial Planning Data
- L.A. County Population Data (English / Spanish)
- MHSA Clients Served by Service Area and Specific Racial/Ethnic Groups (English / Spanish)
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- 2021 Foster Youth Placement & Removal Rate
- 2022 Homeless Count and Justice Equity Need Rank
- 2022 Justice Equity Need Rank

MHSA Community Planning Team Meeting – July 28, 2023, 9 a.m. to noon
We are looking forward to seeing you at the upcoming Community Planning Team (CPT) session this Friday, July 28, 2023, to continue preparing for the *MHSA Three-Year Plan* for fiscal years 2024-25 and 2025-26.
The primary goal for the July sessions is to prepare CPT members for the community planning process. These sessions involve providing foundational information on the community planning process and the Mental Health Services Act, as well as obtaining important feedback to calibrate the planning process in terms of support and expectations.

Friday's session will be in-person at St. Anne's Conference Center, located at 155 N Occidental Blvd, Los Angeles, CA 90026. We encourage everyone to be physically present so that we can meet each other. However, if you need to access the meeting online, please let us know by 12 PM this Thursday, July 27th at MHSAAdmin@dmh.lacounty.gov. This will help us plan accordingly for copies and food. Please use the following link:
Click here to join the meeting
Meeting ID: 223 670 495 924 | Passcode: Yb2dqh
Or call in (audio only): +1 323-776-6996,,461156040# / Phone Conference ID: 461 156 040#
Please click here to access meeting materials. (Meeting Agenda / MHSA Program List)
The meeting will focus on three important objectives:

1. Expectations for communication, self-care, and access to ensure that CPT sessions provide a safe and creative space for everyone.
2. Overview of the Mental Health Services Act (MHSA), including a list of MHSA-funded programs.
3. Feedback on stakeholder input questions, the CPT diversity survey, and planning data.

RECORDATORIO AMISTOSO: Reunión del equipo de planificación comunitaria de la MHSA: 28 de julio de 9 a 12
Esperamos verlo en la próxima sesión del Equipo de planificación comunitaria (CPT) este viernes, 28 de julio de 2003, para continuar preparándonos para el Plan de tres años de la MHSA para los años fiscales 2024-25 y 2025-26.

El objetivo principal de las sesiones de julio es preparar a los miembros de ECAP para el proceso de planificación comunitaria. Estas sesiones implican proporcionar información fundamental sobre el proceso de planificación comunitaria y la Ley de Servicios de Salud Mental, así como obtener comentarios importantes para calibrar el proceso de planificación en términos de apoyo y expectativas.

La sesión del viernes será en persona en St. Anne's Conference Center, ubicado en 155 N Occidental Blvd, Los Ángeles, CA 90026. Alentamos a todos a estar físicamente presentes para que podamos conocernos. Sin embargo, si necesita acceder a la reunión en línea, infórmenos antes de las 12:00 p. m. de este jueves 27 de julio en MHSAAdmin@dmh.lacounty.gov. Esto nos ayudará a planificar en consecuencia las copias y la comida. Utilice el siguiente enlace:
Click here to join the meeting
Identificación de reunión: 223 670 495 924 | Clave: Yb2dqh
Llamar (solo audio): +1 323-776-6996,,461156040# / Identificacion de conferencia telefónica: 461 156 040#
Haga clic aquí para acceder a los materiales de la junta (Agenda de la Reunión / MHSA Lista de Programas)
La reunión se centrará en tres objetivos importantes:

1. Expectativas de comunicación, autocuidado y acceso para garantizar que las sesiones de CPT brinden un espacio seguro y creativo para todos.
2. Resumen de la Ley de Servicios de Salud Mental (MHSA), incluida una lista de programas financiados por la MHSA.
3. Comentarios sobre las preguntas de aportes de las partes interesadas, la encuesta de diversidad de CPT y los datos de planificación.

Recording Available to MHSA Community Planning Process Kick Off Meeting on July 11, 2023
You can click here to watch the recording of the meeting.

Invitation to MHSA Community Planning Process Kick Off Meeting on July 11, 2023 (Updated 7/7/23)
Dear Community Planning Team Members,

Thank you for agreeing to be part of the Community Planning Team (CPT) that will be developing recommendations for Los Angeles County's *MHSA Three-Year Program and Expenditure Plan* for fiscal years 2024-25 and 2025-26. We are looking forward to kickstarting the Community Planning Process with you on **Tuesday, July 11, 2023, from 9a to noon**.
If you have not done so already, please fill out the CPT member information form https://forms.office.com/g/FeWS5FQ0uR at the latest by Wednesday, July 5th so that we can take inventory of the group's diversity. We will be sending you a packet on Thursday, July 7th. The packet provides an agenda and an overview of the Community Planning Process. Please read the information prior to our session so that we can spend most of our time responding to your questions. If you have any questions about this message, feel free to reach out to us at MHSAAdmin@dmh.lacounty.gov.

MATERIALS FOR THE MHSA COMMUNITY PLANNING KICKOFF MEETING
Please click here to access the packet for the online kickoff meeting for the MHSA community planning process. The packet contains the agenda and a description of the community planning process. Please review prior to the meeting.
You can join the meeting using the below information:
Click here to join the meeting
You can click here to watch the recording of the meeting.
Or call in (audio only)
+1 323-776-6996,,985971650#
Phone Conference ID: 985 971 650#

If you have any questions about this message, feel free to reach out to us at MHSAAdmin@dmh.lacounty.gov.

MATERIALES PARA LA REUNIÓN DE INICIO DE PLANIFICACIÓN COMUNITARIA DE LA MHSA

Haga clic aquí para acceder al paquete de la reunión inicial en línea para el proceso de planificación comunitaria de la MHSA. El paquete contiene la agenda y una descripción del proceso de planificación comunitaria. Por favor revise antes de la reunión.
Como recordatorio, puede unirse a la reunión a través de este enlace:

Haga clic aquí para unirse a la reunión
O llame (para solamente el audio)
+1 323-776-6996,,985971650# Estados Unidos, Los Ángeles
Identificación de la Conferencia Telefónica: 985 971 650#
Si tiene alguna pregunta sobre este mensaje, no dude en comunicarse con nosotros en MHSAAdmin@dmh.lacounty.gov.

Appendix B – Stakeholder/Provider Training – MHSA 101

Session 2 discussed the MHSA 101 Foundations and information on MHSA Funded programs.

Los Angeles County Department of Mental Health

MHSA Three-Year Plan – Community Planning Process

Session 2

Community Planning Team

July 28, 2023

9:00 AM – 12:00 PM

St. Anne's Conference Center
155 N Occidental Blvd
Los Angeles, CA 90026

WELCOME!

Dear Community Stakeholders,

We are looking forward to the upcoming stakeholder sessions to provide input on the *MHSA Annual Update* for fiscal year 2023-24

Open to the public, the sessions will be in-person at St. Anne's Conference Center, located at 155 N Occidental Blvd, Los Angeles, CA 90026.

Access and Norm setting
MHSA 101 Foundations
MHSA Funded Programs
Questions and Stakeholder Input

Future Meetings. ADD

If you have any questions about this message, feel free to reach out to us at MHSAAdmin@dmh.lacounty.gov.

Sincerely,

Dr. Darlesh Horn
Division Chief
MHSA Administration Division

AGENDA

FRIDAY, JULY 28, 2023 | 9:00-12:00

PURPOSE	Prepare Community Planning Team (CPT) members to be active participants in the community planning process to generate recommendations for the *MHSA Three-Year Plan*.
OBJECTIVES	1. Brainstorm community guidelines to ensure that CPT meetings provide a safe and creative space for everyone. 2. Review key MHSA background information, including the list of MHSA-funded programs. 3. Obtain feedback on questions for stakeholder input for August and September. 4. .
TIME	**ITEM**
8:30 – 9:00	Registration & Continental Breakfast
9:00 – 9:15	Session Opening
9:15 – 10:00	CPT Members Brainstorm Community Guidelines
10:00 – 10:45	Provide Key MHSA Background Information and Review the Current List of MHSA-Funded Programs.
10:45 – 10:55	Public Comments
10:55 – 11:00	Break
11:00-11:50	Provide Feedback on the Stakeholder Input Questions and Data Needed for the Planning Process
11:45-11:55	Public Comments
11:55-12:00	Closing Reflections Next Steps
12:00	Adjourn

COMMUNICATION & SELF-CARE GUIDELINES

Over the past twelve months, community stakeholders have used the following communication and self-care expectations to foster a safe and creative space for all participants:

COMMUNICATION EXPECTATIONS

The following communication expectations will help us all build positive and constructive relationships over the course of the planning process.

6. **BE PRESENT**: Be on time and do your best to participate and engage each other in the spirit of conversation and learning.

7. **SPEAK FROM YOUR OWN EXPERIENCE**: Sharing your perspective based on your experiences helps us build community. It helps us find areas where we can relate and connect with each other. It also helps us in hearing and honoring the experiences of others.

8. **PRACTICE CONFIDENTIALITY**: The practice of respecting and protecting sensitive information that people share with you helps to builds trust.

9. **STEP UP, STEP BACK**: To ‘step up’ means to being willing to share your thoughts and experiences with others so that your voice is part of the conversation. To ‘step back’ means being aware and mindful that others also need time to speak, and that some people take a little longer to compose their thoughts.

10. **SEEK TO UNDERSTAND AND THEN BE UNDERSTOOD**: Ask questions to understand someone’s view before expressing your view. This helps everyone feel heard and prevent misunderstandings.

TAKING CARE OF YOURSELF & FINDING SUPPORT

- If during the session you find yourself feeling uneasy, we encourage you to take care of yourself by reaching out to designated people who can help you process thoughts and feelings. We will also have a designated lounge area for reflection and support.

COMMUNITY GUIDELINES

At the Community Planning Team meeting held on July 11, 2023, two concerns were prominently raised pertaining to making online participation accessible to all (e.g., the use of the Chat Box during the meeting, among other items) and revising the diversity survey to enable better representation of all individuals and groups. Because we are just starting the community planning process, we want to pause and address these concerns, while at the same time affirm community guidelines.

As an individual, please think about the following two questions and write your response in the table below: Is there anything else that you need to make this a safe and creative space? What can you offer to make this a safe and creative space?

What I need to feel safe and creative in these meetings…	What I can offer the group to make everyone feel safe and creative…

As a table (at the meeting), share your thoughts with your group and create a list for the table:

What WE need to feel safe and creative in these meetings…	What WE can offer each other to make everyone feel safe and creative in these meetings…

PART 1: MHSA FOUNDATIONS

KEY CONCEPTS

BACKGROUND

- As early as 1967 and especially in the early 1990s, the State of California began cutting back its services in state hospitals for people with severe mental health needs. Without adequate funding for mental health services in the community, many people became homeless.

- Prior to MHSA funding, mental health services were significantly deficient. For example, Los Angeles County authorities estimated providing services to only half of those needing public mental health services.

- On November 2, 2004, California voters passed Proposition 63 by majority. Also known as the millionaires' tax, MHSA seeks to expand and improve mental health services across the state by providing additional funding and oversight and accountability. Proposition 63 became effective as a statute, the Mental Health Services Act (MHSA), on January 1, 2005.

WHAT IS THE MENTAL HEALTH SERVICES ACT (MHSA)?

- Proposition 63 establishes a 1% tax on personal income above $1 million dollars to fund MHSA programs and projects to greatly improve the delivery of community-based mental health services and treatment across California.

- Welfare and Institutions Code (WIC) 5891 states that MHSA revenues may only fund mental health services, MHSA programs and activities and prohibits these funds from supplanting other existing County funds.

- Since the State of California decentralized its behavioral health system, most MHSA funding is administered by each California county.

MHSA MISSION

MHSA's mission is contained in MHSA Section 3. Purpose and Intent, which states the following: *The people of the State of California hereby declare their purpose and intent in enacting this act to be as follows:*

(a) *To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.*

(b) *To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.*

(c) *To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.*

(d) *To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.*

(e) *To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.*

MHSA VISION

MHSA pledges to go beyond business as usual to build a community mental health system where:

- Access to care is easier;
- Services are more effective;
- Out-of-home and institutional care are reduced; and
- Stigma toward those with severe mental health needs no longer exists.

MHSA FOCUS

- Increased and targeted access to services for un-served and underserved population
- Prioritizing individuals' recovery and wellness goals
- Implementation of effective and sustainable programs and services
- Administration and oversight of cost-effective expenditures
- Engaging stakeholder in meaningful involvement in the ongoing development and implementation of programs and services based on their individual community needs

MHSA CORE PRINCIPLES

- Client/Family Driven Services
- Cultural Competence
- Community Collaboration
- Service Integration
- Focus on Recovery, Wellness, and Resilience

HOW DOES MHSA WORK?

- Funds programs and services that aim to reduce the long-term adverse impact of untreated mental illness.

- Transforms the public mental health system from fail-first system – often resulting in treatment delivery through the criminal justice system, the courts, and emergency rooms – to a help-first system with a commitment to service, support, and assistance through community-based intensive and preventative treatments and interventions on individual need.

- Addresses a broad continuum of county mental health services for all populations: children, transitional age youth, adults, older adults, families, unserved and underserved.

MHSA COMPONENTS

Community Services and Supports (CSS)

Direct mental health services and supports for children and youth, transition age youth, adults, and older adults. Permanent supportive housing for clients with serious mental health needs.
The largest of the 5 components. Includes:

- FULL-SERVICE PARTNERSHIP (FSP): Community collaboration and a "whatever it takes" approach to ensure full spectrum community-based mental health service delivery to individuals from identified focal populations

- GENERAL SERVICE DEVELOPMENT (GSD): Services that include programs to improve mental health services and supports for all consumers

- PLANNING OUTREACH AND ENGAGEMENT (POE): Activities aimed at engaging the unserved, underserved, and inappropriately served populations

- HOUSING: Partnership with the California Housing Finance Agency, CSS provides funding for permanent supportive, affordable housing for individuals with serious mental health needs and their families, especially those who are houseless.

Prevention and Early Intervention (PEI)

Services to engage individuals before the development of serious mental health need or at the earliest signs of mental health struggles. Statewide projects: Suicide Prevention, Student Mental Health Initiative, Stigma and Discrimination Reduction. The second largest of the 5 components, PEI includes:

- PREVENTION: Proactive approach that targets those with risk factors or increases protection factors

- STIGMA AND DISCRIMINATION REDUCTION (SDR): Training, campaigns and activities to reduce and eliminate barriers that prevent people from accessing mental health services. Services feature anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive tools; connecting and linking resources to schools, families, and community agencies; and educating and empowering clients and families

- SUICIDE PREVENTION: Services and training to strengthen the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. Services include: community outreach and education to identify suicide risks and protective factors; linking services, including access to trained suicide hotline agents, to individuals contemplating, threatening, or attempting suicide

- EARLY INTERVENTION: For individuals and families for whom a short, relatively low-intensity intervention is appropriate to resolve or improve mental health issues and avoid the need for higher levels of care

Innovation (INN)

Opportunities to design and test time-limited new or changing mental health practices that have not yet been demonstrated as effective, and to fuse such practices into the mental health system, thereby increasing:

- Access to underserved communities,
- Promotion of interagency collaboration, and the
- Overall quality of mental health services

An Innovation project must have one of the following primary purposes:

- Increase access to mental health services to underserved groups
- Increase the quality of mental health services, including measurable outcomes
- Promote interagency and community collaboration related to mental health services or supports or outcomes
- Increase access to mental health services

Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

Workforce Education and Training (WET)

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

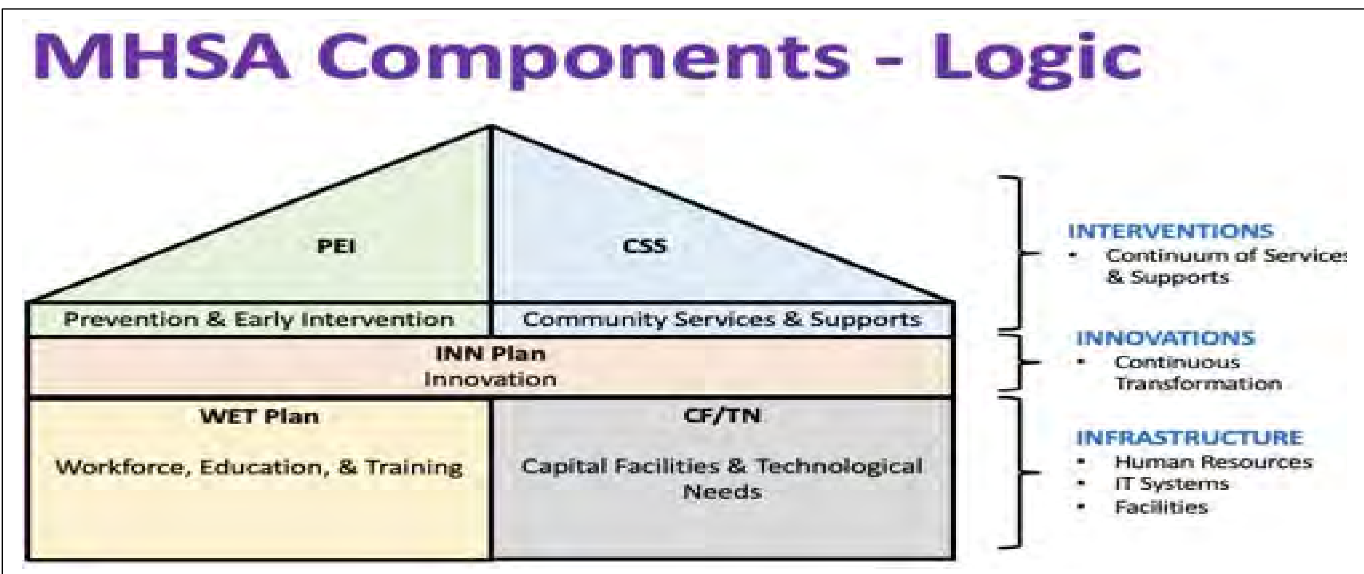
- Supports programs designed to create and support a workforce (present and future) that is culturally competent, provides consumer/family centered mental health services, and adheres to the principles of wellness, recovery, and resilience.

- Aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental health needs. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

Capital Facilities and Technological Needs (CFTN)

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

- Increase and improve existing capital facilities infrastructure and support technology projects to accommodate the implementation of MHSA plans.
- Finance necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.



MHSA OVERSIGHT

State Department of Mental Health

- The former SDMH was responsible for planning the sequential phases of development for the five MHSA components and overseeing county implementation of MHSA

State Department of Health Care Services (DHCS)

- DHCS is primarily responsible for overseeing local mental health agencies' spending of MHSA funds.

- DHCS contracts with each county for the following components: PEI programs; Children’s services; and Adult services

MHSA Oversight & Accountability Commission (OAC)

- The OAC oversees MHSA implementation; develops strategies to overcome stigma; reviews and approves innovation’s projects; and provides technical assistance and training to counties, providers, and stakeholders.

MHSA REPORTING

MHSA Three Year Program and Expenditure Plan & MHSA Annual Update

- Welfare and Institutions Code (WIC) Section 5847 states that county mental health programs shall prepare and submit a *Three-Year Program and Expenditure Plan* (Plan) followed by *Annual Updates* for Mental Health Services Act (MHSA) programs and expenditures.

- The MHSA Plan provides an opportunity for the Los Angeles County Department of Mental Health (LACDMH) to review its MHSA programs and services and obtain feedback from a broad array of stakeholders on those services. Any changes made to the MHSA programs would need to be in accordance with the MHSA, current regulations, and relevant State guidance.

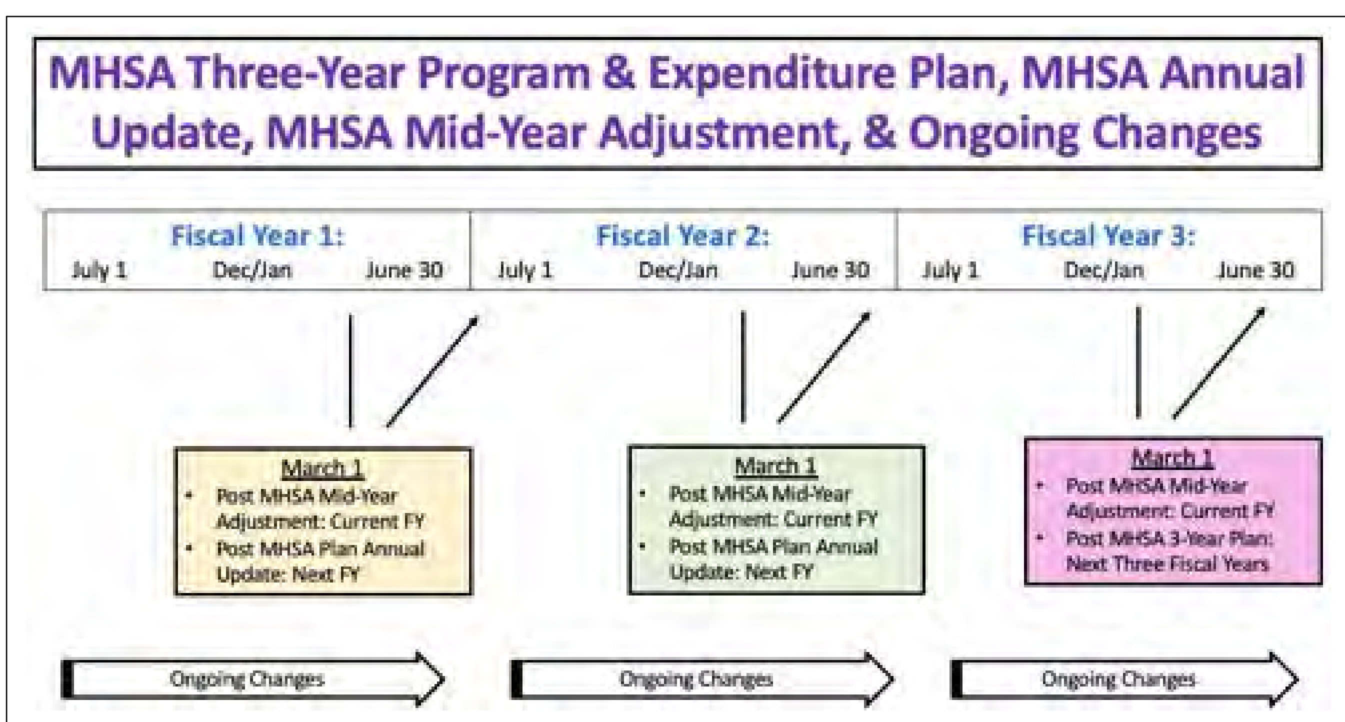
MHSA Mid-Year Adjustment

For updates, other than the *MHSA Annual Update*, the County shall conduct a local review process that includes:

- A 30-day public comment period: The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the update, to representatives of stakeholders’ interests and any other interested parties who request the draft.

- A summary and analysis of any substantive recommendations.

- A description of any substantive changes made to the proposed update that was circulated.



STAKEHOLDER ENGAGEMENT

California Code of Regulations

- Title 9 CCR 3300 requires CA Counties to provide a Community Program Planning Process (CPPP) for developing MHSA Three-Year Plans and Annual Updates and to ensure stakeholders have the opportunity to participate in the CPPP (referred to as CPP)

MHSA-Funded Initiatives Should Engage…

According to Title 9 CCR 3300, MHSA-funded programs should include the following stakeholders:

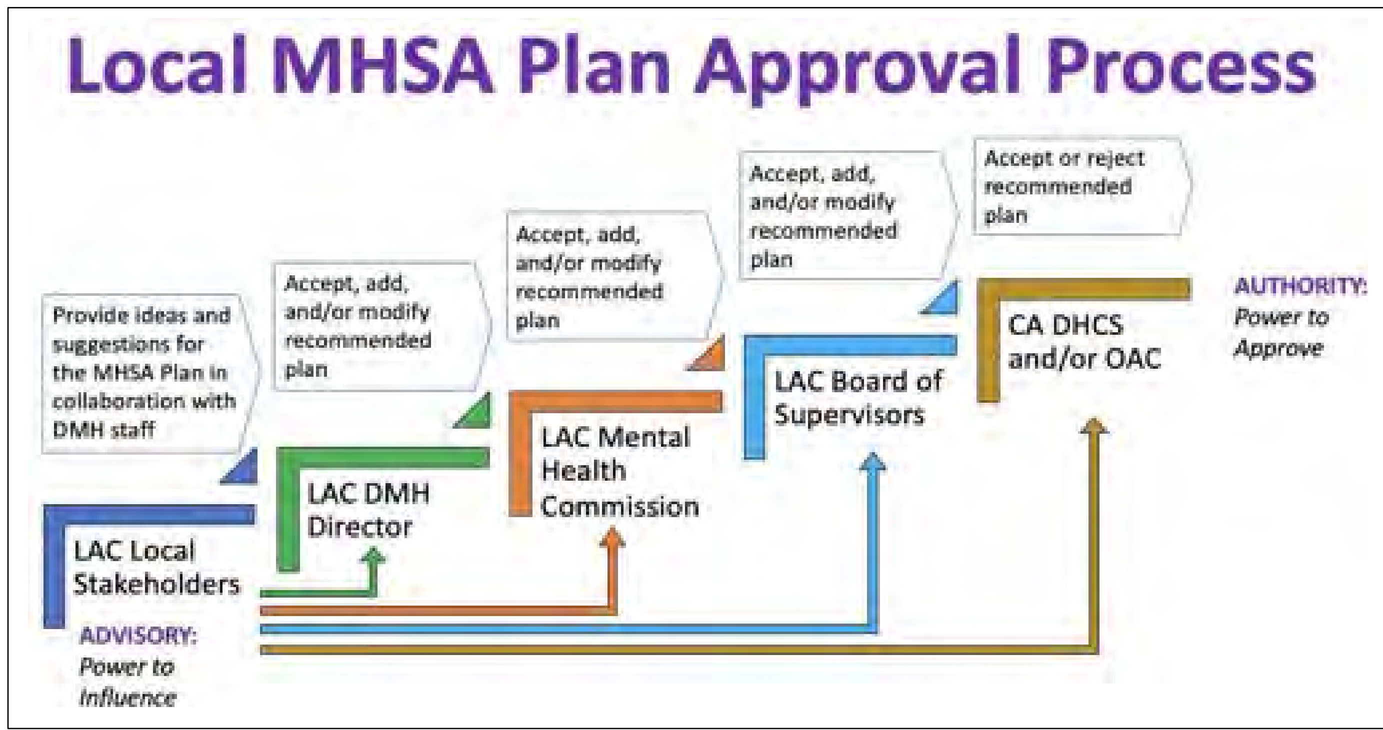
1. Families of Children, Adults, and Seniors with serious mental illness or severe emotional disturbance
2. Providers of Mental Health Services
3. Law Enforcement Agencies
4. Education and Social Services agencies
5. Veterans and representatives from Veterans organizations
6. Providers of alcohol and drug services
7. Health Care organizations
8. Other important interests

Meaningful Stakeholder Engagement

Title 9 CCR 3300 also stipulates that "meaningful stakeholder involvement should be reflected in mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocation."

LOCAL MHSA PLAN APPROVAL PROCESS

- Los Angeles County Local Stakeholders
- Los Angeles County DMH Director
- Los Angeles County Mental Health Commission
- Los Angeles County Board of Supervisors
- California Department of Health Care Services and Oversight and Accountability Commission



LIST OF MHSA FUNDED PROGRAMS

QUESTIONS OF CLARIFICATION

After hearing the presentation, what questions do you have?

Questions	Response(s)

FEEDBACK

STAKEHOLDER INPUT QUESTIONS

The following are the questions we would like all stakeholder groups to address in August and September. We are trying to make these questions as simple as possible to enable anyone to participate (without having much knowledge of MHSA):

Area	Possible Questions	Reflections? What do you like? What suggestions do you have?
Prevention	1. What resource (or resources) does your community and/or institution already have to prevent trauma and/or mental health issues? 2. What helps people access and/or obtain current resources to prevent trauma and/or mental health issues? 3. What resource(s) is your community and/or institution missing that can make a difference in preventing trauma and/or mental health issues? 4. What keeps people from accessing and/or obtaining these resources? 5. Other	
Early Intervention	1. What resource (or resources) already exists in your community and/or institution to help a person experiencing early onset of mental health issues from becoming more severe? 2. What helps people access and/or obtain current resources to prevent trauma and/or mental health issues? 3. What resource does your community and/or institution need to help a person experiencing early onset of mental health issues from becoming more severe? 4. What keeps people from accessing and/or obtaining these resources? 5. Other	

Area	Possible Questions	Reflections? What do you like? What suggestions do you have?
Community Supports Continuum	1. For individuals experiencing more severe mental health struggles, what resource or resources already exist in your community and/or institution to help address their immediate needs and support their movement towards recovery and well-being? 2. What helps them access and/or obtain current resources to address their mental health challenges? 3. For individuals experiencing more severe mental health struggles, what is missing in your community and/or institution that can help them to help address their immediate needs and support their movement towards recovery and well-being? 4. What keeps people from accessing and/or obtaining these resources? 5. Other	
Homeless Services and Housing Resources	1. For individuals experiencing more severe mental health struggles, what resource or resources already exist in your community and/or institution to help address their immediate housing needs and support their movement towards permanent housing? 2. What helps them access and/or obtain current homeless services and housing resources? 3. What is missing in your community and/or institution that can help them to address their immediate housing needs and support their movement towards permanent housing? 4. What keeps people from accessing and/or obtaining these resources? 5. Other	
Workforce	1. What workforce opportunities exist in the context of the mental health system?	

Area	Possible Questions	Reflections? What do you like? What suggestions do you have?
	2. How do people access these opportunities? 3. What is missing? 4. What keeps people from accessing these opportunities? 5. Other	

DATA

What kind of information would be helpful to you, overall and for each of the areas above (Prevention and Early Intervention; Community Supports Continuum; Homeless Services and Housing Resources; and Workforce Education and Training?

CLOSING REFLECTIONS

Purpose: Gather feedback on today's session.

Instructions: Please share your reflections on today's session, as it will help us improve the process for next week's session. Turn in this sheet before you leave. You can choose to keep this anonymous or put your name.

Questions
1. How do you feel about today's session?
2. What worked well today?
3. What can be improved?
4. Anything else you want to share?

COMMUNITY PROGRAM PLANNING PROCESS

9 CCR § 3300 Community Program Planning Process

(a) The County shall provide for a Community Program Planning Process as the basis for developing the Three-Year Program and Expenditure Plans and updates.

(b) To ensure that the Community Program Planning Process is adequately staffed, the County shall designate positions and/or units responsible for:

(1) The overall Community Program Planning Process.

(2) Coordination and management of the Community Program Planning Process.

(3) Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process.

(A) Stakeholder participation shall include representatives of unserved and/or underserved populations and family members of unserved/underserved populations.

(4) Ensuring that stakeholders that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity have the opportunity to participate in the Community Program Planning Process.

(5) Outreach to clients with serious mental illness[1] and/or serious emotional disturbance, and their family members, to ensure the opportunity to participate.

(c) The Community Program Planning Process shall, at a minimum, include:

(1) Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.

(2) Participation of stakeholders, as stakeholders is defined in Section 3200.270.

[1] NOTE: The term ‘serious mental illness’ is in the California Code of Regulations.

(3) Training.

(A) Training shall be provided as needed to County staff designated responsible for any of the functions listed in 3300(b) that will enable staff to establish and sustain a Community Program Planning Process.

(B) Training shall be offered, as needed, to those stakeholders, clients, and when appropriate the client's family, who are participating in the Community Program Planning Process.

(d) Beginning with Fiscal Year 2006-07, or in fiscal years when there are no funds dedicated for the Community Program Planning Process, the County may use up to five (5) percent of its Planning Estimate, as calculated by the Department for that fiscal year, for the Community Program Planning Process.

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5840, 5848(a), 5892(c), and 5813 Welfare and Institutions Code.

HISTORY

1. New article 3 (sections 3300-3360) and section filed 12-29-2006 as an emergency; operative 12-29-2006 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-30-2007 or emergency language will be repealed by operation of law on the following day.

2. New article 3 (section 3300-3360) and section refiled 5-1-2007 as an emergency; operative 5-1-2007 (Register 2007, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-29-2007 or emergency language will be repealed by operation of law on the following day.

3. New article 3 (section 3300-3360) and section refiled 8-23-2007 as an emergency; operative 8-30-2007 (Register 2007, No. 34). A Certificate of Compliance must be transmitted to OAL by 12-28-2007 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 8-23-2007 order transmitted to OAL 12-28-2007 and filed 2-13-2008 (Register 2008, No. 7).

This database is current through 7/29/22 Register 2022, No. 30
9 CCR § 3300, 9 CA ADC § 3300

CALIFORNIA CODE OF REGULATIONS
TITLE 9 - REHABILITATIVE AND DEVELOPMENTAL SERVICES DIVISION 1
DEPARTMENT OF MENTAL HEALTH
SECTION 3200.270 - STAKEHOLDERS

UNIVERSAL CITATION: 9 CA Code of Regs 3200.270

STAKEHOLDERS

"Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to:

- individuals with serious mental illness and/or serious emotional disturbance and/or their families;
- providers of mental health and/or related services such as physical health care and/or social services;
- educators and/or representatives of education;
- representatives of law enforcement;
- and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families.
  Cal. Code Regs. Tit. 9, § 3200.270

Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5814.5(b)(1) and 5848(a), Welfare and Institutions Code.

1. New section filed 12-29-2006 as an emergency; operative 12-29-2006 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-30-2007 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 5-1-2007 as an emergency; operative 5-1-2007 (Register 2007, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-29-2007 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 8-23-2007 as an emergency; operative 8-30-2007 (Register 2007, No. 34). A Certificate of Compliance must be transmitted to OAL by 12-28-2007 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 8-23-2007 order transmitted to OAL 12-28-2007 and filed 2-13-2008 (Register 2008, No. 7).

This section was updated on 5/23/2020 by overlay.

LOCAL REVIEW PROCESS

Cal. Code Regs. Tit. 9, § 3315 - Local Review Process
Current through Register 2022 Notice Reg. No. 14, April 8, 2022

(a) Prior to submitting the Three-Year Program and Expenditure Plans or annual updates to the Department, the County shall conduct a local review process that includes:

(1) A 30-day public comment period.

(A) The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the draft Three-Year Program and Expenditure Plan, or annual update, to representatives of stakeholders' interests and any other interested parties who request the draft.

(2) Documentation that a public hearing was held by the local mental health board/commission, including the date of the hearing.

(3) A summary and analysis of any substantive recommendations.

(4) A description of any substantive changes made to the proposed Three-Year Program and Expenditure Plan or annual update that was circulated.

(b) For updates, other than the annual update required in Section 3310(c), the County shall conduct a local review process that includes:

(1) A 30-day public comment period.

(A) The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the update, to representatives of stakeholders' interests and any other interested parties who request the draft.

(2) A summary and analysis of any substantive recommendations.

(3) A description of any substantive changes made to the proposed update that was circulated.

NOTES:
Cal. Code Regs. Tit. 9, § 3315
Note: Authority cited: Section 5898, Welfare and Institutions Code. Reference: Sections 5848(a) and (b), Welfare and Institutions Code.

1. New section filed 12-29-2006 as an emergency; operative 12-29-2006 (Register 2006, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-30-2007 or emergency language will be repealed by operation of law on the following day.

2. New section refiled 5-1-2007 as an emergency; operative 5-1-2007 (Register 2007, No. 18). A Certificate of Compliance must be transmitted to OAL by 8-29-2007 or emergency language will be repealed by operation of law on the following day.

3. New section refiled 8-23-2007 as an emergency; operative 8-30-2007 (Register 2007, No. 34). A Certificate of Compliance must be transmitted to OAL by 12-28-2007 or emergency language will be repealed by operation of law on the following day.

4. Certificate of Compliance as to 8-23-2007 order transmitted to OAL 12-28-2007 and filed 2-13-2008 (Register 2008, No. 7).

Appendix C – Community Planning Team & Workgroup Recommendations

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
Community Planning Process –
MHSA Three-Year Program and Expenditure Plan, Fiscal Years 2024-2026
Total Community Planning Team (CPT) & Workgroup Recommendations

BACKGROUND

This document contains the total set of recommendations from the Community Planning Team and consensus recommendations from the four CPT Workgroups:

A. Community Supports Continuum (CSC)
B. Homeless Services and Housing Supports (HSHR)
C. Prevention and Early Intervention (PEI)
D. Workforce Education and Training (WET)

The recommendations are organized into two types:

A. Program, Service, or Intervention (PSI) Recommendations:
   1. Exists Already: Expand and/or Improve Existing PSI
   2. Does Not Exist: Add New PSI

B. Policy, Practice, and/or Advocacy Recommendations

The last column in each table color-codes each recommendation based on its status in the following manner:

COLOR	DESCRIPTON
GREEN	DMH or partner agency is already doing this work, ongoing funds are already appropriated, and/or additional funds can be appropriated.
RED	MHSA regulations prohibit funding this recommendation, or the program can not be implemented with one time limited funding, or the recommendation is outside of the DMH's authority, or the recommendation was not clear. CPT members can still advocate for these recommendations.
YELLOW	DMH needs Workgroup members to provide additional feedback.

COMMUNITY SUPPORTS CONTINUUM (CSC)

BACKGROUND

This section contains the recommendations of the CSC Workgroup for each of the following categories:

CATEGORIES	GOALS
5. Emergency Response	*Improve Emergency Response*
6. Psychiatric Beds	*Expand and/or Improve Existing Program, Service, or Intervention*
7. Full Service Partnerships	*Improve access to and efficacy of Full Service Partnerships (FSPs)*
8. Access to Quality Care	*Increase Access to Quality Care*

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

1. <u>EXISTS ALREADY</u>: Expand and/or Improve Existing PSI

   More information on existing programming is located in section VIII. Programs and Services (by Component) of the Three Year Program and Expenditure Plan (Plan).

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
1	Call Center & Triaging	1. Expand the call center and strengthen the triage process to improve the client experience, based on review key metrics and qualitative data.	Expand & Improve	PEI: Suicide Prevention
1	PMRT	2. Expand the Psychiatric Mobile Response Team (PMRT) service, provide cultural competence training to all PMRT staff, and prioritize hiring culturally competent individuals reflective of their communities.	Expand & Improve	CSS: Linkage
1	LET, MET & SMART	3. Expand the Law Enforcement Teams (LET), Mental Evaluation Teams (MET), and Systemwide Mental Assessment Response Teams (SMART) and provide sensitivity training to Law Enforcement partners.	Expand & Improve	CSS: Alternative Crisis Services
1	Therapeutic Transport	4. Improve the collaboration between the Los Angeles County Fire Department staff, peers, and mental health specialists responding to mental health calls.	Expand	Innovation 7: Therapeutic Transportation
1	Mental Health Training-Law Enforcement	5. Provide sensitivity training to Law Enforcement on working with individuals with mental illness.	Expand	CSS: Alternative Crisis Services
1		6. Provide trainings that build the capacity of community leaders and	Expand	PEI: Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		community-based organizations to provide support during psychiatric emergencies, e.g., Mental Health First Aid and Suicide Prevention and Grief Training		PEI: Suicide Prevention
1		7. Provide aftercare program/services after encounter with law enforcement and fire and medical services (EMS).	Expand	CSS: Outpatient Care Services CSS: Linkage
2	Peer Respite Care Homes	8. DMH contracts for two peer-run residential homes offering short-term respite. Expand to at least two peer-run residential homes per Service Area.	Expand	Innovation: Hollywood 2.0 Project
2	Crisis Residential Treatment (CRT) Programs	9. CRTP serves individuals experiencing a mental health crisis who need support but not hospitalization. CRTP provides short-term intensive residential services in a home-like environment. DMH is currently expanding CRTP to serve youth.	Expand	Innovation: Children's Community Care Village CSS: Alternative Crisis Services
2	Enhanced Care Management	10. Inform and educate community-based organizations about potential opportunities to contract with managed care plans to provide a full referral system to community services (including linkage and warm handoffs in real time) to individuals being discharged from hospitals.	Improve	
2		11. Establish a Korean-speaking, culturally responsive team within DMH to ensure effective linkage and follow up.		
3	FSP	12. Expand FSP teams and providers countywide to provide additional support and services in the field, in culturally responsive and linguistically appropriate manner.	Expand	CSS: Full Service Partnership
4	PMRT/ HOME/ FSP	13. PMRT/HOME/FSP is expanding their programs to increase street outreach to individuals with Serious and Persistent Mental Illness (SPMI) with the aim of increasing access to services.	Expand	CSS: Linkage CSS: Full Service Partnership
4	Community Health Promoters	14. Community Health Workers Promoters work to increase awareness about mental health issues and disseminate resources to reduce mental health stigma and to improve working relationships within the community in order to deliver mental health services. DMH is expanding this program to include	Expand	PEI: Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		work in public spaces including libraries.		
4	Service Area Navigation Teams	15. Expand Service Area Navigator Teams work across age groups and 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 mental health system clients.	Expand	CSS: Linkage
4	WET – Recruitment & Training (Cultural Competency)	16. DMH already provides a program, service, and support to strengthen outreach and recruitment efforts to meet the specific needs of our diverse multicultural communities by recruiting multidisciplinary staff with diverse cultural backgrounds, linguistic expertise, and who may have lived experience.	Expand	Workforce Education and Training
4	TAY Drop In Centers	17. Drop In Centers for TAY Youth funded by DMH are available throughout Los Angeles County.	Expand	CSS: Outpatient Care Services PEI: Prevention
4	Peer Services	18. Increase peer supports.	Expand	CSS: Outpatient Care Services
4		19. Develop or integrate into existing programming MH services for victims of domestic violence, and train direct service staff to respond to domestic violence when working with clients.		CSS: Planning, Outreach and Engagement: UsCC: Domestic Violence Task Force Workshops
4		20. Develop or integrate mental health services into existing programming for women veterans who have experienced trauma.		
4		21. Establish a centralized source of information to access culturally and linguistically appropriate services and supports in a timely manner. This can take the form of a dashboard for service providers to know what is available in real time and specific referral pathways. This system entails entering data efficiently and using data to gauge evolving needs and provide services and supports. Improve customer service, a website (multiple languages, drop-down menus, chat box, etc.) that is easy to use with simple language targeting different	Expand & Improve	

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		age groups and audiences, including training and accountability.		
4		22. Increase self-help support groups.	Expand	
4		23. Expand services in Peer-Run Centers, including space, time available, oversight, collaboration with community organizations, cultural competency, and availability to family members and across all Service Areas.		CSS: Outpatient Care Services
4		24. Timely access to services for people with substance use and mental health issues.		

2. DOES NOT EXIST: Add New PSI

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1	1. Develop a media campaign to raise awareness about available crisis services including urgent care and mental health crisis teams; and to integrate more CBOs, community leaders, faith-based organizations within DMH to serve their communities. This includes developing and implementing trainings and resource materials focused on increasing the communities' and stakeholders' knowledge of services provided by DMH.	DMH	
3	2. Develop and implement a program to meet the varying levels of needs of FSP graduates who may still need field-based and occasional intensive services.	DMH	
3	3. Provide comprehensive, culturally competent, and person-centered services that aim to enhance the well-being of African immigrants, underserved communities, and other vulnerable immigrant adults facing significant mental health needs by (1) building a collaborative network to ensure connections to services that increase the accessibility of outpatient mental health and coordination of psychiatric rehabilitation supportive services, (2) utilizing several Evidence-based Practices (EBPs) to reduce behavioral health challenges for targeted populations, (3) providing opportunities for mentoring, clinical support, outpatient mental health care, and psychiatric support rehabilitation services, and substance use or abuse rehabilitation, and (4) tackling co-existing conditions such as substance abuse,		

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
	homelessness, and involvement with judicial and/or child welfare services.		
4	4. Develop and implement trainings and materials to improve coordination of care among DMH Programs and other County Departments and contract providers, e.g., individuals with developmental delays.	BOTH	
4	5. Develop quality improvement projects and processes to existing programs and services (e.g. OCS, drop-in/wellness center, age specific services, etc.)	BOTH	
4	6. Provide a one-stop mental health center that provides direct mental health services to deaf, hard of hearing, deafblind, and deaf-disabled individuals and families fully accessible in American Sign Language (ASL). Services include mental health therapy, anger management counseling, substance abuse counseling, case management, and aftercare support, which are the areas historically lacking accessibility and support within Los Angeles County.		
4	7. A mental health summer camp for trans/gender-diverse youth and youth affected by HIV/AIDS (aged 6-17) that aims to provide an emotionally safe, supportive, and enriching environment for these vulnerable populations. Designed to address the unique mental health and wellness needs of trans/gender-diverse youth and those affected by HIV/AIDS, offering a holistic approach to support, combining therapeutic interventions, education, and recreational activities to create a well-rounded experience that improves each camper's mental health.		
4	8. Provide quality early intervention services to children ages two to five years old in Foster and Post Adoptive Care who have experienced early childhood trauma to help them learn new skills and change behavior to help them be successful in home, public, and school settings. Program addresses the social, emotional, and behavioral issues of at-risk children in Foster and Post Adoptive Care under the guidance of therapeutic professionals and trained staff through a therapeutic learning center day treatment program.		
4	9. Develop and implement a field-based program in eight (8) geographical service areas throughout Los Angeles County to identify housed and unhoused individuals exhibiting symptoms of hoarding disorder (HD) and provide a range of field-based		

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
	services including assessment, intervention, intensive case management, medication management, peer support, co-occurring disorder identification and treatment, and advocacy. Teams conduct intensive outreach and receive referrals from public agencies and community organizations; possess specialized training to build trust and partner with individuals who exhibit symptoms of HD; and, along with individual CBT, utilize the peer-run Buried in Treasures support group model to achieve positive change. The National Study Group on Chronic Disorganization's (NSGCD) Clutter Hoarding Scale will be used to monitor individuals' progress. Adults age 18+ across the life span, including those who are housed or experiencing homelessness who exhibit symptoms of HD that negatively impact the individual and/or community.		
4	10. A mobile health outreach intervention that partners with youth serving community-based organizations in South Los Angeles to provide mental health care for Transitional Aged Youth, ages 18-25 by focusing on primary, secondary and tertiary levels of prevention and appropriate interventions. Targets unstably housed or unsheltered youth and young adults (ages 18-25 years old) in the SPA6 community of South Los Angeles.		
4	11. Implement Freespira Digital Therapeutic (Freespira) as a treatment for Post-Traumatic Stress Disorder (PTSD) and panic disorder. Freespira is a first-in-class FDA-cleared, medication-free digital therapeutic indicated for treatment of PTSD and panic disorder. Freespira is the subject of multiple published clinical trials that measured clinical and economic outcomes as well as rigorous review and clearance by the FDA. Targets clients 13+ years old identified with a diagnosis or suspected diagnosis of PTSD and/or panic disorder.		
4	12. Address the mental health of veterans from a family perspective, as recognized by the US military and Department of Veterans Affairs. Innovations and extensions of couple and family interventions have the potential to increase the reach and impact of treatments for service members and veterans, as well as to ultimately improve the quality of their family relationships (NIH, 2023). The proposed Wilderness Family Therapy program fills in family-based treatment gaps		

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
	and other barriers to veterans connecting with mental health support. Targets all ages seeking help, veterans, and family members, with a separate camp for teens.		

B. POLICY, PRACTICE, AND/OR ADVOCACY RECOMMENDATIONS

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
1	1. Prohibit armed law enforcement in emergency responses.
1	2. Create greater accountability for law enforcement in emergency responses.
2	3. Identify funding resources to increase number of psychiatric beds (locked psychiatric beds cannot be paid for with MHSA funds).
2	4. When funding psychiatric beds, consider need for services for minor to moderate medical issues as well, like basic diabetes, basic hypertension, so that we're not wasting that space and that resource.
2	5. Take steps to make sure the full spectrum of crisis response services from field teams to respite homes, to hospitals are culturally competent.
2	6. Ensure hospital discharge planners are aware of all housing and support options and other programs within DMH, specifically the availability of Peer Run respite homes.
3	7. Review contract language, policies, procedures and trainings related to field-based service to ensure clarity of expectations and follow up actions when those expectations are not met.
3	8. Expand ongoing reviews and provide technical assistance, focus on areas such as outreach and engagement, and delivery of FSP services at the frequency needed.
4	9. Reduce systemic bias in order to access services.
4	10. Provide affordable services
4	11. Improve pre-diagnosis or under-diagnosis for Black and Brown men
4	12. Provide safe and respectful space.
4	13. Increase peer support to adequate amount, highlighting the role and success stories of peers.
4	14. Provide a BAH review panel for BAH related care court cases, so the people in these cases are not being taken advantage of by the process. This will be addressed through Care Court.
4	15. Provide transportation to obtain services.

CSC WORKGROUP – CONSENSUS RECOMMENDATIONS

CPT Recommendations/MHSA Proposals Needing Additional Feedback

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q3	Expand Service Area Navigator Teams work across age groups and 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 mental health system clients.	92%	ENDORSED: Adopted Consent Agenda
Q10	Develop a media campaign to raise awareness about available crisis services including urgent care and mental health crisis teams; and to integrate more CBOs, community leaders, faith-based organizations within DMH to serve their communities. This includes developing and implementing trainings and resource materials focused on increasing the communities' and stakeholders' knowledge of services provided by DMH. Ensure crisis services are in place before launching campaign.	92%	CONSENSUS: Language changed
Q6	Establish a centralized source of information to access culturally and linguistically appropriate services and supports in a timely manner. This includes a dashboard for service providers to know what is available in real time and specific referral pathways. This system entails entering data efficiently, using data to gauge evolving needs and provide services and supports, bringing stakeholders to the table, and developing a guide to navigate services. Improve customer service, a website (multiple languages, drop-down menus, chat box, etc.) that is easy to use with simple language targeting different age groups and audiences, including training and accountability.	85%	CONSENSUS: Added Q9 to Q6
Q11	Develop and implement a program to meet the varying levels of needs of Full Service Partnership (FSP) graduates who may still need field-based and occasional intensive services.	85%	ENDORSED: Adopted Consent Agenda
Q4	Develop or integrate mental health services into existing programming for victims of domestic violence, and train direct service staff to respond to domestic violence when working with clients.	85%	ENDORSED: Adopted Consent Agenda
Q24	Provide transportation to obtain services.	54%	CONSENSUS: Moved to Tier 1
Q23	Increase peer support to adequate amount, highlighting the role and success stories of peers.	38%	CONSENSUS: Moved to Tier & Language changed
Q1	Provide aftercare program/services after encounter with law enforcement and fire and emergency medical services (EMS).	77%	CONSENSUS: Language changed

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q9	Improve customer service, a website (multiple languages, drop-down menus, chat box, etc.) that is easy to use with simple language targeting different age groups and audiences, including training and accountability.	77%	CONSENSUS: Combined with Q6 Language changed
Q5	Develop or integrate mental services into existing programming for women veterans who have experienced trauma.	77%	ENDORSED: Adopted Consent Agenda
Q13	Develop and implement trainings and materials to improve coordination of care among DMH Programs and other County Departments and contract providers, e.g., individuals with developmental delays.	77%	ENDORSED: Adopted Consent Agenda
Q15	Provide a one-stop mental health center across all Service Areas that provides direct mental health services to deaf, hard of hearing, deafblind, and deaf-disabled individuals and families fully accessible in American Sign Language (ASL). Services include mental health therapy, anger management counseling, substance abuse counseling, case management, and aftercare support, which are the areas historically lacking accessibility and support across all Service Areas in Los Angeles County.	77%	CONSENSUS: Language changed
Q12	Provide comprehensive, culturally and linguistically competent, and person-centered services that aim to enhance the well-being of African immigrants, underserved communities, and other vulnerable immigrant adults facing significant mental health needs by (1) building a collaborative network to ensure connections to services that increase the accessibility of outpatient mental health and coordination of psychiatric rehabilitation supportive services, (2) utilizing several Evidence-based Practices (EBPs) to reduce behavioral health challenges for targeted populations, (3) providing opportunities for mentoring, clinical support, outpatient mental health care, and psychiatric support rehabilitation services, and substance use or abuse rehabilitation, and (4) tackling co-existing conditions such as substance abuse, homelessness, and involvement with judicial and/or child welfare services.	62%	CONSENSUS: Moved to Tier 2
Q17	Provide quality early intervention services to children ages two to five years old in Foster and Post Adoptive Care who have experienced early childhood trauma to help them learn new skills and change behavior to help them be successful in home, public, and school settings. Program addresses the social, emotional, and behavioral issues of at-risk children in Foster and Post Adoptive Care under the guidance of therapeutic professionals and trained staff through a therapeutic learning center day treatment program. This should	69%	CONSENSUS: Language changed

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
	include coordination with other programs for effective use of resources beyond DMH.		
Q22	Ensure hospital discharge planners are aware of all housing and support options and other programs within DMH, including the availability and oversight of Peer Run respite homes and other services across all Service Areas.	69%	CONSENSUS: Language changed
Q2	DMH contracts for two peer-run residential homes offering short-term respite. Expand to at least two peer-run residential homes per Service Area, including oversight.	62%	CONSENSUS: Language changed
Q8	Expand services in Peer-Run Centers, including space, time available, oversight, collaboration with community organizations, cultural competency, and availability to family members and across all Service Areas.	62%	CONSENSUS: Language changed
Q19	A mobile health outreach intervention that partners with youth serving community-based organizations in South Los Angeles to provide mental health care for Transitional Aged Youth, ages 18-25 by focusing on primary, secondary and tertiary levels of prevention and appropriate interventions. Targets unstably housed or unsheltered youth and young adults (ages 18-25 years old) in the SPA6 community of South Los Angeles.	62%	ENDORSED: Adopted Consent Agenda
Q21	Address the mental health of veterans from a family perspective, as recognized by the US military and Department of Veterans Affairs. Innovations and extensions of couple and family interventions have the potential to increase the reach and impact of treatments for service members and veterans, as well as to ultimately improve the quality of their family relationships (NIH, 2023). The proposed program fills in family-based treatment gaps and other barriers to veterans connecting with mental health support. Targets all ages seeking help, veterans, and family members, with a separate camp for teens.	62%	ENDORSED: Adopted Consent Agenda
Q7	Increase self-help support groups.	54%	ENDORSED: Adopted Consent Agenda
Q14	Develop quality improvement projects and processes to existing programs and services, e.g. Outpatient Care Services (OCS), drop-in/wellness center, age specific services, etc.	54%	ENDORSED: Adopted Consent Agenda
Q16	A mental health summer camp for trans/gender-diverse youth and youth affected by HIV/AIDS (aged 6-17) that aims to provide an emotionally safe, supportive, and enriching environment for these vulnerable populations. Designed to address the unique mental health and wellness needs of trans/gender-diverse youth and those affected by HIV/AIDS, offering a holistic approach to support, combining therapeutic interventions, education, and	54%	ENDORSED: Adopted Consent Agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
	recreational activities to create a well-rounded experience that improves each camper's mental health.		
Q18	Develop and implement a field-based program in eight (8) geographical service areas throughout Los Angeles County to identify housed and unhoused individuals exhibiting symptoms of hoarding disorder and provide a range of field-based services including assessment, intervention, intensive case management, medication management, peer support, co-occurring disorder identification and treatment, and advocacy. Teams conduct intensive outreach and receive referrals from public agencies and community organizations; possess specialized training to build trust and partner with individuals who exhibit symptoms of hoarding disorder; and, along with individual CBT, utilize a peer-run Buried in Treasures support group model to achieve positive change. The National Study Group on Chronic Disorganization's (NSGCD) Clutter Hoarding Scale will be used to monitor individuals' progress. Adults age 18+ across the life span, including those who are housed or experiencing homelessness who exhibit symptoms of hoarding disorder that negatively impact the individual and/or community.	54%	ENDORSED: Adopted Consent Agenda
Q20	Implement Freespira Digital Therapeutic (Freespira) as a treatment for Post-Traumatic Stress Disorder (PTSD) and panic disorder. Freespira is a first-in-class FDA-cleared, medication-free digital therapeutic indicated for treatment of PTSD and panic disorder. Freespira is the subject of multiple published clinical trials that measured clinical and economic outcomes as well as rigorous review and clearance by the FDA. Targets clients 13+ years old identified with a diagnosis or suspected diagnosis of PTSD and/or panic disorder.	46%	ENDORSED: Adopted Consent Agenda

HOMELESS SERVICES AND HOUSING RESOURCES (HSHR)

BACKGROUND

This section contains the recommendations of the HSHR Workgroup for each of the following categories:

CATEGORIES	GOALS
6. Eviction Prevention	*Strengthen eviction prevention services and supports.*
7. Street Outreach	*Strengthen street outreach.*
8. Service Quality	*Improve service quality.*
9. Types of Housing Options	*Increase types of housing options.*
10. Specific Populations	*Provide targeted support to specific underserved populations.*

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

1. EXISTS ALREADY: Expand and/or Improve Existing PSI
   More information on existing programming is located in section VIII. Programs and Services of the Three Year Program and Expenditure Plan (Plan).

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
1	Preventing Homelessness & Promoting Health	1. Expand the Preventing Homelessness and Promoting Health (PH Square) collaborative program with Department of Health to provide psychiatric, medical, and other social service interventions to prevent imminent eviction.	Expand	PEI: Prevention Services: Prevent Homelessness Promote Health
1	Full Service Partnerships	2. Provide flex funds for enrolled clients which can be used for eviction prevention and improve FSP to include life skills training to prevent eviction.	Improve	CSS: FSP
1	Interim Housing – Outreach Program	3. Provide mental health supports for interim housing sites to reduce exits to the streets (eviction) and increase movement to Permanent Supportive Housing (PSH) through an integrated approach. (This is also a job training opportunity for Peer Specialist positions.)	New Service January 2024	Innovation: Interim Housing Multidisciplinary Assessment and Treatment Teams
1	Housing Support Services Program (HSSP)	4. Expand HSSP services in PSH units in collaboration with Department of Health Service's Intensive Case Management Services providers and Department	Expand	CSS: Housing: Supportive Services for Individuals in PSH

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		of Public Health's Client Engagement and Navigation Services. When new PSH buildings open, services providers are contracted to render these services.		
1	Housing Services	5. Expand permanent congregate housing with on-site peer supportive services.	Expand	
1	Housing Assistance Program	6. Provide financial assistance to DMH clients of one month of unpaid rent, based on an individualized client plan for self-sufficiency.	Expand	CSS: Housing: Housing Assistance Program, Housing for Mental Health
2	SKID ROW Concierge Program	7. This program provides street-based engagement and support to connect to mental health treatment and housing for individuals experiencing unsheltered homelessness in the skid row area.	Expand	Capital Facilities Technological Needs: Crocker Street Project
2	HOME	8. Expand HOME to increase street outreach to individuals with serious and persistent mental illness (SPMI) and to fill the need of new programming (e.g., Interim Housing Outreach Program)	Expand	CSS: Linkage
2	PMRT	9. PMRT (Psychiatric Mobile Response Team) provides field-based crisis services. Expand PMRT to include contracted Field Intervention Teams that are designated to respond to mental health crises of individuals in various types of housing.	Expand	CSS: Alternative Crisis Services
2	Community Health Promoters (CHWs)	10. Utilize CHWs to increase awareness about mental health issues and to disseminate resources to reduce mental stigma and improve working relationships within the community in order to deliver mental health services. Expand this program to include work in public spaces including libraries.	Expand	PEI: Stigma and Discrimination Reduction
3	Housing Data Collection Infrastructure	11. Improve infrastructure to support better data collection of homelessness and housing data that can be used to improve programs via Housing and Homelessness Incentive Program (HHIP).	Improve	CSS: Housing Programs
3	Mental Health Support	12. Provide mental health support in shared housing and traditional housing.	Expand	CSS: Housing Programs

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
3	Peer Services	13. Use Peer Services for social supports and navigating benefits and paperwork available in Peer Run Centers, MHSA Outpatient, and FSP programs.	Expand	CSS: Outpatient Care Services CSS: FSP
3	Peer Run Respite Care Homes	14. Provide Peer Run Respite Care to support individuals in crisis to prevent homelessness.	Expand	
4	Interim Housing Beds	15. Create new interim housing beds, enhance staffing/services in existing non-congregate interim housing sites, and provide CARE Court clients with rental assistance resources by accepting Behavioral Health Bridge Housing (BHBH) funding from the State. Expand interim housing in high need areas such as Skid Row.	Expand	
4	Interim Housing Families	16. Increase interim housing resources for families.	Expand	
4	Enriched Residential Care (ERC) & Board and Cares (B&Cs)	17. Increase access for Persons Experiencing Homelessness (PEH) to ERC and licensed residential care facilities by accepting funds in Community Care Expansion (CCE) State subsidies to ERC and provide funds for all licensed residential are facilities.	Expand	
4	Hollywood 2.0 - Interim Housing, ERC, & PSH	18. Continue current pilot of community-inclusive programming to support, treat, and house individuals in the Hollywood area.	Expand	
4	Dedicated Hotel/Motel Beds - HOME	19. Expand dedicated hotel/motel beds for Homeless Outreach Mobile Engagement (HOME), which provides street outreach for individuals who may need extensive engagement and support. This includes reentry programs for women and men.	Expand	
4	Permanent Supportive Housing	20. Expand Permanent Supportive Housing (PSH) across LA County	Expand	CSS: Housing: Capital Investment Program
4	Beds for Very Vulnerable Individuals	21. Provide housing in a home setting for up to 6 young adult males diagnosed with serious mental illness that face housing insecurity and are unable to live independently, grouped by same age range and same diagnosis (schizophrenia) in a supportive home model with 24/7 trained staff		

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		in the LEAP method and in-house holistic program that stimulates motivation, engagement and provides improvement in behavioral and physical health through nutrition, music and nature outings, besides job coaching to create purpose in staying well. The supportive housing model creates a social community where they can grow in trust and confidence and forge friendships, and the model also provides a sense of belonging and community, reducing the isolation and stigma that people with serious mental illness face.		
5	Transition Age Youth (TAY)	22. Expand TAY housing and service options including shelters, interim housing, and PSH, focused on youth transitioning from child welfare and probation systems	Expand	PEI: Prevention: TAY Drop In Centers CSS: Outpatient Care Services: TAY Drop In Centers CSS: Housing: MHSA Project-Based Permanent Supportive Housing Developments
5	Justice Involved - Office of Diversion and Reentry	23. Support the Office of Diversion and Reentry (ODR) to fund Intensive Case Management Services (ICMS), Interim Housing, Enriched Residential Care (ERC) and Permanent Supportive Housing for individuals who are homeless, have a Serious Mental Illness and are incarcerated at LA County Jail. Incentivize psychiatrists, including with loan repayment programs at DMH and DHS to work with this population. Also ensure parity of pay for psychiatrists at DMH, DHS, VA and other County programs.	Expand	CSS: Housing
5	Justice Involved - Care First Community Investment	24. Expand the Care First Community Investment (CFCI) model of interim housing for those with justice involvement to other sites.	Expand	
5	Justice Involved - Women's Community Re-entry	25. Expand hotel/motel beds that will serve as interim housing for Women's Community Re-Entry Program clients.	Expand	CSS: Housing: Interim Housing

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
5	LGBTQIA & Transgender	26. Expand or create housing settings specific to Transgender communities and provide extended hours to meet needs.	Expand	CSS: Housing
5	BAH + UsCC: Utilities Support	27. Ensure funding for support services i.e. utilities for the Black and African Heritage (BAH) and other underserved communities	Expand	CSS: Housing
5	Undocumented Clients – Interim Housing	28. At interim housing sites, increase staff capacity to provide culturally and linguistically appropriate services for undocumented clients and mental health support. IHOP will be implemented in 2024.	Improve	CSS: Interim Housing
5	Senior older adult population	29. All types of housing and housing that meets their unique needs including related to deteriorating physical and mental health.	Improve	CSS: Housing

2. DOES NOT EXIST: Add New PSI

CATEGORY	DESCRIPTION: NEW PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1	1. Develop and implement trainings and materials focused on eviction prevention and available resources to train mental health providers to assist and educate clients at all levels of care. This includes information on community resources, legal services, and first-time homeowner programs.	Partner	YES
1	2. Develop and implement trainings and materials on working with individuals with mental health needs for landlords, law enforcement, and others involved in the eviction process.	Partner	YES
1	3. Develop rehabilitation and skill-building groups focused on helping consumers to maintain housing (e.g. budgeting, communication with property owners, being a good neighbor, employment etc.) as part of the service array in DMH clinics and contract agencies.	DMH Partner	YES
1	4. Develop a countywide eviction prevention program that has a central phone number for support, provides training for law enforcement and landlords and property managers on working with mental health issues and available resources, helps individuals access eviction prevention funds available through county programs, and provides life skills trainings in the community.	Partner	YES
1	5. Develop a housing resources landing page on the DMH website that lists information on how to access all available resources for eviction prevention, housing support, and/or services related to housing retention.	DMH	YES

CATEGORY	DESCRIPTION: NEW PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1	6. Develop and implement a comprehensive communication strategy that informs clients about housing resources. This communication strategy would include Community Health Workers (e.g., *Promotoras* and Peer Specialists) in delivering this information.	DMH	YES
2	7. Develop and implement trainings and resource materials focused on finding resources in the community (e.g., sobering centers, *SafeParkingLA*, mobile showers, housing resources).	Partner	YES
2	8. Develop and implement trainings and materials for improving coordination of care among service teams and passing out the available resources in the various levels of care including interoperability with public safety. Ensure there is an investment in technology and a centralized system.	DMH	YES
2	9. Develop PMRT Team dedicated to the skid row area and other areas where PEH are concentrated to improve mental health crisis response time.	DMH	YES
2	10. Develop and implement programs that assign mental health treatment and peer services staff to places where PEH are located including shopping centers and local libraries to treat and support library patrons experiencing homelessness.	DMH	YES
2	11. Incorporate mobile showers as part of the services provided by DMH Street Outreach by partnering with existing CBOs including the faith community that manage these resources.	DMH	
2	12. Develop public education about Senate Bill 43 which modernizes the definition of grave disability and probable cause for conservatorship. The bill broadens eligibility to people who are unable to provide for their personal safety or necessary medical care. In addition, Senate Bill 43 encompasses people with a severe substance use disorder, such as chronic alcoholism. Incorporate the new definition in HOME services in Los Angeles County if permissible. This should be done as an anti-stigma campaign to ensure we do not further stigmatize people.	DMH	YES
2	13. Develop safe sleep programs.	DMH	YES
2	14. Develop stationary hubs (centralized services) so there is a direct pipeline to DMH in the community including transportation with wheelchair access.	Partner	YES
3	15. Develop a one-stop online site that centralizes information about housing resources.	DMH & Partner	YES
3	16. Develop or integrate into an existing program training and support for landlords and housing developers on working with and the needs of individuals with mental illness (e.g., implicit bias training).	Partner	YES
3	17. Implement or partner with services providing supports to adult children with SMI to improve access to support groups such as NAMI, and respite care options.	Partner	YES

CATEGORY	DESCRIPTION: NEW PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
4	18. Develop a damage mitigation pool of funding to repair damage in interim and permanent housing to repair damage by DMH clients.	DMH & Partner	YES
4	19. Use a community land trust model building upon innovative solutions presented in the Alameda County Supportive Housing Community Land Alliance Project Proposal to bring permanent affordability and community control to help ease Los Angeles County's housing crisis for SMI consumers whose income is 200% of the federal poverty level.		YES
4	20. Implement independent living centers and supports to increase the ability to live independently.		YES
5	21. Justice-Involved and/or Undocumented Clients: Support the Legacy Flexible Housing Subsidy Pool (FHSP) Program that provides ongoing rental assistance to clients who are homeless and do not qualify for federal housing subsidies due to their documentation status or type of felony offense (e.g., Registered Sex Offenders).	Partner	
5	22. Justice-Involved Clients: Continue the operation of Interim Housing beds for those with justice involvement funded with CFCI dollars when the funding source terminates on June 30, 2024.	DMH	
5	23. Justice-involved Clients: Establish dedicated interim housing beds for formerly incarcerated clients served through the Men's Community Reentry Program.	DMH	
5	24. Veterans: Implement awareness campaign to improve access to housing resources for veterans.	Partner	YES
5	25. TAY, LGBTQ, Transgender, Domestic Violence, and Older Adults: Develop or expand existing housing resource guides to identify housing available to specific populations.	Partner	YES
5	26. LGBTQIA: Invest in housing specific to LGBTQ community.	Partner	YES
5	27. Low-Income People Not Meeting the Definition of Homeless: Increase MHSA funds for the Flexible Housing Subsidy Pool which can be used for rent subsidies in a variety of housing types, such as licensed care facilities, for individuals who do not meet the definition of homeless but do not have the income to move to other forms of housing such as licensed residential facilities. This Flexible Housing Subsidy Pool can help create more flow for special populations across different housing types.	DMH	YES
	28. Utilize a comprehensive, community-based approach, leveraging existing strengths to provide housing, a coordinated continuum of culturally competent health services, employment support and other recovery support services tailored to the needs of African immigrants, refugees and underserved populations experiencing homelessness in Los Angeles County, California.		YES

B. POLICY, PRACTICE, AND/OR ADVOCACY RECOMMENDATIONS

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
1	1. Integrate mental health needs/practices into the current eviction practices/protocols.
1	2. Use tools like the CEO Equity tool to identify specific geographic areas of need within each Service Area and to target specific underserved populations when implementing and/or expanding programs.
1	3. Address the high cost of living.
1	4. Improve law enforcement response to avoid losing housing.
1	5. Provide restorative housing.
1	6. Increase homeownership opportunities.
2	7. Tap into some of the models in West Hollywood, homeless outreach teams, collaboratives with different organizations including The People Concern/Step Up on Second/Tarzana Treatment Center/etc.
2	8. Involve community leaders and CBOs with funding to outreach and relate to these sites.
2	9. Identify existing community services and advocate for more services, such as safe parking and mobile showers. Collaborate with those in the community that provide these resources.
2	10. Help individuals with substance use disorders to accept housing in real time.
2	11. Provide better support and training for peer specialists who support street outreach work.
2	12. Provide better assistance to individuals that are homeless to get access to hot food and to find adequate housing.
2	13. Add peer support across all programs.
2	14. Strengthen hiring and selection processes and reduce barriers for people with lived experience. Provide opportunities for CHW to meet to collaborate together and identify and advocate for training and supports needed.
2	15. Implement resource fairs and collaborate with the community.
2	16. Hire staff that are reflective of the communities served and ensure cultural and linguistic competence and provide training on implicit bias.
2	17. Implement client satisfaction surveys across programs use that information to improve programs/services.
2	18. Develop a structured approach to support individuals that have “failed” in many different programs and to coordinate across programs.
2	19. Collect and analyze 911 usage for PEH issues.
3	20. Integrate a housing navigator focused on supporting the Fire Department and EMS to avoid unnecessary emergency room visits for clients who qualify for housing supports.
3	21. Promote awareness and access to benefits establishment services available throughout LA County
3	22. Establish an oversight committee which is community-based and peer-led to assure and improve accountability for contract providers
3	23. Remove barriers such as requirement of referrals to programs (allow self-referrals), verifications of identity (in forms of ID’s and/or certificates) for homeless individuals seeking housing services/supports.
3	24. Improve timely access to temporary and permanent housing, and reduce bureaucratic barriers
3	25. Improve safety in housing units and ensure housing developers include 24-hour security when underwriting projects. People that are providing security should be trained on de-escalation and trauma informed responses.
3	26. Enhance staffing/services in existing congregate interim housing sites.

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
3	27. Provide training, GED classes and employment opportunities.
3	28. Implement customer satisfaction surveys
3	29. Focus on client driven goals.
3	30. Increase self-sufficiency and independent living skills especially while in shelters.
3	31. Collect performance measures and provide incentives for workers that are burned out.
3	32. Train staff on how to develop quality SSI applications that will be approved.
4	33. Contain costs per bed at less than $100K.
4	34. Eliminate site control to expand types of housing.
4	35. Provide relentless engagement.
4	36. Reduce bureaucracy to access housing.
4	37. Ensure supportive services in PSH are adequate and focused on self-sufficiency.
4	38. When DMH has resource fairs include housing resources.
4	39. Ensure there is throughput between different types of housing including pathways out of shared housing settings.
4	40. Inform PEH about peer support job opportunities.
5	41. Strengthen communication between DMH's Enhanced Emergency Shelter Program staff and other providers of TAY Interim and Transitional Housing and improve connection to mental health and housing services for the youth in these settings.
5	42. Establish funding for African American (AA) population to own/lead interventions related to their communities outside of faith-based groups.
5	43. Strengthen coordination with DCFS and Probation.
5	44. Increase access for both documented and undocumented clients.

HSHR WORKGROUP – CONSENSUS RECOMMENDATIONS

CPT Recommendations/MHSA Proposals Needing Additional Feedback

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q1	Expand the Preventing Homelessness and Promoting Health (PH Square) collaborative program with Department of Health to provide psychiatric, medical, and other social service interventions to prevent imminent eviction.	92%	CONSENSUS: Leave as is
Q3	Provide housing in a home setting for up to 6 young adult males diagnosed with serious mental illness that face housing insecurity and are unable to live independently, grouped by same age range and same diagnosis (schizophrenia) in a supportive home model with 24/7 trained staff in the LEAP method and in-house holistic program that stimulates motivation, engagement and provides improvement in behavioral and physical health through nutrition, music and nature outings, besides job coaching to create purpose in staying well. The supportive housing model creates a social community where they can grow in trust and confidence and forge friendships, and the model also provides a sense of belonging and community, reducing the isolation and stigma that people with serious mental illness face.	92%	ENDORSED: Adopted Consent Agenda
Q2	Expand on congregate housing (such as shared and permanent supportive housing) with on-site peer supportive services. Develop glossary of key terms, such as shared housing; permanent supportive housing; congregate housing;	85%	CONSENSUS: Language change
Q14	Implement independent living centers and supports to increase the ability to live independently.	85%	ENDORSED: Adopted Consent agenda
Q16	Justice-Involved Clients: Continue the operation of Interim Housing beds for those with justice involvement funded with CFCI dollars when the funding source terminates on June 30, 2024.	85%	ENDORSED: Adopted Consent agenda
Q21	Low-Income People Not Meeting the Definition of Homeless: Increase MHSA funds for the Flexible Housing Subsidy Pool which can be used for rent subsidies in a variety of housing types, such as licensed care facilities, for individuals who do not meet the definition of homeless but do not have the income	85%	CONSENSUS: No change

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
	to move to other forms of housing such as licensed residential facilities. This Flexible Housing Subsidy Pool can help create more flow for special populations across different housing types.		
Q23	Add peer support across all programs.	85%	ENDORSED: Adopted Consent agenda
Q19	TAY, LGBTQ, Transgender, Domestic Violence, and Older Adults: Develop or expand existing housing resource guides to identify housing available to specific populations.	69%	CONSENSUS: Moved to Tier 1
Q17	Justice-involved Clients: Establish dedicated interim housing beds for formerly incarcerated clients served through the Men's and Women's Community Reentry Program.	77%	CONSENSUS: Moved to Tier 1 and language change
Q18	Veterans: Implement awareness campaign targeting veterans and their families to address and target barriers to improve access to housing resources.	77%	CONSENSUS: Moved to Tier 1 and language change
Q24	Improve safety in housing units and ensure housing developers include 24-hour security when underwriting projects. People that are providing security Should be trained on de-escalation and trauma informed responses.	77%	ENDORSED: Adopted Consent agenda
Q4	Develop a countywide eviction prevention program that has a central phone number for support, provides training for law enforcement and landlords and property managers on working with mental health issues and available resources, helps individuals access eviction prevention funds available through county programs, and provides life skills trainings in the community.	77%	ENDORSED: Adopted Consent agenda
Q5	Develop PMRT Team dedicated to the skid row area and other areas where PEH are concentrated to improve mental health crisis response time.	77%	ENDORSED: Adopted Consent agenda
Q28	Establish funding for African American (AA) population to own/lead interventions related to their communities outside of faith-based groups.	54%	CONSENSUS: Leave as is and move to Tier 2.
Q6	Develop and implement programs that assign mental health treatment and peer services staff to places where Person Experiencing Homelessness (PEH) are located including shopping centers and local libraries to treat and support library patrons experiencing homelessness.	69%	ENDORSED: Adopted Consent agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q9	Develop stationary hubs (centralized services) so there is a direct pipeline to DMH in the community including transportation with wheelchair access.	69%	ENDORSED: Adopted Consent agenda
Q12	Develop a damage mitigation pool of funding to repair damage in interim and permanent housing to repair damage by DMH clients.	69%	ENDORSED: Adopted Consent agenda
Q13	Use a community land trust model building upon innovative solutions presented in the Alameda County Supportive Housing Community Land Alliance Project Proposal to bring permanent affordability and community control to help ease Los Angeles County's housing crisis for SMI consumers whose income is 200% of the federal poverty level.	69%	CONSENSUS: Leave as is
Q25	Enhance staffing and supportive services (such as, trauma informed training and job/employment support) in existing congregate interim housing sites.	69%	CONSENSUS: Language change
Q7	Develop public education about Senate Bill 43 which modernizes the definition of grave disability and probable cause for conservatorship. The bill broadens eligibility to people who are unable to provide for their personal safety or necessary medical care. In addition, Senate Bill 43 encompasses people with a severe substance use disorder, such as chronic alcoholism. Incorporate the new definition in HOME services in Los Angeles County if permissible. This should be done as an anti-stigma campaign to ensure we do not further stigmatize people.	62%	ENDORSED: Adopted Consent agenda
Q8	Develop safe sleep programs.	62%	ENDORSED: Adopted Consent agenda
Q10	Develop or integrate into an existing program training and support for landlords, property managers and housing developers on working with and addressing the needs of individuals with mental illness (e.g., implicit bias training, cultural awareness concepts and information on supportive programs).	62%	CONSENSUS: Language change
Q11	Implement or partner with services providing supports to adult children with SMI to improve access to support groups such as NAMI, and respite care options.	62%	ENDORSED: Adopted Consent agenda
Q20	LGBTQIA: Invest in housing specific to LGBTQ community.	62%	ENDORSED: Adopted Consent agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q22	Utilize a comprehensive, community-based approach, leveraging existing strengths to provide housing, a coordinated continuum of culturally and linguistic competent health services, employment support and other recovery support services tailored to the needs of, but not limited to, African heritage populations, indigenous immigrants, refugees and other underserved populations experiencing homelessness in Los Angeles County, California.	62%	CONSENSUS: Language change
Q15	Justice-Involved and/or Undocumented Clients: Support the Legacy Flexible Housing Subsidy Pool (FHSP) Program that provides ongoing rental assistance to clients who are homeless and do not qualify for federal housing subsidies due to their documentation status or type of felony offense (e.g., Registered Sex Offenders).	54%	ENDORSED: Adopted Consent agenda
Q27	Eliminate site control to expand types of housing.	31%	NO ACTION: Lack of understanding
Q26	Contain costs per bed at less than $100K.	38%	CONSENSUS: Remove from recommendations

PREVENTION AND EARLY INTERVENTION

BACKGROUND

This section contains the recommendations of the PEI Workgroup for each of the following categories:

CATEGORIES		GOALS
4. Populations	C. Early Childhood/Birth to 5	*Strong and effective prevention and early intervention programs/services for various stages of childhood from prenatal and birth to five.*
	D. Underserved Communities	*Improve the cultural and linguistic capacity of prevention and early intervention programs/services to reach hard to reach underserved populations*
5. Access	C. School-Based: K-12 Schools, Colleges, Universities, and Trade Schools	*Increase Access for services to youth in School-Based: K-12 Schools, Colleges, Universities, and Trade Schools*
	D. Community Engagement (Including TAY Advisory Group)	*Increase Access for PEI services leveraging community platforms/partners.*
6. Effective Practices	E. Suicide Prevention	*Strengthen suicide prevention programs/services*
	F. Evidence Based Practices/Treatment	Increase use of evidence-based practices and community defined evidence

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

1. EXISTS ALREADY: Expand and/or Improve Existing PSI
   More information on existing programming is located in section VIII. Programs and Services (by Component) of the Three Year Program and Expenditure Plan.

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
1A	Intensive Care Coordination	1. Focuses on engagement and support of families and includes Child and Family teaming a practice the puts the child and family in the driver seat. This service is integrated into all outpatient services	Expand	Prevention and Early Intervention: Early Intervention Services
1A	Birth to Five Training	2. This year, twelve trainings on core competencies are offered focus on birth to five to expand expertise in the workforce. DMH can look into the next two fiscal years to offer an additional 6-8 trainings in the year. Will utilize DMH/ UCLA PCOE Fellowship. PEI will work	Expand	Prevention and Early Intervention: Early Intervention Services

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		with stakeholders to identify the gap in program/services.		
1A	Birth to Five Services	3. DMH services for Birth to 5 include (but are not limited to) Incredible Years, Parent Child Interaction Therapy, Triple P, Nurturing Parenting, and Managing and adapting practice. Available trainings are also offered through the DMH/UCLA Public Partnership for Wellbeing.	Expand	Prevention and Early Intervention: Early Intervention Services
1A	Home Visitation	4. DMH offers three models of home visiting services, Deepening Connections and Enhancing Services in partnership with First 5 LA, Healthy Families America, and Parents as Teachers	Expand	Prevention and Early Intervention: Early Intervention Services
1A	Active Parenting Programs	5. DMH offers programs including Incredible Years, Nurturing Parenting, Triple P, Reflective Parenting, Child Parent Psychotherapy, and Managing and Adapting Practice. Triple P is offered in community settings, including Libraries and offer information directly to Parents	Expand	Prevention and Early Intervention: Early Intervention Services
1A	Perinatal Services	6. DMH offers specialty consultation for providers treating perinatal women and offers evidenced based practices such as Interpersonal Psychotherapy (IPT) for postpartum depression. DMH has offered 2 free online Learning Pathway for Perinatal training to all staff, from UCLA Prevention Center of Excellence.	Augment & Expand	Prevention and Early Intervention: Early Intervention Services
1B	Transforming Los Angeles	7. Supports CBOs with training and grant supports, expand and include CBO's which focus on underserved cultural communities	Expand	Prevention and Early Intervention: Early Intervention Services
1B	Mental Health Promoters	8. The Mental Health Promoters program aims to reduce mental health stigma. Particularly in underserved community by increasing awareness about mental health issues and improving access to culturally	Expand	Prevention and Early Intervention: Stigma and Discrimination Reduction

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		and linguistically appropriate resources provided by trained community members		
1B	Mental Health service sites and programming that target underserved populations	9. DMH offers culturally specific services through both Directly operated and Contracted providers that service the American Indian, API, Black/African Heritage, Latino, and Middle Eastern communities. Transitional Age Youth (TAY) and Older Adults.	Expand and Augment to Other UsCCs	CSS: Planning Outreach and Engagement
2A	School Based Community Access Point (SBCAP)	10. Offers programing to support youth getting connected to services. Including an annual Summit for Districts/Schools to attend. DMH SBCAP team provides Technical Assistance (TA) to school districts. TA supports includes: 1) participating in resource campaigns/fairs and providing student and caregiver workshops to build an understanding of mental health and wellbeing. 2) Coordinated Care in bridging schools and school mental health providers. 3) Crisis Postvention supports that include debrief and planning with schools and mobilizing resources to support in the aftermath of an incident, with a focus on suicide.	Expand	Prevention and Early Intervention: Prevention Services
2A	Partnerships/ Collaborations	11. DMH continues to collaborate with Los Angeles County Office of Education (LACOE), LAUSD and other school districts to expand school services. • Working with LACOE and Managed Care Plans (MCP) in the implementation of State-wide initiatives: Student Behavioral Health Incentive Program (SBHIP) and Children Youth Behavioral Health Initiative (CYBHI). • DMH SBCAP Team, Directly Operated Programs, and Legal Entity Network provide EI services. • LA Suicide Prevention Network has a Youth Advisory Board and provides training	Expand	Prevention and Early Intervention: Prevention Services

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		resources/information. Also has an annual Suicide Prevention Summit. • Youth Summit – Public health-Office of Violence Prevention • Prevention Programming with other Departments and organizations that work directly with youth at schools: • Dept. of Arts & Culture – Creative Wellbeing – artists in the community and afterschool programs/assemblies • Wolf Connection - Power of the Pack Program, a multi-tiered program is an immersive digital education and empowerment experience for students aged 11-18 • Friends Of The Children (FOTC) - a program that aims at preventing foster care entry and improve family stability and wellbeing for families identified by DCFS. It provides professional 1:1 mentorship to children for 12+ years starting around 4-6 years old. • UCLA Center Of Excellence (COE) Wellbeing for LA Learning Center delivers a personalized and accessible learning environment that is available to learners at home, at work, or in transit. Designed for the workforce across Los Angeles County that supports the mental health and wellbeing of children, families, and adults within systems of care. Trainings designed for school staff, teachers, and school mental health staff. • **Abundant Birth** (with DPH) **-** *This program is a private-public partnership that seeks to provide support to a minimum of 400 pregnant people in LA County from marginalized populations most likely to experience the worst birth outcomes with a variety of supports for 18 months (i.e. mental health, financial*		

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		coaching, wellness supports, housing assistance, education, etc. • **Credible Messenger -** *(with DYD) This program consists of mentoring youth transitioning out of probation/juvenile justice facilities to increase access to resources and services for young people of color disproportionately negatively impacted by traditional systems and services.* • **Medical Legal** - (with DHS) *Addresses clients' legal problems and increases awareness of their rights to which lessens undue stress and empowers them with the information.* • **Neurofeedback** - *a short-term treatment complementary and alternative medicine (CAM), that uses electronic devices to help people with self-regulation and self-control.* • **Peer, Family Community Supports Toward Stigma and Discrimination Reduction** (with NAMI Greater LA and Urban LA) - *Provides Countywide community based prevention programs and approaches and supports to reduce stigma and discrimination targeting people living with mental illness, their families, friends and communities.* • **Prevention & Aftercare** - (with DCFS) *Ten leading community agencies proving a variety of services to the community to empower, advocate, educate, and connect with others.* • **School of Los Angeles (SEED LA)** - *is the county's first public, charter, college-preparatory, tuition-free boarding high school for at-risk youth. The school while provide on-site support, wellness services and socio-emotional counseling for students.*		

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		• **Youth Development Network** (with DYD) - *Based in 5 geographic regions: This program will support youth by providing and/or referring to a range of youth development services based on an assessment of individual strengths, interests, and needs.*		
2A	Olweus Bully Prevention Programming (OBPP)	12. OBPP is an Evidence Based Practice (EBP) proven to prevent and reduce bullying. It is a systems-change program which intervenes at the school, classroom, individual, and community levels to impact everyone who comes in contact with the students. OBPP aims to restructure the elementary, middle, and high school environment to reduce opportunities and rewards for bullying. OBPP has been more thoroughly evaluated than any other bullying prevention/reduction program so far.	Expand	Prevention and Early Intervention Services: Early Intervention Services
2A	CALMHSA-Directing Change	13. Statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students, through film. Programming implemented in school districts from middle-high school.	Expand	Prevention and Early Intervention Services: Prevention Services
2A	Know the Five Signs	14. Training that provides a common language to identify when someone is suffering, connecting to help, and how to stay emotionally healthy.	Expand	Prevention and Early Intervention Services: Prevention Services
2A	Mental Health First Aid (MHFA)	15. Course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	Expand	Prevention and Early Intervention Services: Stigma and Discrimination Reduction

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
2A	Psychological First Aid	16. Provides guidance on responding to disaster, terrorism, or violence events that occur at a school using the Psychological First Aid for Schools intervention.	Expand	Prevention and Early Intervention Services: Stigma and Discrimination Reduction
2A	More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	17. Is an approximately 120-minute program that teaches educators to recognize signs of mental health distress in students and refer them for help.	Expand	Prevention and Early Intervention Services: Stigma and Discrimination Reduction
2A	Child Adolescent Suicide Review Team (CASRT)	18. A multidisciplinary team that conducts mortality reviews of any child in L.A. County who has died by suicide. DMH, DPH, DCFS, Medical Examiner's Office, LACOE, Probation participate in a closed door review. Meeting is not open to public due to PHI/HIPAA.	Expand	
2A	Community School Initiative	19. Is currently in 15 schools – embedding community within school. The State's California Community Schools Partnership Program (CCSPP) is funding several of the original community schools. DMH can expand into other school sites including some middle schools and elementary schools.	Expand	Prevention and Early Intervention Services: Prevention Services
2A	College and Universities increase to access to care	20. Both Directly Operated and Legal Entity providers collaborate with Colleges and Universities to increase access to care for students. Services include linkage, case management, and therapy services.	Expand	CSS: Linkage and POE
2B	Community Family Resource Center (CFRC)	21. The CFRC is designed to create a coordinated, community owned and driven space where families and individuals can easily access the services, they need to enhance their wellbeing. The CFRCs will create partnerships with trusted networks of care, individual community leaders, CBOs, and public and private entities to leverage the strengths and capacities of each to best respond to the needs of individuals and	Expand	Prevention and Early Intervention Services: Prevention Services

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		families in the community it serves.		
2B	IPrevail	22. It is accessible through any device connected to the internet. This platform offers a one-of-a-kind network of mental health support. From interactive lessons, chats with peer support coaches, to topic-based community support groups, you can see your progress being made & connect with other people going through similar life experiences all in one place.	Expand	Prevention and Early Intervention Services: Prevention Services
2B	United Mental Health Promoters Network	23. The Mental Health Promoters Network project is a community outreach effort, serving to strengthen communities and create career paths for those community members functioning under the umbrella of Mental Health Promoters.	Expand	Prevention and Early Intervention Services: Prevention Services
2B	Partnerships with the Library	24. New Parent Engagement-Welcome to the Library and the World : Public Libraries and DHS Women's Health will offer a Welcome to the Library and the World kit which will include information on the library Smart Start Early Literacy programs and services. The program will be offered at 45 locations twice a year, and though a virtual program every quarter. Triple P Parent/Caregiver Engagement. Triple P is an effective evidence based practice that gives parents and caregivers with simple and practical strategies to help them build strong, healthy relationships, confidently manage their children's behavior and prevent problems developing. School Readiness. An early literacy program designed for toddlers and preschoolers to help empower parents and guardians in supporting the education needs of their children. While enjoying books, songs, rhymes and fun, kids build early literacy skills, basic	Expand	Prevention and Early Intervention Services: Prevention Services

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		math skills, and social skills, and other essential school readiness competencies.		
2B	Partnerships with Parks and Recreation	25. Our SPOT Teen Program: Social Places and Opportunities for Teens After-School Program: is a comprehensive after-school teen program aimed at engaging and providing community youth with the support, life-skills and positive experiences that will empower them to create bright futures for themselves. • We Rise Parks at Sunset – A program which creates access to self-care programming in 58 LA County parks and is offered during mental health awareness month. It provides repeated opportunities to access resources and information on mental health support including free mental well-being workshops. • DPR Safe Passages: Community Engagement and Safe Passages for Youth and Communities: utilizes trained gang interventionists and ambassadors to implement peace maintenance among gang neighborhoods to ensure safety to and from parks, and during park activities and provide crisis intervention services at the parks. • Parks after Dark Parks at Sunset – Designed for families and adults to participate in workshops and classes promoting self-care and healing, three evenings a week over 8-weeks. Activities include sports, fitness, arts and culture, movies and concerts and more.	Expand and Improve	Prevention and Early Intervention Services: Prevention Services
2B	Phone number for crisis support	26. 988 Suicide & Crisis Lifeline officially launched across the	Expand	Prevention and Early Intervention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		United States on July 16, 2022. Comprised of a national network of local crisis centers, 988 counselors provide free, confidential, 24/7 support and resources to people experiencing or affected by suicidal, mental health, and/or substance use crisis. Callers can access this lifesaving service by simply calling or texting 988, or via online chat on their website. The Los Angeles County Department of Mental Health (LACDMH) supports the wellbeing of our County residents and communities. LACDMH's Help Line is available 24/7 to provide mental health support, resources and referrals at (800) 854-7771.		Services: Suicide Prevention
2B	Youth Services	27. DMH is developing a Youth Advisory Group to help lift up these services. For PEI, the majority of existing services are for youth and TAY populations. DMH is currently in partnership with LACOE to implement the Community School Initiative (CSI) in High Schools. With CSI, DMH is able to provide an array of services, including navigation support.	Expand	Prevention and Early Intervention Services: Prevention Services
2B	Peer services, supports and training	28. DMH currently has Mental Health Promotors, Parent Partner Training Academy and Peer Training Certifications that increase the use and capacity of peers within the department. We will increase partnership with new DMH Chief of Peers to offer more peer support and increased roles.	Expand	Prevention and Early Intervention Services: Prevention Services and Stigma and Discrimination Reduction
2B	Senior services and centers	29. DMH currently has specialized programing through Generaciones en Accion (Laugh Therapy & Gratitude & Older Latino Adults and Caregivers)	Expand	CSS: Outpatient Care Services
2B	Support Group Referrals	30. Strengthen the referral support for groups suffering from: trauma, lived experiences, family members and children.	Improve	Prevention and Early Intervention Services: Early Intervention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		Current: Seeking Safety, Survivors of Suicide Loss for adults/youth, Triple P, IY, MAP, CBT, IPT, Clinician and LE specific programming.		
2B	Domestic violence support	31. DMH has funded wellbeing services with community providers in the past but does not have specific programs currently. Directly operated and Legal Entities provide mental health services in the service areas. The Department is actively exploring how we can expand these services through partnerships with CBOs.	Expand & Improve	CSS: Outpatient Care Services
2B	Partnerships with faith-based organizations	32. DMH has expanded partnership with faith-based organizations, provided trainings to clergy, leaders, and staff. • DMH currently has the Health Neighborhood Liaison, Faith Based Meetings. Faith based centers request and receive training and identify resources needed in the communities represented/served. • DMH's Faith Based Advisory Council (FBAC) can help coordinate and expand this work. • DMH will engage with the FBAC to engage in activities around capacity building.	Expand	CSS: Planning Outreach and Enagement
3A	Mental Health First Aid	33. Teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training provides the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.	Expand	Prevention and Early Intervention: Stigma and Discrimination Reduction
3A	Know the 5 Signs	34. Training provides a common language to identify when someone is suffering, connecting to help, and how to stay emotionally healthy	Expand	

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		(offered in junior and high school).		
3A	Directing Change	35. Statewide efforts to prevent suicide, reduce stigma and discrimination related to mental illness, and to promote the mental health and wellness of students, through film.	Expand	Prevention and Early Intervention: Prevention
3A	It's Real-Teens and Mental Health	36. Intended for high school classes or community settings with groups of teens, ages from 14 to 18, It's Real: Teens and Mental Health for High School Students is a 45-minute program that provides young people with mental health education and resources. The program raises awareness about mental health issues, how to start a conversation about mental health, the importance of self-care, and how to reach out for help.	Expand	Prevention and Early Intervention: Prevention
3A	988 Services/Tool Kit	37. 988 Suicide & Crisis Lifeline officially launched across the United States on July 16, 2022. Comprised of a national network of local crisis centers, 988 counselors provide free, confidential, 24/7 support and resources to people experiencing or affected by suicidal, mental health, and/or substance use crisis. Callers can access this lifesaving service by simply calling or texting 988, or via online chat on their website.	Expand	Prevention and Early Intervention: Suicide Prevention
3A	Korean Hotline	38. Aims to break the stigma of mental illness and enhance the mental health awareness so help the community get support right on time to prevent the mental illness worse even to suicide. We also run K-hot line in Korean via texts, social media posts such as YouTube and phone calls.	Improve	Prevention and Early Intervention: Suicide Prevention
3A	Question, Persuade, Refer (QPR)	39. Suicide First Aid for gatekeepers: audience will learn how to Question, Persuade and Refer someone to get help and prevent death by suicide.	Expand	Prevention and Early Intervention: Suicide Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
3A	NAMI Prevention/Postvention	40. Postvention Training is offered to providers who will respond to a death by suicide and take an active role in coordinating and/ or responding to agency/community in reducing contagion, encouraging safe messaging and media response. • Suicide Prevention and Intervention training for service providers includes a review of National Best Practice suicide prevention/intervention policies and procedures specific to social service organizations, interactive case scenarios and discussion on how to integrate key community services for an effective and comprehensive response. • In addition, NAMI is also providing: Ending the Silence programming and also has NAMI campus clubs.	Expand & Improve	Prevention and Early Intervention: Stigma and Discrimination Reduction
3A	Assessing & Managing Suicide Risk (AMSR)	41. Knowledge-based training that covers 24 competencies required for effective clinical assessment and management of individuals at risk for suicide.	Expand	Prevention and Early Intervention: Suicide Prevention
3A	Suicide Loss Groups	42. Adult Group Facilitators are responsible for fostering a community that promotes and encourages a safe and supportive environment where group members can share their grief. Facilitators and co-facilitators are compassionate and caring individuals who can facilitate supportive discussions and maintain appropriate boundaries during the group. Rolled out in 2023 in service areas 1,2,4,8. Will expand to remaining service areas in 2024.	Expand	Prevention and Early Intervention: Suicide Prevention
3A	Suicide Prevention Trainings for Parents	43. Talk Saves Lives / Hablar Salva Vidas- A community-based presentation that covers the general scope of suicide,	Expand	Prevention and Early Intervention: Suicide Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		the research on prevention, and what people can do to fight suicide		
3A	Los Angeles County Suicide Prevention Network (LASPN) Youth Advisory Board	44. An inclusive group of up to 10 youth (16-24 years old) who advocate for improving mental health and well-being and its related social determinants of health for youth countywide.	Improve	Prevention and Early Intervention: Suicide Prevention
3A	Contextual-Conceptual Therapy	45. This is new cutting-edge approach to suicidality, has sought to understand the core experience of being suicidal by exploring the language of suicidal persons during suicidal crises. The model will teach participants: the importance of conceptually understanding the bifurcation of the suicidal context, how the suicidal crisis is, at its core level, a crisis of identity. How the crisis can be turned into a liminal opportunity for transformation towards authentic selfhood.	Expand	Prevention and Early Intervention: Suicide Prevention
3A	Striving for Zero-Learning Collaborative for California	46. This builds on the previous collaborative offered by the California Mental Health Services Authority/Each Mind Matters technical assistance team. The Mental Health Services Oversight and Accountability Commission is forming a multi-county collaborative to support the development and implementation of local suicide prevention strategic planning and program delivery. The Commission is inviting all counties to join its Striving for Zero Suicide Prevention Strategic Planning Learning Collaborative. This collaborative will deliver technical assistance and support to participating counties to share lessons learned, help expand each county's capacity to build a system of suicide prevention and align with California's Strategic Plan for Suicide Prevention. The Striving for Zero Learning Collaborative	Expand	Prevention and Early Intervention: Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		has been a unique opportunity for counties around California to support one another in creating strategic plans and coalitions that address our common goal of striving for zero suicides in our state.		
3A	Olweus Bully Prevention Programming (OBPP)	47. An Evidence Based Practice (EBP) proven to prevent and reduce bullying. OBPP is a systems-change program which intervenes at the school, classroom, individual, and community levels to impact everyone who comes in contact with the students. OBPP aims to restructure the elementary, middle, and high school environment to reduce opportunities and rewards for bullying. OBPP has been more thoroughly evaluated than any other bullying prevention/reduction program so far. DMH trains up to 35 schools per year.	Expand	Prevention and Early Intervention: Early Intervention
3A	CDPH Youth Suicide Prevention Program Pilot Partnership with DPH and DMH	48. Offer the following activities/interventions: • Surveillance • Rapid Reporting • Crisis Response. • General Suicide Prevention • Evaluation • Suicide Deaths/Attempts: Both suicide attempts and suicide deaths. Target population: Youth (LA County residents under age 25)	Improve	
3A	i-Prevail	49. Can be accessed through any device connected to the internet. The iPrevail platform offers a one-of-a-kind network of mental health support. From interactive lessons, chats with peer support coaches, to topic-based community support groups, you can see your progress being made & connect with other people going through similar life experiences all in one place.	Expand language	Prevention and Early Intervention: Prevention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
3A	Veteran Programming	50. Suicide Prevention Trainings offered to agencies and the Veteran community by Veteran Peer Access Network (VPAN). Los Angeles Veterans Suicide Review Team (VSRT). The VSRT conducts mortality reviews to increase protective factors in the Veteran community to prevent future death by suicides.	Expand	Prevention and Early Intervention: Prevention
3B	Mental Health First Aid Training	51. Offered throughout the County with the DO clinics and the Community Providers. DMH also has the Health Neighborhood Faith Based Liaisons. We can expand using the Mental Health Promoters, community providers, and directly operated programming.	Expand	Prevention and Early Intervention: Prevention
3B	EBPs & CDEs	52. DMH currently has 36 EBPs and CDEs. (See document: EI Evidence Based/ Promising Practices/ Community Defined Programs)	Improve	Prevention and Early Intervention: Early Intervention
3B	Children and Youth Behavioral Health Initiative	53. Provides grants to CBOs to expand the number of community-defined evidence practices (CDEP)	Expand	Prevention and Early Intervention: Early Intervention
3B	Evidence-based interventions for parents	54. DMH provides programs including but not limited to: Incredible Years, Nurturing Parenting, Triple P, Make Parenting a Pleasure, Active Parenting, Project Fatherhood, UCLA SEEDS, PCIT, Reflective Parenting, FOCUS, Child Parent Psychotherapy, Functional Family Therapy, Multisystemic Therapy, and Managing and Adapting Practice.	Expand	Prevention and Early Intervention: Early Intervention
3B	CAL AIM	55. DMH offers trainings through Quality Assurance and Outcomes Division regarding performance measures, clear process and implementation.	Expand	
3B	EBP: Sexual Abuse & Trauma	56. DMH offers Seeking Safety is a present-focused, coping skills therapy to help people attain safety from trauma and/or substance abuse. • Trauma-Focused Cognitive Behavior Therapy (TF-CBT)		Prevention and Early Intervention: Early Intervention

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		is an early intervention for children (ages 3-18) 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. • Multi-Systemic Therapy (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. • Functional Family Therapy (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 interfamilial and extra-familial 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. • Cognitive Behavioral Therapy (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.		

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
3B	Parents Anonymous	57. Explore partnership with Parents Anonymous to provide culturally responsive support to families, parents, children and youth.		Prevention and Early Intervention: Prevention Program: Incubation Academy

2. DOES NOT EXIST: Add New PSI

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1A	1. Increase awareness and access to Birth to Five services through: Health Promoters, awareness campaigns, increasing visibility of resources through websites and social media, targeting strategies to reach underserved communities	DMH	
1A	2. Implement a Parent Navigator program familiar with community- based resources, social service agency resources, and DMH Programming	DMH	
1A	3. A peer support program for birthing people in Los Angeles County affected by perinatal mental health disorders to reduce stigma, relieve symptoms, and navigate the perinatal mental health care system so that they can care for themselves as well as their children. Objectives include: (1) hire and train a team of individuals with firsthand experience with perinatal mental health disorders to be certified perinatal peer supporters; (2) provide peer support and systems navigation services to 900 prenatal and postpartum people across Los Angeles County per year; (3) facilitate weekly peer support groups for 1,050 pregnant and postpartum persons across Los Angeles County per year.	Partner	
1B	4. Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family.	Partner	
1B	5. Explore culturally relevant, non-traditional programs in partnership with CBOs.	DMH	
1B	6. Explore how to increase awareness of existing services in the community through health promoters, awareness campaigns, increasing visibility through websites and social media	Partner	YES
1B	7. Explore programs to educate CBOs regarding LGBTQIA-S+ community needs and creating welcoming environments. Focus on schools and religious institutions.	DMH	YES

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1B	8. Explore new programs and services focused on the Deaf and Hard of Hearing community.		YES
1B	9. Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities (Talking Circles), health education on mental health and/or SUDs, and wellness classes on meditation, fitness, healthy cooking, relaxation strategies, caregiver support, cultural activities, workforce development, and community wellness events. Targets individuals below 200% of federal poverty level in the Antelope Valley, including individuals experiencing homelessness and justice involved.	Partner	
1B	10. With over five years of rigorous longitudinal evaluation, this community defined evidence-based program reduces violence, PTSD symptoms, recidivism, trauma symptoms, and depression, and increasing resilience. The program consists of 80 hours of intensive intervention activities (5 workshops, 8 two-hour sessions over an 8-week period) that focus on developing and enhancing protective factors, healing trauma, financial literacy, and emotional intelligence. This program focuses on youth (18 and under), adults (18 and older), and African American male youth (ages 15 – 29) who are on probation, parole, foster and former foster care, and lack a support system.	Partner	
1B	11. Facilitate the Two-Spirit Storytelling as Medicine Project for American Indian/Alaska Native Transition Age Youth (TAY), Adults, and Elders through different forms of storytelling (oral storytelling, folk stories, film) along with art therapy, painting, poetry, and a final showcase to highlight the work throughout the project.	Partner	
1B	12. Biofeedback therapies are a non-invasive treatment that encourages the brain to develop healthier activity patterns to assist children and Transition Age Youth (TAY) with improved self-regulation to address trauma and stressors with the ultimate treatment goal of achieving optimal functioning. Biofeedback can be used as a complement to talk therapy or without talk therapy. Project aims to increase community access to biofeedback therapy, using state-of-the-art technology tools for sensory treatment through a current site in Santa Monica, CA, Service Planning Area 5, while also implementing field-based services and partnering with other	Partner	

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
	community-based organizations, community colleges, juvenile halls, and directly operated programs throughout Los Angeles County to increase access to this preventive service. Biofeedback therapies have been available for many decades, but those who can pay out-of-pocket or have top-of-the-line insurance pay for these interventions, making it out of reach for individuals receiving mental health services within the public sector. The program will impact access across ethnic, racial, and other diverse communities that have traditionally been under- or un-served.		
2A	13. Expand service to Transitional Age Youth (TAY) who are not enrolling in colleges, universities, or trade schools. Youth struggling with transitioning into adulthood.	DMH/ Partners	YES
2A	14. Explore conducting an annual youth summit with DMH and medical doctors.	DMH/ Partners	YES
2A	15. Include kindergarten and preschoolers, youth and parent component to curriculum.	Partner	
2A	16. Explore expanding Safe Passages program.		YES
2A	17. Provide a coordinated, eight-tier Prevention and Early Intervention program to engage and instill Adverse Childhood Experiences (ACE) buffers in young children (zero to eight years of age), their families, neighborhoods, support systems, caregivers, schools, and communities in Los Angeles County.	Partner	
2A	18. Provide camping trips and retreats with activities for children experiencing foster care/children ages 7 through 17, to help create a sense of belonging, connectivity, and promotes youth participation in recreational and extracurricular activities as an intervention in fostering positive behaviors, relationships, and teamwork.	Partner	
2A	19. Provide a 6-week program in the Antelope Valley to provide small group equine-based therapy sessions for foster TAY that integrates experiential learning, mindfulness instruction, and collaboration with identified community resources available for foster care TAY (ages 16 to 24). Program will provide small group Equine-Assisted Psychotherapy (EAP) sessions focused on understanding personal choices and implications of them through experiences with therapy herd to identify potential risk factors. Participating youth with learn how to utilize appropriate resources as they build their support network, and be provided tools to develop a sense of self, identifying and fostering protective factors with healthy independent living skills.	Partner	

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
2A	20. MakerMobile (MākMō) vehicles are a mobile delivery system to support makerspaces and promote Science, Technology, Engineering, Arts, and Math (STEAM) programs for children and teens. MakMo programs develop social and emotional skills including teamwork, problem solving, working with others, dealing with conflict, resilience, and creativity. MakMo vehicles, staffed by MakMo Librarians and Library Assistants, travel throughout LA County bringing creative programming to libraries, parks, and local community and outreach events. MakMo staff use high- and low-tech equipment to spark an interest in STEAM while building skills necessary to thrive in a 21st Century workforce. Technology includes circuits, 3D modeling and printing, robotics, microscopes, and tools, and with participants of all ages working in diverse teams.	Partner	
2A	21. This prevention program offers several in-person and virtual training academies for youth throughout Los Angeles County, focusing on understanding their position within the social determinants of health and how to reduce the stigmas related to gaining access to resources to support their development in each of these areas and as a means of preventing unhealthy behaviors and life trajectories. Workshops are trauma and culturally informed, focusing on social-emotional resilience, mentoring, peer support, education, and behavioral health career preparation. The target population for outreach and engagement is youth from 16-25, serving approximately 6,000 youth annually.	Partner	
2B	22. Strengthen the referral support for groups suffering from: trauma, lived experiences, family members and children	DMH	
2B	23. Increase programming for older adults. Identify programs that offer/have focus on older adults. Develop and launch a documentary as an educational storytelling tool to promote mental and physical health among Latino immigrant elderly women (60+ years) and emphasize the importance of maintaining friendships and strong support systems. The documentary aims to improve health in California by spotlighting the mental resilience and inspirational stories of elderly immigrant women who have faced adversity in California.	DMH and Partners	YES
2B	24. An interactive theatrical performance in Spanish to engage intergenerational Latino	Partner	

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
	families to teach them to identify eight emotions (anger, happiness, love, fear, sadness, etc.), based on scientific evidence that supports how the use of culture and laugh therapy can heal depressive and anxiety-like symptoms. Theater is used as a tool to stay entertained and learn faster, while using family-friendly activities that unite generations with people you love.		
2B	25. Organize a community concert event targeting young adults/college students in Inglewood, Hawthorne, and South Los Angeles to provide mental health education, resources, and support through a culturally relevant and engaging event. Conducted in collaboration with mental health professionals, local organizations, and artists to promote early intervention, increase mental health awareness, reduce stigma, and provide resources to access mental health services. Serves as a platform to promote the importance of community support for mental health and encourage peers and family members to support individuals struggling with mental health.		
2B	26. This program focuses on four mechanisms of support intended to change perceptions, decrease stigma, and improve community mental health for families in the Boyle Heights community. The four mechanisms are (1) substance abuse prevention, (2) physical wellness and nutrition, (3) self-esteem and mindfulness, and (4) digital mental health and safety.		
2B	27. Augment the reach of Reading & Rhythm and Life Skills Drumming to more children, TAY, adults and older adults in Los Angeles County.	Partner	
3A	28. Explore partnerships to expand the suicide support groups available within DMH, including but not limited to general loss and grief; LGBTQIA2-S support groups; culturally responsive support groups; and faith/spiritual support groups.	Partner	YES
3A	29. Explore utilizing the MY3 mental health app to further reach and connect with individuals who are at-risk for suicide or experiencing thoughts of suicide with a responsive support network.	Partner	
3A	30. Explore programs and services for individuals who have/are suffering as a result of human sex trafficking trauma.	Partner	
3A	31. Explore programs that provide evidence-based practices for the LGBTQIA2-S population related to suicide prevention.	Partner	YES

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
3A	32. Explore suicide prevention programs that address and provide services for young black males (ages 18-25).	Partner	YES
3A	33. Explore effective non-traditional programs, services and forms of healing for those suffering from mental health issues.	Partner	YES
3B	34. Explore possibility of utilizing Eye movement desensitization and reprocessing (EMDR) therapy.	Partner	YES
	35.		
3B	36. Explore possibility of utilizing/offering Foster All Wisdom Program for foster adoptive parents, along with neurofeedback therapy.	Partner	
3B	37. Explore strengthening and increasing number of self-help support groups, including but not limited: Self-Help Clearing House	Partner	
3B	38. Explore integrating the evidence-based practice: Shared Recovery Housing for early intervention for youth.	Partner	
3B	39. Explore offering non-traditional, culturally responsive EBPs: Positive Indian Parenting and Honoring Children.	Partner	
3B	40. DMH will explore effective non-traditional programs, services, and forms of healing for those suffering from mental health issues, specifically underserved populations including, but not limited to: LGBTQIA2-S, deaf and hard of hearing.	Partner	
3B	41. Explore program/service offering electroencephalographic biofeedback (EGG) neurofeedback for children 0-5.	Partner	
3B	42. Explore partnership with Drumming for Life to offer: Life Skills Drumming program; Reading and Rhythm.	Partner	YES
3B	43. Review the culturally responsive evidence-based practices from the Underserved Cultural Communities (UsCC) to be offered county-wide.	Partner	
3B	44. Explore programs/services that can take mental health support to the unhoused population where they are.	Partner	
3B	45. Explore a partnership with law enforcement departments to offer/support suicide prevention programs/services. [23]	Partner	
3B	46. Explore developing a centralized phone number dedicated to crisis support without having to contact law enforcement that can provide care on the streets and resources for experts.	Partner	

B. POLICY, PRACTICE, AND/OR ADVOCACY RECOMMENDATIONS

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
1A	1. Complete development of a Transition Aged Youth Advisory Group.
1A	2. Partner with and fund CBOs to deliver new programming and where possible to expand existing programming. Expand.
1A	3. DMH will continue to explore, and offer, programs, services and evidence-based practices that are trauma informed and responsive, for communities which are disproportionately impacted by violence, social and economic injustice, inequality, and structural, institutional and system racism.
1B	4. DMH will continue to increase workforce capacity to serve monolingual populations and underserved populations through more focused recruitment efforts (hiring fairs in local community), increase promoting awareness of job opportunities in local communities and schools.
1B	5. Increase workforce capacity to serve monolingual populations and underserved populations through more education and training opportunities, including a focus on youth to promote interested in mental health.
1B	6. Maintain a racial equity lens in program implementation through use of tools such as the CEO equity explorer.
1B	7. New and expanded program to focus on underserved communities, API, BAH, American Indian, LGBTQIAS+, Individuals with Disabilities, and Middle Eastern Communities.
1B	8. For new and expanded programs, increase investment in CBO service and expand the number of providers that work with underserved cultural communities.
1B	9. Conduct an impact analysis of the effects of a possible reduction of PEI funding on underserved communities.
1B	10. Continue to instill in all DMH programming and services to focus on diversity, equity and inclusion (DEI).
1B	11. Explore options to increase accessibility for training and services for individuals with disabilities.
2B	12. Increase DMH efforts to decriminalize mental illness, especially for those with mental illness in public spaces.
2B	13. Reduce the silos and barriers that keep CBOs and systems from working together to engage in cross-sector collaborations/solutions.
2B	14. Increase legal support for community organizations to apply for master agreement. Streamline the RFP process for community organizations.
2B	15. Increase Stakeholder Participation in meetings and planning workgroups.
2B	16. Increase marketing/publicity of existing resources that address social determinates of health online (website and social media).
2B	17. Increase support for navigating services to address the technological divide.
2B	18. Increase investment in service promotion, such as updated booklets, resource guides and leverage technology to promote services.
2B	19. Increase the level of cultural humility within the department.
2B	20. Strengthen DMHs linguistic competency.
2B	21. Increase the amount of Peer and Family/Caregiver support for groups and classes.
3A	22. Ensure that cultural responsiveness and accessibility is embedded throughout all DMH programs and services.
3A	23. DMH will continue to offer programs and services utilizing trauma informed and responsiveness interventions. [11]
3A	24. DMH will work with stakeholders to brainstorm and implement strategies to best communication and sharing the suite of mental health programs and services currently being offered by the department. [10]
3A	25. DMH will continue to strengthen and improve a system-wide warm handoff for clients who seek and/or need other services to prevent drop off or not following through with need mental health supports.
3A	26. Continue to strengthen referral support for families and children suffering from: trauma lived experiences. [7, 8]

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
3B	27. Ensure that cultural responsiveness and accessibility is embedded throughout all DMH programs and services. [21, 22, 23]
3B	28. DMH will continue to offer programs and services utilizing trauma informed and responsiveness interventions.
3B	29. DMH will work with stakeholders to brainstorm and implement strategies to best communication and sharing the suite of mental health programs and services currently being offered by the department.
3B	30. DMH will continue to review community defined evidence/practices to determine which qualify as evidence-based practices (ongoing internal process). [23]
3B	31. DMH will continue to explore and implement strategies (within regulations) to limit the loss of clinicians/staff being trained and leaving before training is complete.

PEI WORKGROUP – CONSENSUS RECOMMENDATIONS

CPT Recommendations/MHSA Proposals Needing Additional Feedback

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q2	Implement a Parent Navigator program familiar with community- based resources, social service agency resources, and DMH Programming	93%	ENDORSED: Adopted Consent Agenda
Q4	Implement a child-and-family teaming process to help children and Transition Age Youth (TAY) maintain a stable placement with family.	86%	ENDORSED: Adopted Consent Agenda
Q5	Explore how to increase awareness of existing services in the community through health promoters, awareness campaigns, increasing visibility through websites and social media	86%	ENDORSED: Adopted Consent Agenda
Q3	A peer support program for birthing people in Los Angeles County affected by perinatal mental health disorders to reduce stigma, relieve symptoms, and navigate the perinatal mental health care system so that they can care for themselves as well as their children. Objectives include: (1) hire and train a team of individuals with firsthand experience with perinatal mental health disorders to be certified perinatal peer supporters; (2) provide peer support and systems navigation services to 900 prenatal and postpartum people across Los Angeles County per year; (3) facilitate weekly peer support groups for 1,050 pregnant and postpartum persons across Los Angeles County per year.	79%	CONSENSUS: Moved to Tier 1
Q9	With over five years of rigorous longitudinal evaluation, this community defined evidence-based program reduces violence, PTSD symptoms, recidivism, trauma symptoms, and depression, and increasing resilience. The program consists of 80 hours of intensive intervention activities (5 workshops, 8 two-hour sessions over an 8-week period) that focus on developing and enhancing protective factors, healing trauma, financial literacy, and emotional intelligence. This program focuses on youth (18	79%	CONSENSUS: Moved to Tier 1

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
	and under), adults (18 and older), and African American male youth (ages 15 – 29) who are on probation, parole, foster and former foster care, and lack a support system.		
Q19	This prevention program offers several in-person and virtual training academies for youth throughout Los Angeles County, focusing on understanding their position within the social determinants of health and how to reduce the stigmas related to gaining access to resources to support their development in each of these areas and as a means of preventing unhealthy behaviors and life trajectories. Workshops are trauma and culturally informed, focusing on social-emotional resilience, mentoring, peer support, education, and behavioral health career preparation. The target population for outreach and engagement is youth from 16-25, serving approximately 6,000 youth annually. Broaden focus to all youth in LA County, not just Latinx.	79%	CONSENSUS: Moved to Tier 1 & Language change
Q20	• Q20: Increase programming for older adults. • Q25: Identify and increase available programs that are focused on older adults. • Q30: Develop and launch a documentary as an educational storytelling tool to promote mental and physical health among Latino immigrant elderly women (60+ years) and emphasize the importance of maintaining friendships and strong support systems. The documentary aims to improve health in California by spotlighting the mental resilience and inspirational stories of elderly immigrant women who have faced adversity in California.	79%	CONSENSUS: Added Q30 & Q25 to Q20 & Moved to Tier 1
Q36	Reduce the silos and barriers that keep CBOs and systems from working together to engage in cross-sector collaborations/solutions.	79%	CONSENSUS Moved to Tier 1
Q8	Provide a wellness center that offers community support groups for people with mental health and substance use disorders (SUDs), including traditional healing activities (Talking Circles), health education on mental health and/or SUDs, and wellness classes on meditation, fitness, healthy cooking, relaxation strategies, caregiver support, cultural activities, workforce development, and community wellness events. Targets individuals below 200% of federal poverty level in the Antelope Valley, including individuals experiencing homelessness and justice involved.	71%	CONSENSUS Moved to Tier 1
Q12	Expand service to Transitional Age Youth (TAY) who are not enrolling in colleges, universities, or trade schools. This includes youth struggling	71%	CONSENSUS Moved to Tier 1 & Language change

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
	with transitioning into adulthood and outside of the school systems.		
Q16	Provide camping trips and retreats with activities for children experiencing foster care/children ages 7 through 17, to help create a sense of belonging, connectivity, and promotes youth participation in recreational and extracurricular activities as an intervention in fostering positive behaviors, relationships, and teamwork.	71%	CONSENSUS Moved to Tier 1
Q29	DMH will explore effective non-traditional programs, services and forms of healing for those suffering from mental health issues.	71%	CONSENSUS Moved to Tier 1 & Language change
Q30	Identify programs that offer/have focus on older adults.	64%	CONSENSUS Add Q30 to Q20 & CONSENSUS Moved to Tier 1
Q14	Explore expanding Safe Passages program.	57%	CONSENSUS Moved to Tier 1
Q22	Organize a community concert event targeting young adults/college students in Inglewood, Hawthorne, and South Los Angeles to provide mental health education, resources, and support through a culturally relevant and engaging event. Conducted in collaboration with mental health professionals, local organizations, and artists to promote early intervention, increase mental health awareness, reduce stigma, and provide resources to access mental health services. Serves as a platform to promote the importance of community support for mental health and encourage peers and family members to support individuals struggling with mental health.	27%	CONSENSUS Moved to Tier 1
Q24	Augment the reach of Reading & Rhythm and Life Skills Drumming to more children, TAY, adults and older adults in Los Angeles County.	57%	CONSENSUS Moved to Tier 1
Q1	Increase awareness and access to Birth to Five services through: Health Promoters, awareness campaigns, increasing visibility of resources through websites and social media, targeting strategies to reach underserved communities	79%	ENDORSED: Adopted Consent Agenda
Q15	Provide a coordinated, eight-tier Prevention and Early Intervention program to engage and instill Adverse Childhood Experiences (ACE) buffers in young children (zero to eight years of age), their families, neighborhoods, support systems, caregivers, schools, and communities in Los Angeles County.	79%	ENDORSED: Adopted Consent Agenda
Q35	Explore options to increase accessibility for training and services for individuals with disabilities.	79%	ENDORSED: Adopted Consent Agenda
Q37	Increase marketing/publicity of existing resources that address social determinants of health online (website and social media).	79%	ENDORSED: Adopted Consent Agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q39	Increase the amount of Peer and Family/Caregiver support for groups and classes.	79%	ENDORSED: Adopted Consent Agenda
Q7	Explore new programs and services focused on the Deaf and Hard of Hearing community.	71%	ENDORSED: Adopted Consent Agenda
Q17	Provide a 6-week program in the Antelope Valley to provide small group equine-based therapy sessions for foster TAY that integrates experiential learning, mindfulness instruction, and collaboration with identified community resources available for foster care TAY (ages 16 to 24). Program provides small group Equine-Assisted Psychotherapy (EAP) sessions focused on understanding personal choices and implications of them through experiences with therapy herd to identify potential risk factors. Participating youth with learn how to utilize appropriate resources as they build their support network and be provided tools to develop a sense of self, identifying and fostering protective factors with healthy independent living skills.	71%	ENDORSED: Adopted Consent Agenda
Q18	MakerMobile (MākMō) vehicles are a mobile delivery system to support makerspaces and promote Science, Technology, Engineering, Arts, and Math (STEAM) programs for children and teens. MakMo programs develop social and emotional skills including teamwork, problem solving, working with others, dealing with conflict, resilience, and creativity. MakMo vehicles, staffed by MakMo Librarians and Library Assistants, travel throughout LA County bringing creative programming to libraries, parks, and local community and outreach events. MakMo staff use high- and low-tech equipment to spark an interest in STEAM while building skills necessary to thrive in a 21st Century workforce. Technology includes circuits, 3D modeling and printing, robotics, microscopes, and tools, and with participants of all ages working in diverse teams.	71%	ENDORSED: Adopted Consent Agenda
Q34	For new and expanded programs, increase investment in community-based organization (CBO) service and expand the number of providers that work with underserved cultural communities.	71%	ENDORSED: Adopted Consent Agenda
Q6	Explore programs to educate CBOs regarding LGBTQIA-S+ community needs and creating welcoming environments. Focus on schools and religious institutions.	71%	ENDORSED: Adopted Consent Agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q11	Biofeedback therapies are a non-invasive treatment that encourages the brain to develop healthier activity patterns to assist children and Transition Age Youth (TAY) with improved self-regulation to address trauma and stressors with the ultimate treatment goal of achieving optimal functioning. Biofeedback can be used as a complement to talk therapy or without talk therapy. Project aims to increase community access to biofeedback therapy, using state-of-the-art technology tools for sensory treatment through a current site in Santa Monica, CA, Service Planning Area 5, while also implementing field-based services and partnering with other community-based organizations, community colleges, juvenile halls, and directly operated programs throughout Los Angeles County to increase access to this preventive service. Biofeedback therapies have been available for many decades, but those who can pay out-of-pocket or have top-of-the-line insurance pay for these interventions, making it out of reach for individuals receiving mental health services within the public sector. The program will impact access across ethnic, racial, and other diverse communities that have traditionally been under- or un-served.	71%	ENDORSED: Adopted Consent Agenda
Q32	Complete development of a Transition Aged Youth Advisory Group.	71%	ENDORSED: Adopted Consent Agenda
Q10	Facilitate the Two-Spirit Storytelling as Medicine Project for American Indian/Alaska Native Transition Age Youth (TAY), Adults, and Elders through different forms of storytelling (oral storytelling, folk stories, film) along with art therapy, painting, poetry, and a final showcase to highlight the work throughout the project.	64%	ENDORSED: Adopted Consent Agenda
Q13	Explore conducting an annual youth summit with DMH and medical doctors.	64%	ENDORSED: Adopted Consent Agenda
Q23	This program focuses on four mechanisms of support intended to change perceptions, decrease stigma, and improve community mental health for families in the Boyle Heights community. The four mechanisms are (1) substance abuse prevention, (2) physical wellness and nutrition, (3) self-esteem and mindfulness, and (4) digital mental health and safety.	64%	ENDORSED: Adopted Consent Agenda
Q26	Explore partnerships to expand the suicide support groups available within DMH, including but not limited to general loss and grief; LGBTQIA2-S support groups; culturally responsive support groups; and faith/spiritual support groups.	64%	ENDORSED: Adopted Consent Agenda

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q28	Explore suicide prevention programs that address and provide services for young black males (ages 18-25).	64%	ENDORSED: Adopted Consent Agenda
Q33	New and expanded program to focus on underserved communities, API, BAH, American Indian, LGBTQIAS+, Individuals with Disabilities, and Middle Eastern Communities.	64%	ENDORSED: Adopted Consent Agenda
Q38	Increase investment in service promotion, such as updated booklets, resource guides and leverage technology to promote services.	64%	ENDORSED: Adopted Consent Agenda
Q21	An interactive theatrical performance in Spanish to engage intergenerational Latino families to teach them to identify eight emotions (anger, happiness, love, fear, sadness, etc.), based on scientific evidence that supports how the use of culture and laugh therapy can heal depressive and anxiety-like symptoms. Theater is used as a tool to stay entertained and learn faster, while using family-friendly activities that unite generations with people you love.	57%	ENDORSED: Adopted Consent Agenda
Q25	Develop and launch a documentary as an educational storytelling tool to promote mental and physical health among Latino immigrant elderly women (60+ years) and emphasize the importance of maintaining friendships and strong support systems. The documentary aims to improve health in California by spotlighting the mental resilience and inspirational stories of elderly immigrant women who have faced adversity in California.	57%	CONSENSUS Integrate with Q20 and Q30
Q27	Explore programs that provide evidence-based practices for the LGBTQIA2-S population related to suicide prevention.	50%	ENDORSED: Adopted Consent Agenda
Q31	Explore possibility of utilizing Eye movement desensitization and reprocessing (EMDR) therapy.	29%	ENDORSED: Adopted Consent Agenda

WORKFORCE EDUCATION AND TRAINING (WET)

BACKGROUND

This section contains the recommendations of the WET Workgroup for each of the following categories:

CATEGORIES	GOALS
5. Mental Health Career Pathways	Strong partnerships and mental health career pathways with local colleges/universities to increase the availability and diversity of the potential workforce pool.
6. Residency and Internship	Increase the department's residency and internship opportunities.
7. Financial Incentives	Strengthen the available financial incentives for recruiting new and retaining current DMH staff.
8. Training and Technical Assistance	Highly trained DMH workforce with the skills and capacity to deliver quality services

A. PROGRAM, SERVICE, AND/OR INTERVENTION RECOMMENDATIONS (PSI)

1. EXISTS ALREADY: Expand and/or Improve Existing PSI
More information on existing programming is located in section VIII. Programs and Services (by Component) of the Three Year Program and Expenditure Plan.

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
1	Work with Universities	1. Continue Affiliation Agreements with local universities to deliver intern placement and training services.	Expand and Improve	WET: Residency and Internship
1	Post-Doctorate Programs	2. Continue and potentially expand post-doctoral program already in place at Harbor-UCLA.	Expand	WET: Residency and Internship: LACDMH + Semel Institute National Clinician Scholars Program (NCSP) WET: Professional Trainees (UCLA Public Partnership for Wellbeing Agreement)
1	Peer Training	3. Under the direction of the Chief of Peer Services, the Department is committed to securing specialty training to peers interested in employment in the public mental health system. Efforts also include training for securing Medi-Cal certification and overall enhancement of skillset of those already employed in specialty	Expand	WET: Mental Health Career Pathway: Intensive Mental Health Recovery Specialist Training Program

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		mental health services programs.		
1	Parent Advocate Training	4. Potentially expand training program targeted to promote knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and children.	Expand	WET: Financial Incentive: Parent Partners Training Program
1	The Stipend Program for MSWs, MFTs, Psychiatric Nurses, Psychologists and Psychiatric Technicians.	5. DMH can explore the viability of offering Stipends to other future workforce front line staff beyond those already identified.	Expand	WET: Financial Incentive: Stipend Program for Direct Service Positions
1	Nurse pathways	6. Follow up with Chief of Nursing to discuss relationships with nursing schools. DMH already has affiliation agreements with select schools for nursing practicum placement.	Expand	
1	Open Position Outreach	7. DMH holds regular job fairs that are only available to DMH/mental health employees. The Department also utilizes internal job announcements and advertisings to all current staff.	Improve	WET: Financial Incentive: Stipend Program for Direct Service Positions
2	Master's Level Interns	8. The Department currently has a robust Student Intern training program with Master's level students placed throughout the county as part of their degree training requirements. In addition, intern placements have increased through a Board Motion. (Potentially expand # of interns and potential internship sites)	Expand	WET: Training and Technical Assistance: LACDMH + Semel Institute National Clinician Scholars Program (NCSP) WET: Professional Trainees (UCLA Public Partnership for Wellbeing Agreement)
2	Increase intern opportunities for Staff of color	9. The Department's Internship program provides opportunities for students of color to practice and be exposed to the specialty public mental health system. (Potentially expand # of interns and potential internship sites)	Expand	
2	Residency Programs	10. Residency opportunities are available in the public mental health system thru various	Expand	WET: Training and Technical Assistance: DMH +

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		agreements with educational institutions, some examples include UCLA, Charles Drew, Harbor, etc. Priority is given to those representing or serving un- or under- served communities. (Potentially expand # residents/cohort)		WET: UCLA General Medical Education, Adult Psychiatry Residency Training Program WET: Residency and Internship: Charles R. Drew Affiliation Agreement: Psychiatric Residency Program, WET: DMH + UCLA General Medial Education (GME): UCLA Public Partnership for Wellbeing Agreement
2	Post-Doctoral Program	11. At Harbor-UCLA, the Department operates an APA approved Post-Doctoral Program. (Potentially expand # of post-doctoral slots) Funds itself.	Expand	WET: Training and Technical Assistance: LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees
2	Psychiatrist Financial Incentive Programs	12. Mental Health Psychiatrist Student Loan Repayment Incentive • DMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. • MH Psychiatrist Recruitment Incentive Program – This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. • MH Psychiatrist Relocation Expense Reimbursement • Available to full-time, newly hired Mental Health Psychiatrists or Supervising	Expand	WET: Financial Incentive: Mental Health Psychiatrist (MHP) Student Loan Repayment Incentive

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
		Mental Health Psychiatrists who have been recruited by DMH. This program is expected to increase awards during the following Fiscal Years.		
3	Stipend Program	13. DMH's Stipend Program provides graduating MSW, MFT, Psychology, Psych Tech and Psychiatric Nurse Practitioner (PNP) students with a stipend in exchange for one year service commitment. (Improve outreach and advertisement/awareness)	Improve and Expand	WET: Financial Incentive: Stipend Program for MSWs, MFTs and Psychiatric Nurses
3	Nurse Recruitment	14. The Department's Chief of Nursing coordinates nurse recruitment efforts. (Targeted hiring fairs are ongoing)	Improve	WET
3	Increase financial incentives for specialty public mental health staff	15. Increase financial incentives for specialty public mental health staff, such as Mental Health Loan Repayment Program, which will require LA County MHSA WET funding.	Expand	WET
3	Hiring Bilingual Staff	16. The Department already utilizes candidate lists of pre-tested bilingual individuals to ensure priority during hiring process in those areas where the need exist. (Targeted Hiring Fairs)	Move to HR	
4	Digital and Technology skill development	17. DMH currently provides online training for its entire workforce through Udemy and other offerings (for technical skill development).	Improve	WET: Training and Technical Assistance: Public Mental Health Partnership
4	Workforce Training on Cultural Competence and Culturally Competent Practices	18. DMH's Training Unit coordinates and delivers training covering these topics, many with consultation from the UsCCs. All staff also have an annual cultural competency requirement.	Expand	WET: Training and Technical Assistance: Interpreter Training Program (ITP)
4	Trainings to retain workforce	19. DMH provides training on how to manage high levels of stress to avoid burnout and compassion fatigue. Additional resources through UCLA Wellbeing site that offers accessible trainings.	Improve	WET: Training and Technical Assistance: Public Mental Health Partnership
	Interpreter Training Program	20. DMH has an existing interpreter training program for all mental health interpreters.	Improve	WET: Training and Technical Assistance:

CATEGORY	EXISTING PSI	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	EXPAND OR IMPROVE	LOCATION IN PLAN
				Interpreter Training Program (ITP)
4	Workforce Training on Cultural Competence and Culturally Competent Practices	21. Trainings for staff regarding mental health issues impacting the LGBTQIA2-S and can be expanded to include a culturally diverse focus (including, but not limited to: specific Latinx LGBTQIA2-S)	Expand	WET
4	Intake Trainings	22. The department provides trainings on the clinical intake process. Can look into expanding and improving regarding immigration.	Improve & Expand	WET
4	UsCC Related Trainings	23. DMH currently has ongoing training related to all UsCCs yearly. Can expand to include other topics related to: immigration, Eastern European/Middle Eastern population)	Improve & Expand	WET
4	Peer Certification	24. The Certified Peer Specialist program exists to certify peers to work in clinical settings.	Improve & Expand	WET
4	Peer Training	25. Internal program to provide peers training/practicum opportunities to build their capacity.	Expand	WET
4	Customer Service Training	26. Ongoing DMH trainings to all staff on how to provide appropriate customer service.	Improve & Expand	WET
4	Training Unit	27. Currently offering training that covers 5150 and 5250 in partnership with LPS authorization, Patient's Rights Office and Public Guardian.	Improve & Expand	WET
	Incubation Academy	28. Increase the number of partnerships with community organizations to better serve communities.	Expand	WET
	Career Pathways for New Staff	29. DMH can improve the pathway/access for new interested applicants through MHLA Intensive MH Rehab Specialist program 2023-2024.		WET

2. DOES NOT EXIST: Add New PSI

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1	1. Explore a way to embed youth employment opportunities in the mental health system.	DMH	

CATEGORY	DESCRIPTION: PROGRAM, SERVICE, OR INTERVENTION	DMH OR PARTNER	ADDTL FUNDS
1	2. Explore developing a pilot program for DMH to partner with middle and high schools/school districts to increase the opportunities into mental health. (outreach, fairs, after school programs, etc.)	DMH	
1	3. Explore developing a marketing campaign/program for mental health services and careers.	DMH	
1	4. Explore developing recruitment opportunities with community colleges to create pathways for potential mental health employees.	DMH	
1	5. Explore develop pilot project/mentorship program to mentor individuals from diverse backgrounds interested in future leadership positions.	DMH	
1	6. Explore developing a program to build capacity among DMH staff to utilize American Sign Language (ASL).	Partner	
1	7. Explore innovative efforts to recruit junior and high school students into employment/careers in the public mental health system. This would be a long-term project. *(Moved from Category 3)*	Both	
1	8. Funding opportunities post high school (i.e., certification, AA, and BA) for people from under-served populations who desire a career in public specialty mental health.		
1	9. Explore a new program with leadership from Chief of Peer Services to offer peers paid internship (yearly stipend), or yearlong apprenticeship, leading to potential employment in public mental health. (Launching 2024)	Both	YES
3	10. Explore offering retention bonuses to current DMH staff (TBD which staff category(s) specifically).		
4	11. Explore potential trainings for ASL interpreters on working with individuals with mental health disabilities.	DMH	

B. POLICY, PRACTICE, AND/OR ADVOCACY RECOMMENDATIONS

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
1	1. Increase partnerships with universities to find staff who have similar culturally relevant backgrounds to clients served.
1	2. Continue using inclusive criteria for all pathways to ensure a diverse mental health workforce. (System: Human Resources)
1	3. DMH is prioritizing hiring diverse staff to be reflective of the County population. (System: Human Resources)
1	4. Advocate systemwide to increase the value given to peers within the Department. (System: Peer Services Chief)

CATEGORY	DESCRIPTION: POLICY, PRACTICE OR ADVOCACY
2	5. Implement ARDI committee's recommendations to create a diverse workforce. (System: ARDI)
2	6. Ensure relevant and targeted trainings for DMH staff have a trauma informed approach. (No new funding needed)
2	7. DMH will continue to seek viable solutions to increase accessibility for DMH staff members with disabilities and/or accessibility challenges. (System: Human Resources)
4	8. Assess accessibility to Human Resources for individuals from underserved communities. Use findings to create a more welcoming environment and improve access. (System: Human Resources)
4	9. Advocate for HR to review internally delivered customer services training for own staff. (System: Human Resources)
4	10. Develop system to identify and notify DMH staff of third party trainings that meet requirements/criteria and fill a gap/need within the system.
4	11. DMH is working with Human Resources (HR) and County Civil Service to improve clarity in job descriptions/titles. (System: Human Resources)
4	12. DMH has a priority to hire staff and contract providers that have cultural/linguistic capacity to reach underserved populations. (System: Human Resources)

WET WORKGROUP – CONSENSUS

CPT Recommendations/MHSA Proposals Needing Additional Feedback

QUESTION	DESCRIPTION: RECOMMENDATION OR PROPOSAL	% STRONG VERY STRONG	ACTIONS
Q2	Explore developing a pilot program for DMH to partner with middle and high schools/school districts to increase the opportunities into mental health (outreach, fairs, after school programs, etc.).	**88%**	ENDORSED: Adopted Consent Agenda
Q3	Explore developing a marketing campaign/program for mental health services and careers.	**88%**	ENDORSED: Adopted Consent Agenda
Q4	Explore developing recruitment opportunities with community colleges to create pathways for potential mental health employees.	**88%**	ENDORSED: Adopted Consent Agenda
Q1	Increase financial incentives for specialty public mental health staff, such as Mental Health Loan Repayment Program, which will require LA County MHSA WET funding.	**63%**	CONSENSUS: Moved to Tier 1
Q10	Explore potential trainings for ASL interpreters on working with individuals with mental health disabilities.	**75%**	CONSENSUS: Moved to Tier 1
Q5	Develop pilot project/mentorship program to mentor individuals from diverse backgrounds interested in future leadership positions.	**63%**	CONSENSUS: Moved to Tier 1
Q7	Implement innovative efforts to recruit junior and high school students into employment/careers in the public mental health system. This would be a long-term project.	**63%**	CONSENSUS: Moved to Tier 1
Q6	Explore developing a program to build capacity among DMH staff to utilize American Sign Language (ASL).	**75%**	ENDORSED: Adopted Consent Agenda
Q8	Funding opportunities post high school (i.e., certification, AA, and BA) for people from under-served populations who desire a career in public specialty mental health.	**75%**	ENDORSED: Adopted Consent Agenda
Q11	Increase partnerships with universities to find staff who have similar culturally relevant backgrounds to clients served	**75%**	ENDORSED: Adopted Consent Agenda
Q9	Explore offering retention bonuses to current DMH staff, to be determined later which staff category(ies) specifically.	**50%**	ENDORSED: Adopted Consent Agenda

Appendix D – Client Counts by Specific Racial/Ethnic Groups

NUMBER OF DMH CLIENTS SERVED BY SERVICE AREA AND SPECIFIC RACIAL/ETHNIC GROUPS
FISCAL YEAR 2022-23

Specific Racial/Ethnic Group	Service Area 1	Service Area 2	Service Area 3	Service Area 4	Service Area 5	Service Area 6	Service Area 7	Service Area 8
American Indian/Alaska Native	188	174	254	456	116	325	398	285
Armenian	87	921	62	348	37	44	26	79
Asian - Not Listed	116	348	753	482	134	145	192	423
Asian Indian	6	13	9	12	1	4	7	18
Black - Not Listed	82	79	58	99	41	95	30	130
Black/African-American	7,059	3,968	4,145	8,727	3,256	13,790	2,332	10,450
Cambodian	28	21	78	72	10	21	53	661
Central African	8	13	2	7	3	7	2	14
Central American	581	1,776	508	2,455	305	1,540	795	1,275
Chinese	73	116	1,367	377	69	72	95	206
Cuban	41	82	33	130	36	45	59	88
East African	3	7	4	18	6	18	6	17
Eastern European	12	63	15	52	39	20	15	40
Filipino	148	405	321	400	102	130	201	562
Guamanian	8	43	12	24	19	5	11	26
Hawaiian	14	34	31	165	7	22	25	51
Hispanic or Latino - Not Listed	3,789	7,467	6,424	7,018	1,225	7,203	5,803	8,428
Hmong	1	0	0	0	0	0	0	3
Iranian	18	465	18	63	133	19	7	53
Japanese	32	38	65	94	48	36	30	155
Korean	68	176	158	796	99	105	122	287
Laotian	21	17	100	16	3	6	24	89
Mexican	3,412	6,039	7,095	10,520	1,771	8,015	8,436	8,871
Middle Eastern -Not Listed	48	231	53	102	90	33	43	107
Mien	1	1	8	1	4	1	7	3
North African	7	11	4	19	16	9	4	17
Not Listed	149	299	455	260	78	173	284	315
Other Hispanic or Other Latino	0	0	1	0	0	0	0	0
Pacific Islander - Not Listed	22	36	39	53	19	26	26	88
Puerto Rican	60	91	79	142	53	67	73	132
Samoan	15	7	22	21	3	26	22	72
South American	52	305	99	223	97	98	116	206
Southern African	9	11	26	23	5	14	7	11
Vietnamese	37	122	435	119	13	37	48	211
West African	4	8	6	18	9	18	3	25
White	5,318	7,700	5,730	6,579	3,744	2,737	3,166	7,390
White - Not Listed	23	274	27	56	31	18	16	42

Client counts are based on direct services and not inclusive of community outreach services.

NUMBER OF MHSA CLIENTS SERVED BY SERVICE AREA AND SPECIFIC RACIAL/ETHNIC GROUPS FISCAL YEAR 2022-23

Specific Racial/Ethnic Group	Service Area 1	Service Area 2	Service Area 3	Service Area 4	Service Area 5	Service Area 6	Service Area 7	Service Area 8
Alaskan Native	12	25	49	72	26	31	25	31
American Indian	45	48	52	173	23	114	130	63
Armenian	28	622	3	291	18	28	5	34
Asian	4	23	87	29	10	5	12	78
Asian Native	9	53	209	110	18	19	38	7
Black/African-American	3750	1777	2194	6352	2159	9840	1019	6521
Cambodian	3	15	46	57	7	7	23	430
Central African	4	5	1	5	1	6	1	8
Central American	305	945	255	1361	181	898	399	624
Chinese	14	109	852	272	32	33	69	161
Cuban	13	37	22	96	21	18	38	50
East African	0	3	3	8	3	8	3	6
Eastern European	2	23	6	31	18	8	6	16
Filipino	47	198	156	245	48	59	106	275
Guamanian	4	211	15	50	25	11	8	31
Hawaiian	2	47	31	181	10	19	24	74
Hispanic/Latino	178	450	381	374	65	2295	326	413
Iranian	4	333	11	53	97	13	3	25
Japanese	6	14	31	58	21	14	13	72
Korean	9	78	82	563	51	47	60	156
Laotian	13	12	70	19	1	7	18	219
Mexican	1568	3352	4112	6848	1153	5347	5274	5273
Mien	0	0	3	0	2	1	3	2
Multiple Races	590	780	881	798	386	556	648	1047
Native American	4	2	9	3	1	0	10	3
Native Hawaiian/Pacific Islander	4	4	6	3	2	1	4	10
North African	2	6	5	11	10	4	2	11
Other	394	2299	4813	1414	907	1048	2255	1857
Other Asian	32	163	388	221	75	49	71	163
Other Black	31	31	24	48	17	38	15	58
Other Hispanic or Other Latino	1766	4627	3957	3966	784	3986	3058	5115
Other Middle Eastern	21	132	29	57	54	16	25	61
Other Pacific Islander	6	17	14	29	6	10	8	36
Other Race	124	43	160	82	36	43	40	241
Puerto Rican	22	42	30	90	22	26	30	45
Samoan	4	3	9	11	1	15	11	36
South American	27	166	47	126	51	46	70	110
Southern African	6	9	20	16	2	10	4	3
Unknown/Not Reported	1126	3693	3107	3402	1082	2555	1385	3035
Vietnamese	2	78	241	99	8	20	32	164
West African	3	3	4	15	5	14	1	12
White	2567	4884	3353	4815	2760	1474	1755	4713

Client counts are based on direct services and not inclusive of community outreach services.

Appendix E – Public Hearing Agenda, Presentation and Transcripts

E.1. Meeting Announcement Posted on DMH webpage: MENTAL HEALTH COMMISSION (MHC) REGULAR MEETING AND MHSA PUBLIC HEARING- MARCH 28, 2024 - Department of Mental Health (lacounty.gov)

MHC REGULAR MEETING AND MHSA PUBLIC HEARING

Download agenda English Spanish

Hybrid Meeting

Members of the public can attend the MHC regular meetings in multiple ways:

Watch live broadcast: MS Teams Link

Join in person: 510 S Vermont Ave., 9th floor (T) Level Conference Room, Los Angeles 90020; validated parking is available at 523 Shatto Place, Los Angeles, CA 90020.

Additional access options:

To listen ONLY in English, please call 1-844-291-6362, enter Participant Code 4972277

To listen ONLY in Spanish, please call 1-888-204-5987, enter Participant Access Code 9639884

To listen ONLY in Korean, please call 1-866-434-5269, enter Participant Access Code 6699393

Live Closed Captioning (CART) services are provided, please click HERE.

American Sign Language (ASL) is provided, please click HERE.

To make public comment:

By phone: To make public comment by phone during the live event, please call 1-844-291-6362, enter Participant Code 4972277.

Electronic Mail (Email) Written Public Comment: Public comment may be emailed to the Commission at mhcommission@dmh.lacounty.gov . Email must be received 24 hours prior to the meeting date.

Regular Mail Written Public Comment: Regular mail public comment may be mailed to the following address: Attention: Los Angeles County Mental Health Commission, Vermont Corridor Headquarters, 510 S. Vermont Avenue, (22-111), Los Angeles, CA 90020. Attention: Canetana Hurd. Mail must be received 5 days prior to the meeting date.

For more information about this meeting, please email MHCommission@dmh.lacounty.gov

E.2. Public Hearing Agenda

LA COUNTY MENTAL HEALTH COMMISSION
"Advocacy, Accountability, and Oversight in Action"

REGULAR MEETING

NOTICE IS HEREBY GIVEN that the Mental Health Commission (MHC) regular meeting will be held on **March 28, 2024, at 11:00a.m. Note:** This meeting will include the DMH MHSA Public Hearing. Members of the Public will have the opportunity to provide public comment on general agenda items and comments specific to the MHSA Two Year Program and Expenditure Plan. Public access options are listed below and on the last page of this notice.

Date:	March 28, 2024
Time:	11:00 a.m.
Location:	510 South Vermont Avenue, 9th Floor, Conference Room TK08/11 Los Angeles, Ca 90020

NOTICE: All Commission meetings are recorded (video and audio)

Free validated parking is available at: 523 Shatto Place, Los Angeles, CA 90020. When entering structure, take a parking ticket and bring it with you to the meeting. Security will validate your ticket.

ADDITIONAL ACCESS OPTIONS

To join by computer, click this MS Teams Link or use this shorten link or https://bit.ly/3TILKSU or scan this QR code above.	To listen ONLY by phone and to make public comment, please call **1-844-291-6362, enter participant code 4972277**

AGENDA ON NEXT PAGE

Mental Health Commission - Department of Mental Health (lacounty.gov) 1 | Page

Mental Health Commission (MHC) **Agenda** **March 28, 2024**

Commissioners by Supervisorial District

District	1st	2nd	3rd	4th	5th
Supervisor	**Hilda L. Solis**	**Holly J. Mitchell**	**Lindsey P. Horvath**	**Janice Hahn**	**Kathryn Barger**
Commissioners	Susan Friedman	Kathleen Austria	Stacy Dalgleish	Victor Manalo	Judy Cooperberg
	Bennett W. Root, Jr.	Reba Stevens	Thomas Roache	Michael Molina	Lawrence Schallert
	Imelda Padilla-Frausto	Vacant	Jaqueline Sandoval	Marilyn Sanabria	Brittney Weissman

Member from LAC Board of Supervisors: Supervisor Kathryn Barger, Represented by Anders Corey

Michael Molina, Chair, Presiding

AGENDA

1. **CALL TO ORDER**
2. **ROLL CALL/WELCOME**
3. **GENERAL PUBLIC COMMENT**

4. **CONSENT AGENDA**
   a. *Approval of minutes*
      i. Minutes of the February 22,2024, Meeting
   b. *Follow-up on Constituent Concerns/Issues (Crystal Kibby)*
   c. *DMH Finance Update – MHC Budget Allocation and Expenditure Detail*

5. **STANDING ITEMS**
   a. *DMH Director Updates* (Dr. Lisa Wong, DMH Director)
      i. Update on Proposition 1
   b. *DMH MHSA Updates* (Dr. Darlesh Horn/Kalene Gilbert, DMH MHSA Administration)
      i. MHSA Public Hearing

6. **PUBLIC COMMENT – RELATED TO THE MHSA Two Year Program and Expenditure Plan, Fiscal Years 2024-25 through 2025-26**

7. **NEW BUSINESS**
   a. *Annual Election of Executive Committee Officers FY 2024-2025*
      i. Distribution of interest survey to establish Nominations Committee

8. **ANNOUCEMENTS**
   a. *MHC SA 8 Town Hall – April 25, 2024, 10:30am to 2:30pm*

9. **ADJOURMENT** – Next MHC Regular meeting: April 25, 2024.

Additional call-in and access options:

Spanish line: Please call 1-888-204-5987 enter participant code 9639884	Korean line: Please call 1-866-434-5269, enter participant code 6699393
For American Sign Language (ASL), please click this MS Teams link or https://bit.ly/3TlLKSU	CC For Live Closed Captioning (CART), please click the MHC Live Closed Captioning

Members of the public can address the Commission in the following additional ways:

- **Electronic Mail (Email):** Email your public comment to mhcommission@dmh.lacounty.gov . Email must be received one day prior meeting date.
- **Regular Mail**: Mail your public comment to: Los Angeles County Mental Health Commission, Vermont Corridor Headquarters, 510 S. Vermont Avenue, Attention: Canetana Hurd (22-111), Los Angeles, CA 90020. Mail must be received five days prior to meeting date.

If you need accommodations beyond what is listed above, please contact the MHC support staff at (213) 947-6487 or (213) 947-6628 at least 5 days before the meeting to request additional accommodations. You can also submit this request by email to mhcommission@dmh.lacounty.gov .

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E.3. Public Hearing PowerPoint

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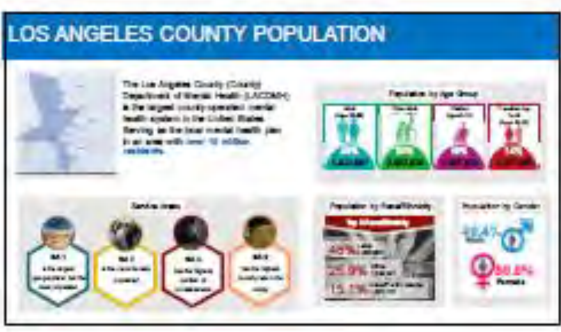

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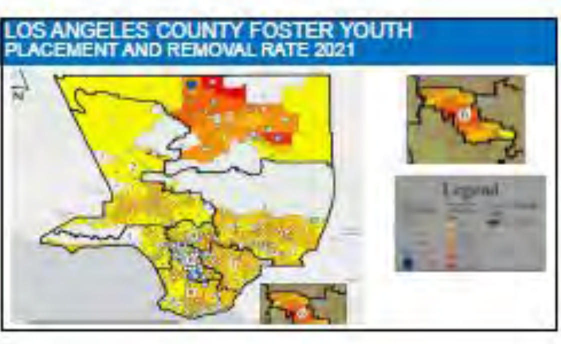

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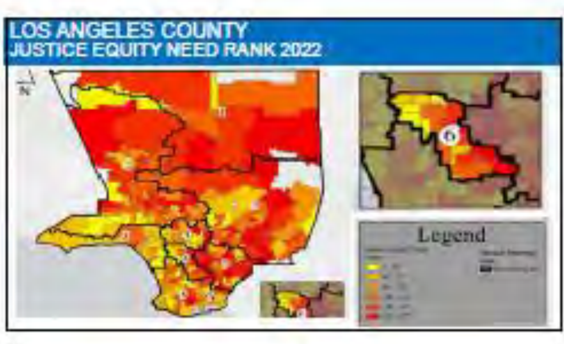

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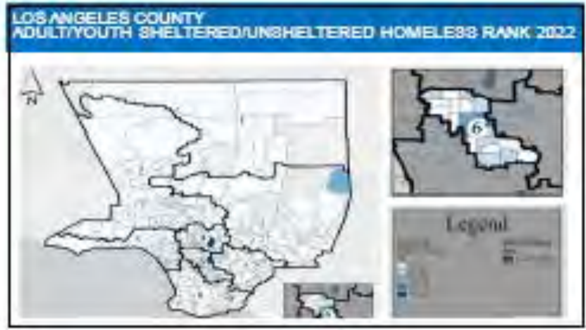

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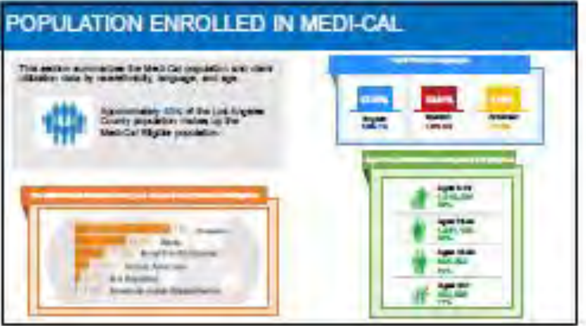

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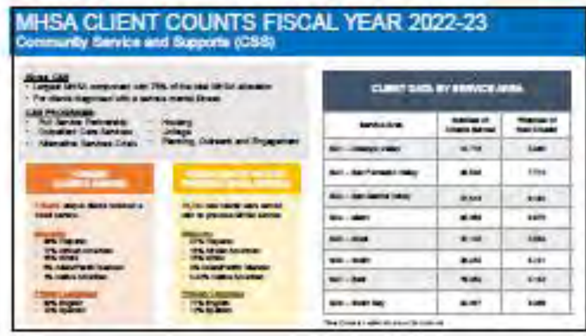

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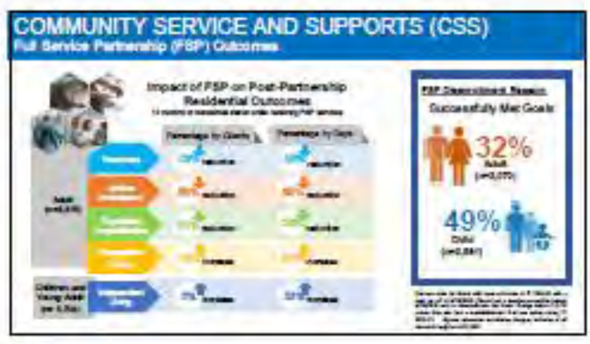

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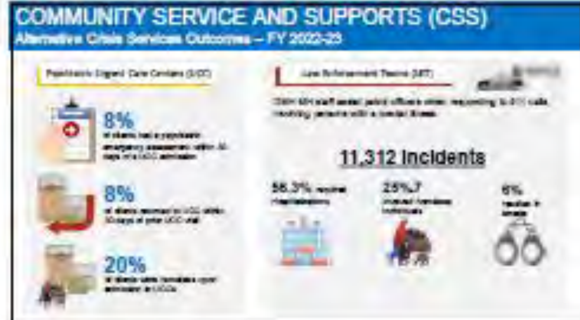

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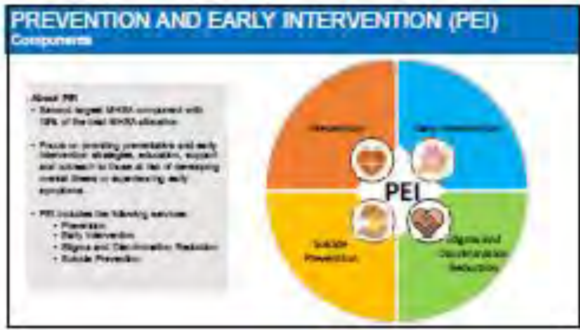

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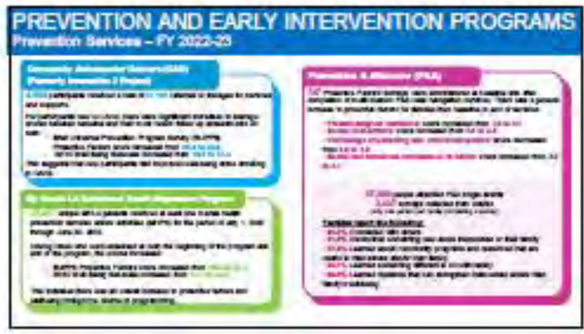

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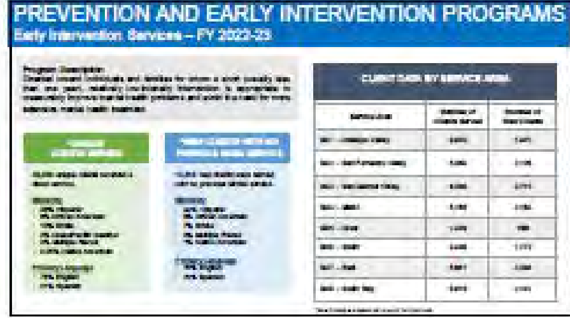

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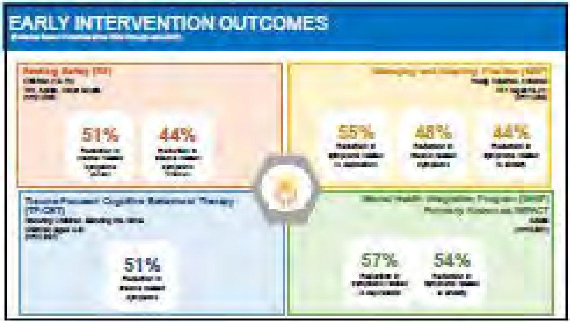

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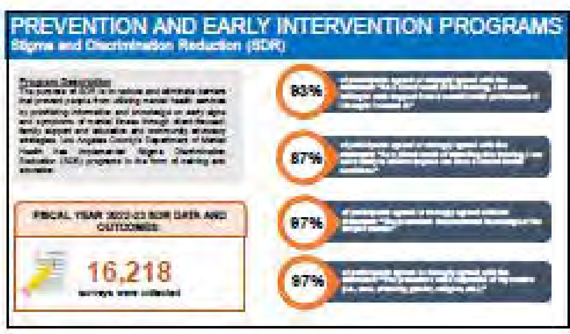

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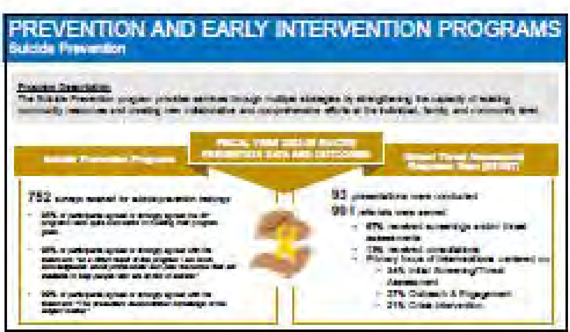

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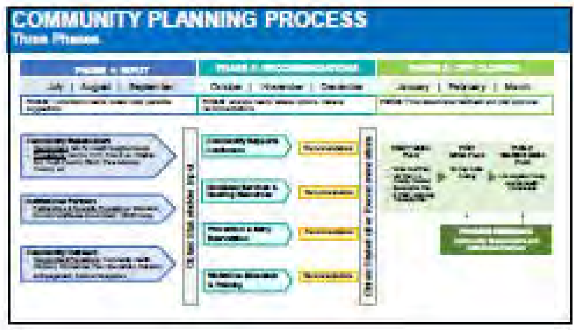

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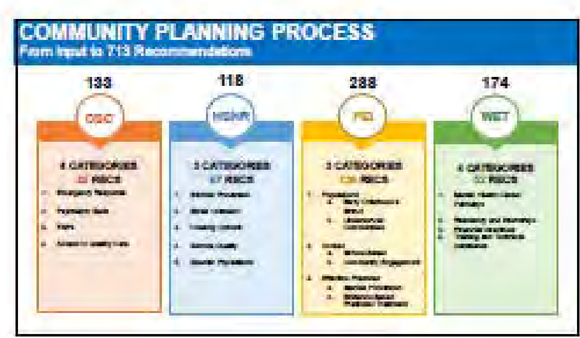

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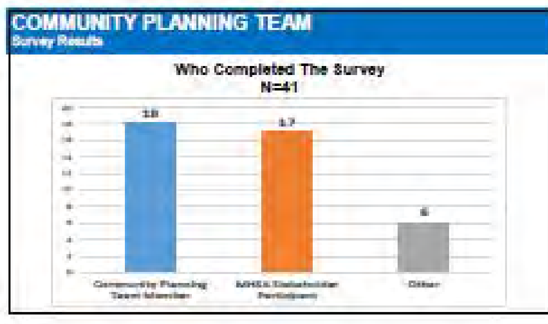

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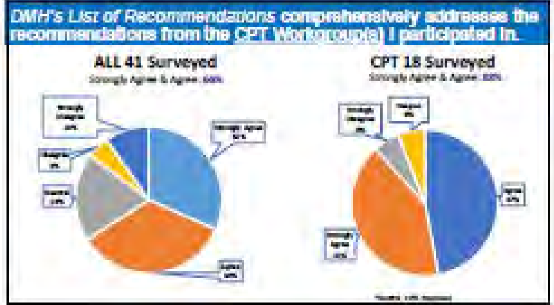

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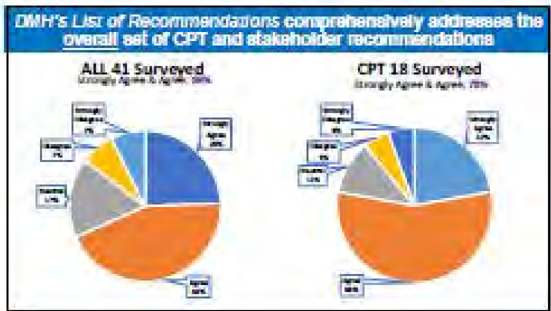

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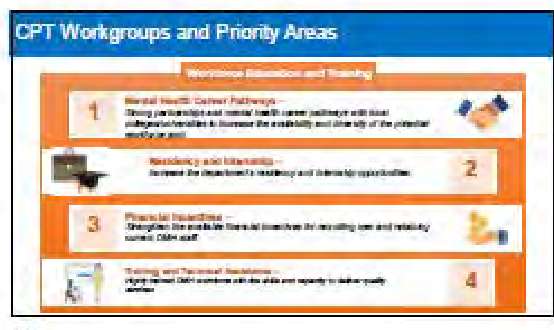

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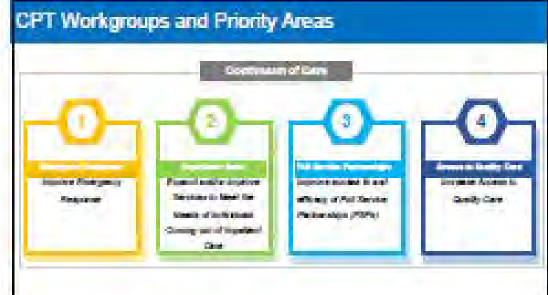

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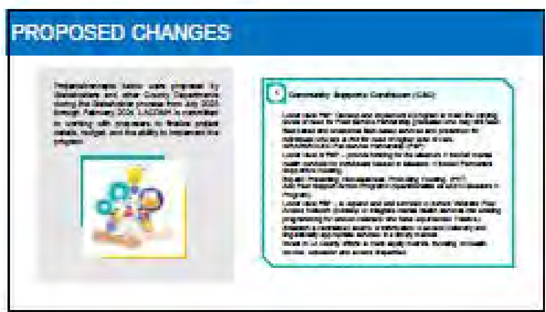

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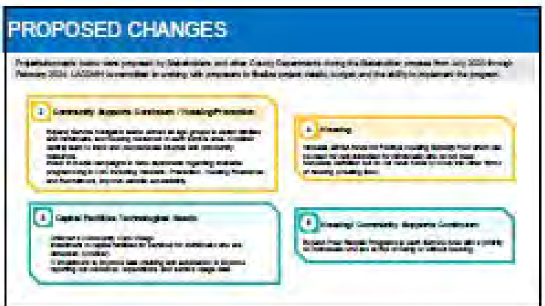

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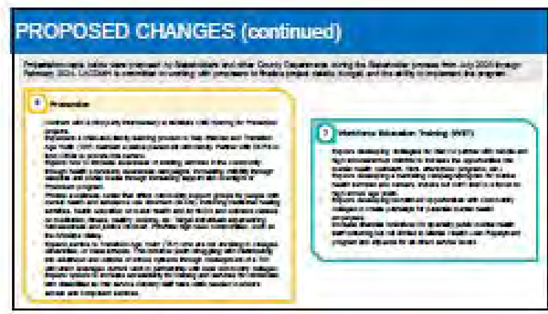

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E.4. Public Hearing Transcripts

DISCLAIMER: This is NOT a certified or verbatim transcript, but rather represents only the context of the class or meeting, subject to the inherent limitations of realtime captioning. The primary focus of realtime captioning is general communication access and as such this document is not suitable, acceptable, nor is it intended for use in any type of legal proceeding.

LOCATION: REMOTE
3/28/2024
R. Farrell

>> Welcome everyone. Everyone seated. Okay. Welcome to the LA county mental health commission this is our regular meeting as well as the DMH MHSA public hearing and just a disclosure we are having a little bit of sound trouble this morning and I hope it got a little bit be better and we will work through it. Today is March 28th, 2024, and I will start with a brief visual introduction and my name is Kenya and I am executive assistant to the commission and my pronouns are she, her, and I have dark brown curly hair brown eyes and brown skin and wearing a brown sweater with brown pants and brown shoes. To our participants if you are joining in-person connect with Daniel or Canetana and Daniel is in the back waving his hand so you can get your forms signed. You have to have proof of attendance to get your stipend. For those joining and watching the virtual broadcast a link has been shared for you to click on it and sign in. Please note that the room has three displays. If you need to see the larger font presentation please sit in the middle of this room. That is where I will display the larger font on the two that are on the side to each end of the room it is smaller and that is where the access ASL services and live captioning are happening.

We also have printed copies for everyone ton to be able to read if that is what had you choose. Daniel has them in the back if you didn't get any. For those watching the live broadcast the links have been shared so you can access this virtually. And welcome to all and make sure all of your mobile devices are turned to silent. Chair?

>> Good morning everyone this is Mike Molina chair of the Los Angeles county mental health commission I welcome you to the monthly meeting and as well as the public hearing and this meeting each year is one of the most important meetings that we hold where we have a public meeting relative to our MHSA plan and look forward to the presentation and learning to you the members of the public item pertaining to the MHSA with that said can you please call roll?

>> Susan freedman .
>> Present .
>> Bennet Ruth .
>> Kathleen Austria .
>> Here .
>> Reba Stevens .
>> Stacy Dalgleish.
>> Present.
>> Thomas ROACHE .
>> Jacqueline, Victor MANALO .
>> Present .
>> Mike MOLINA present .
>> Marilyn. Absent. Judy Cooperberg. Absent .
>> No present. Online.
>> All right. Lawrence shall ert .
>> Present .
>> Brittany Weissman absent. Supervisor Catherine Barger is represented by --
>> Present.
>> You have a quorum. And thank you. Welcome thank you for joining this morning ser rel is advising supervisors office it is a pleasure to have you .
>> Thank you it is a pleasure.
>> I would like to welcome commissioner Sandoval from the thirds -- has appointed a new member. Can you say a few words about yourself using the microphone b please? Look at you .
>> Hello my name is Jacqueline Sandoval and I represent the third district and I have three children and I am 26 years old and born and raised nd ka no va park with a single mother and a father who was a drug addict and had gang relations. Growing up I saw a lot of violence and poverty. That pushed me and my siblings to become more in life than just another community statistics and I am currently a nurse and at a young age I decided I wanted to be the voice for our youth. Growing up around me I only had were to become a gang member or drug addict or work minimum wage job to make ends meet and I decided to per sue nursing and excited to give you a youth perspective and with my experience and firsthand poverty and I guess rough community. Because I grew up in a rough community.
>> Welcome it is great to have you with us. Supervisor I realize at the last meeting I didn't give you a chance to formally introduce yourself. If you feel comfortable doing it say a couple of words of who you are and why you are here .
>> I am Thomas Roach and thank you for the welcoming the last time here. I am seven-year veteran in the United States army and currently a medical student at UCLA it is my retirement plan to be a doctor. And since I have

been in LA I have been involved in the in house communities and UCLA is a clin (Indistinct) and involved in the initiatives at the VA to make sure we have housing and treatment for the ub housed veterans as well. Thank you .

>> Thank you commissioner and again it is terrific to have you and all of the new members. Supervisors are choosing very well in both experience and expertise and that is it is only a contribution to us in the commission. Commissioners we are going to go off of calendar and agenda at this point and ask Dr. Wong to address us. He had every intense to be here this morning and there was an emergency within the department and she is on the phone and if if you can patch Dr. Wong in and welcome doctor. Lisa if you are there go ahead .

>> Yes can you hear me?

>> Yes.

>> Fantastic. Good morning everyone and I am sorry I was unable to be this with you in-person and I am happy to have a few moments to speak with you and I know that the commission has been closely watching what was going on with prop one as we all have. As you know there is a presumption it has passed we a narrow margin. And we have a lot of pluses there and a bond measure that is going to allow us to expand our bed capacity. On the other side of that we will have dedicated housing pool that will unfortunately come at the cost of other mental health services. We are working to study the impacts we will have and how the to mitigate that impact. Our desire is not only not lose services and also want to find a way to continue to expand. Even in the light of the passesage of prop one and last week I went with some of the key executive staff up to Sacramento for lobby day and met with a lot of legislatures and I personally had 11 separate meetings with different did the legislatures and that is the first for me and it was a wonderful experience because it helped me understand that sometimes legislation may be tasked with voting on something and they might not know the details in the way that we know them.

We were able to share some of the impact that prop one is going to have on all of the county departments of mental health across the state and also build an allyship with the Los Angeles county delegation so that they can support us and we can have a great line of communication with them b about what our needs are moving forward with prop one and also moving forward with the implementation of SB 43 which is the bill that recently passed and has to do with the expansion of grave disability criteria.

There was a lot I think that was accomplished last week and I think we will have a good, close working relationship with our Los Angeles county delegation. We have already been invited to have a seat at the table on the planning committee for prop one implementation. We are very happy b about that. And I will keep the commission posted as we move along. I think part of me is anxious about the outcome f of this. And I have to look at the opportunities for us as a department. We are going to face Serb challenges and having increased bed capacity is a God send for us. It I also gives us the opportunity to look at the programming we do. What is most useful to then clients that we serve and what our communities need the most and we will definitely be involving the commission and we will be involving stakeholders and I am sure we will have a robust process as we move forward with that.

That is what is going on with prop one and also I had heard some concerns about salt budgeting and what the salts koultd do with the budgets that they have and a lot of different things and I had some conversations with the folks involved with that and I think, sorry. Mike I am promoting you supervisor MOLI NA. Chair Molina had a wonderful idea and that is have a summer session to level set around Salt planning and budgeting and those types of issues and we are planning to have a session during the summer where we have folks come in to explain about the Salt budgets and what it can be used for and the planning process is like and process to submit proposals and how the SALT will vote on them and as well as exploring ways for greater flexibility to have a budget. The possibility of having a roll over yet keep in mind the fact that we have timelines attached to dollars and we have to spend the money in a certain amount of time. It is a complicated process and I think if we put our heads together we can figure this out. And the we looked at exploring out of the box ideas and maybe we can bring in a consultant to with our SALTs and the budgets process and implementation process and we want to support the SALTs as muches possible they are the ears the to ground for the community. I think more to come around that.

I think that is it for my updates unless chair Molina. Did I leave something out or you have a question?

>> I don't have any questions. The commissioners or comments?

>> Thank you for the report. Did you get the impression that the legislatures are going to be fixes as a result of problem one. We can talk all day about what kind of losses we are going to have. Do you get a sense they are open to the idea of somehow or another mitigating the outcomes that are going to happen with prop one. I don't know if that makes sense .

>> Commissioner SCHALLERT it makes a lot of sense and that is the question on our minds as we approach lobby day and part of the reason I didn't go to lobby day myself. Traditionally it is only the department heads and I took five other high skilled level team members to cover more of the legislatures. And I would say not only are they open to it. They are committed to it.

Now part of this I will be candid with you. Out of the ten legislative meetings I had. Out of the 11 meetings I had. Probably ten of them said they were unaware of the downside of prop one. That they did not realize the impact and once we shared that with them and gave them examples from LA county's budget. What would happen. They had an a ha moment and they were not just open but committed to working with us to find solutions .

>> That is really reassuring. Thank you.

>> It was both disheartening and reassuring right?

>> Yeah.

>> Any other commissioners? Commissioner MANALO.

>> Thank you chairman. Dr. Wong this is victor MANALO and I want to say I enjoyed hearing you are accepting the challenges that may come forth as a result of the proposition and also the fact that you are up in Sacramento and I think what you are saying is that about an ally ship is really an on going relationship with the legislature. They have thousands of bills that they go through every single year and they are not the experts on anything. They know a lot about a lot of things and they may not be experts in mental health and it is crucial that you and your staff and also the commission play a part in translating what is happening in our communities to our legislatures. Thank you very much for that and also by the way I wanted to let you know you saw you riding a ZAMBONI at the LA kings game the other day .

>> Thank you commissioner. If not for mental health you would not be Abe I believe to get me one otherwise. I think one of the valuable things we were able to do is meet with the chair of the Los Angeles county delegation to get her commitment to bring the entire delegation together with the county behavioral health and other parties to work on the solution together. You are right there is so many bills on the table at any given time and two that were low hanging fruit we asked to support outright and everyone we met were going to support them and those are two new bills coming up including removing stigmatizing language from various codes and things that are outdated ch>>: Calling people inebriated and talking about people with mental health issues as a burden and I think we made some progress with getting the legislatures on board with helping our agenda.

>> Thank you commissioner MANALO. Commissioner Austria.

>> Good morning .

>> Good morning commissioner .

>> Sounds like when you went for the legislative visits you had a preliminary analysis of prop one and particularly the budget and if you share that with the commission that would be greatly appreciated. I know everything is very early in the process any drafts and any finished products are critical to help us and also make recommendations along the way and we will need to see early products.

>> We will be happy to share and update you on anything that we have. Right now there is no updates since the last one we shared with the commission and nothing has moved yet. As soon as there is a change I will bring back to the commission and happy to do that .

>> Secondly this is MHSA hearing. Do you have any comments today on that?

>> My only comment is that we have had this planning process and we have all of the things in place and the priorities and listen to the stakeholder. Prop one has the potential of changing a lot of that. And I ask for people's patients in terms of knowing that some things might change and we might have to go back to the drawing board as we receive more direction from the state. Be assured this is an inclusive process and not something DMH will take on by itself. That we will bring back to the commission and back to the stakeholders and we will find the solutions together. They have to be solutions that not just work for the partners and clients but for then communities as well.

We are try to go stay open and try to go stay hopeful at this point as we await clarification from the state. There are a lot of things that even with the passage of prop one we are not very specific in the language of the bill.

>> Thank you for your time and I know you are -- (connection issue) -- again I appreciate the fact that you you are considering looking how we can roll over some of the remaining funds to the next fiscal year. Thank you Dr. Wong and we will see you soon.

>> Thank you very much and just to clarify I am coming are from an emergency and going to an event and luckily I don't have another emergency to go to. Thank you all very much and take care and have a wonderful gathering today bye-bye.

>> The fist time for public comment which is beginning now will be for public comment issues of general nature. Or reports from our various community groups and service areas etc. This is not the public comment per se for the MHSA plan. There is a separate time for public comment after the presentation is made so that we my a have the opportunity to listen to members of the community specifically on MHSA. Again there is two periods of public comment this morning and the first being comments of general nature and we will begin right now. Anything of general issues if you would like to address the commission on and later on in the agenda we will have public comment specific to the MHSA. With that said ken b ya if you can provide instructions on public comment. We will begin with five members here present in person and five menses on the phone.

>> ATT? Can you provide your instructions?

>> Thank you. And if you wish to provide a general public comment please press 1 and 0 on the telephone key pad you may withdraw your question at any time by repeating the ten command. If you using a speakerphone pick up the headset before pressing numbers. If you have a question press 1 and 0 at this time .

>> Reminder to everyone in-person and as well as on the phone we anticipate a robust number of folks who will like to provide public comment and we will time at a two-minute lel ask and I will -- Daniel will provide you with some kind of a sign that your two minutes are coming up. And let us begin with members of the community in the room. I see with two hands up. Please come forward and have a seat at the front table and as you see one person leave please members of the community in the room come up and have a seat at the table so we can have an even flow. Welcome sir, good morning .

>> Thank you for having the meeting and my name is chuck wood rough and I am here to ask ab the (Indistinct) diagnose program and I see a great need for that and my personal experience 20 years ago I had the opportunity to go through the twin peek program and as a result of that I had the opportunity to reinvent myself and my life has been very successful and I haven't been back in the hospital nor do I self-medicate anymore. And I noted they closed the door diagnose program and I you see a great need for that. My question to the board with passing proposition one and implementing more (Indistinct) residential programs.

>> Thank you very much for your comment. I appreciate it. Next? Welcome .

>> Hi all. Thank you for giving me this chance. Dr. Wong she stayed on I wonder why you don't respond to any of the citizens concerns and you are not here. You ran away one day when I was here. It is not the commissioners that can answer the question how your department has been working. With a conflict of interest that exists between your department and the health care providers and some other staff. What do you have to say about that Dr. Wong? Why don't you come here and give your answer to the commissioners and to us as the public. And the the commissioners I want to know what are you doing b about my you reports that I have provided? I hope you are going to give me some answers. Thank you.

>> Thank you very much. Next speaker please come forward .

>> My name is ber net mar tee in easy and mental health advocate and I founded add organization and I am diagnosed since I was 12. Age of 12 I tried today take my own life. Age of 15 I took a handful of pills and that started my (Indistinct) I was dual diagnosed. I have extensive effort on voluntary effort for mental health stability. Two of my adult children are also diagnosed and I deal with I those journeys everyday. It is difficult. And I have questions in regards to potential legislation for statue of limitation for any individual hospitalized tr mental health disability. The liabilities add up like no other. I am not asking for a free pass just a time-out. I did 1.6 million in ten months working for a law firm and negotiating contracts and I have success in advocating and I have saved several lives so far and glad we are on record. Nonetheless my objective now is the to help others not, I m am in a mental health crisis now and homeless living my car. The civil liabilities need to be addressed and doesn't take much to be kind to somebody in pain. Pain is universal and when someone's pain is so severe the only solution is taking your own life and it is deep and difficult to come back and I came back about three times and each time set me back further and further. If we can have a tier type of level of severity and helpfulness because of my extensive background and efforts to have mental health stability I think it would be helpful for the community thank you.

> MICHAEL MOLINA: Thank you very much and thank you for sharing this morning. Next speaker please?

>> Greeting my name is Monica olson and one of the three SALT can o chairs serving the antelope valley and we are planning the meeting for April 1st rs for (Indistinct) monthly meeting. Weapon are also continuing to plan for May mental health awareness event scheduled for May the 4th with no discouragement of agencies ep bracing a Star Wars theme. Rumors of a costume for service area chief. This week we met with Dr. Horn to understand the procurement process and roadblocks for out reach and -- one (Indistinct) Spanish documents without the time to go through the standard 30-day DMH process specifically for SALT one meeting agenda and moo minutes as we want more engagement with the Spanish speak community we ask if it is possible to use part of the budget to contract with a county vendor for the documents that require a quick turn around. Dr. Horn gave a review of the process and gave option for what to do to make the documents available. Another item on which Dr. Horn agreed to follow up is ability the to access and update many micro site and establish a social media present presences and appreciate the time Dr. Horn made in support of this. We are eager to continue to learn existing processes and establish new ones as needed to keep our SALT going and thriving.

> MICHAEL MOLINA: Thank you very much.

>> This question and comment is from Joshua NA. There is a lot of questions related to the previous comments in this MHSA meeting. So there has been many questions and many comments related to the services and I would like to know what the follow up procedure? How you receive the question and comment and how you implement those question and comments and what the result is. And in our community a lot of people, a lot of patients or the consumers they are wondering the results of our comments and ideas and questions. Thank you.

>> MICHAEL MOLINA: Thank you very much. ATT operator and see if we have anyone in the queue? Fsh star t with line number 11 please go ahead .

>> Can you hear me? My name is hector ra mir ez and one of the cochairs for the access for all USCC we had our meeting this month again. We now have had two of the cochairs resign from the subcommittee because of difficulty with DMH staff and getting accessibility services and some really unfortunate stigmatizing behavior that we experience and we have a new cochair and we had our first meeting and discussed new procedures and the three-year MHSA document that is up for review and our members want to highlight the fact it is not ADA accessible for those of us who have disabilities and it is a 370 page long document and it is long to read and to print it is very expensive and through it it is unaccessible. It is in English only and we did request in accessible format and Spanish from staff numerous times and we haven't received it and know today is the deadline and that is a concern we didn't have access to the document because our disabilities or in Spanish and the deadline is today and it highlights one of the biggest concernses with this process not only with this document and how it involves our access for all USCC stakeholders that have disabilities and we want b to thank the commissioners who note and had highlighted these issues and we did send a notice to drcht wong last year and we haven't heard back or know whether or not she received our message with our concerns and we are thankful for those of you who are here to listen to our stakeholders and it is very important that at least somebody recognized our consumers with disabilities have paid a significant burden in the administrative process. Even with the consultant that the department has hired. We will be having our in-person meeting in May. And it will be our first in-person meeting since the pandemic and if we are hoping to have it at the main DMH building and it is a really important meeting for many of us. We lost many of our members throughout the pandemic to COVID and it will be a really pivotal opportunity skchlt and look forward to working with the taun chss that is prop one brings and the benefits and opportunities that are in it. Like the accountability factor to ensure their processes are accessed to people with disabilities and we are glad to be part of the system and hoping that the next time that the DMH delegations consumers are also included in that so the

the narrative is more beneficial and not only to the ten but all 11 legislative representatives that got that opportunity. Thank you.

>> MICHAEL MOLINA: Thank you very much. Operator next speaker please?

>> Next we will go to line seven. Please go ahead .

>> Hello I am Charles Wade. I am with SALT six and want to say thank you for having this meeting.

>> MICHAEL MOLINA: Thank you very much operator next speaker please .

>> Line 18. Please go ahead .

>> Good morning this is Paul stance burry SALT eight cochair and a few brief items we had a long discussion about the MHSA update and two-year plan and shared information with the membership about the resource available and thorough process we have in try to go develop recommendations and thought it was a good process and we are making sure to track the implementation and what is going to happen with the plan and that is one of the issues of this. How to mac sure and I know part of the CPD process is address how this is implemented.

There was a discussion about proposition one. Concerns were expressed and had at that point we didn't know the results and there was a concern about it is happening and how it could impact the department of mental health programs.

Third we also we are planning or give an update on the April 25th town hall at the course community center and looking forward to that and making sure people in the area are aware of the town hall meeting on that date.

Another item to be sure you are aware of in order to do more outreach and engagement we have May 4th meeting at the engage l wood -- that is an in-person meeting and part of the effort to move the meeting around is service area and connect with the different community ins the service area and finally we were looking at how to encourage more membership. We have good participation. We are always looking to make sure we have representation in different communities in our area and we are looking forward to the elections this summertime. That is my report. Thank you.

>> MICHAEL MOLINA: Thank you Paul. Operator next speaker please?

>> Line 16 please go ahead .

>> Good morning this is Y von Sandoval from SALT seven. Cochairs can you har me clearly?

>> MICHAEL MOLINA: Yes go ahead .

>> It has been a good month and we were rattled to see where prop one is going to lie. It is a good fight and I can thank those who voted on it even though it didn't pass and it was very marginalized and of course this is time of getting ourselves dusted off and going back to the bulletin board and seeing how we can process and move forward and continue to help those that need help.

I just want to say that we had our meeting on the second Friday of this month. We gathered and we were talking about our two upcoming mental health events. The first one will be May the 4th. At bell ve der lake park in east Los Angeles and that park is between Brooklyn -- Caesar Chavez avenue and first street. It would be on either side. It is a big park and you will find the tents there in addition to that on May the 4th is NAMI walk and held at the historic Los Angeles park on Spring Street. Unfortunately it is on the same day. Maybe if I p am whimsical I can make it in the morning with the NAMI people and be present and it is not too far, and be able the to get to bell ve der park.

I know for this, for going back to the bulletin board. I am sure Wendy and Kimberly is hearing and I know with you on board it is going to be a good way of coming together and finding better solution to deal with prop one.

I, myself, all month, it has been a month of is now known as MEXICA new year. And this is because a lot of the native tribes basically from Mexico that many indigenous people here are from there. They had created this grouping to celebrate all of those nations.

So the month of March is MEXICA new year and I want to wish everyone a happy new year in this manner.

I was able the to I tend a couple of events that were held at the museum in long beach.

>> MICHAEL MOLINA: If you can wrap up please.

>> Sure. I see my time is up and that is what I wanted to share and we are still looking for another cochair if anybody would like to join us. Get ahold of anyone of us. Is my time up? I believe it is. Thank you so much.

>> MICHAEL MOLINA: Operator next speaker please?

>> We have no one else who wisheses to speak at this time.

>> MICHAEL MOLINA: Thank you operator we will go back to in-person. Ms. Wilson .

>> Good morning commissioners thank you for the time. Despite the fact that I am one of the three cochairs for Spa two I was out of the state and did not attend our meeting and we did have a presentation about men and their mental health need and especially in midlife. My comment today is me as a private citizen.

As I have written already I am very concerned about the new, not new, the continuing and flourishing growth industry that is unlicensed, unregulated facilities that house people. And I would like to, you know, just make you aware of some of the dangers and one of the big dangers of course is that residents have no consumer protections since they are not liepsed. If somebody wakes them up at 2 o'clock in the morning and tells them to get out that is what happens.

Also we have a lot of push back from homeowner groups because they don't know the difference between licensed facilities and unlicensed facilities. They do know that when cops are out in their neighborhoods at two in the morning they don't want them there and say that is bringing the property values down. They go to their city or counsel or whoever the political represent I haves are and demand we don't want any facilities in our neighborhood for the mentals and this puts our licensed facilities at risk.

So, I am hoping that the commission can take a look at that, maybe encourage the board of supervisors to begin to identify where are these facilities located? There is no tracking apparently.

Also if there is a bill, potentially, AB 2650 that is proprosing toen count the number of people in licensed facilities that have serious mental illness and who are low income.

I want to mention to you people who attend day programs in the community in their efforts the grow their stability are actively being recruited by unlicensed facility owners at those sites. Particularly they target people it seems that have family members that are out of state. With that I will close.

>> MICHAEL MOLINA: Thank you. Commissioners reminder I think it is our June meeting we are going to focus that meeting on issues relative to housing and facilities and beds and other issues.

>> You have Korean interpretation as well.

>> MICHAEL MOLINA: Okay we will finish the room and go back .

>> Hi my name is e-Sikh el, update Dr. Horn has come to SALT four and shared with us numerous amounts of information in regards to what we can and can't do as a SALT. We feel reinvigorated because of the information shared and we work together with the liaison so it feel like a team effort now. We are planning for many more events this year in comparison to last year because we have finally found what we can and can't do with the events and planning meetings. Everything is working out so far. It is going slow. COVID hindereded a lot and we are going out of the phase now and looking promising. Thank you so much for that.

For the public comment I I would like to say prop one is the worst thing that could have ever been put together. For the simple fact as of right now we have many homeless. I know many homeless and I spent 15 years on the street due to cancer twice and many of t homeless I do know many are housed and those with who are housed are not forgotten. We have a system now before prop one passed the perp feels homeless before they move out of the houls. They become homeless after they move out of the families house and finally get services and aid connecting them to many people as a community and then they are placed nd a home. In an apartment by themselves and now they are back to square one. And everything is going in a circle for those experiencing homelessness. Again, people may believe homelessness starts when a person becomes unhoused that is not true. Homelessness starts when the child is finally realizing they are the black sheep of the family. That is when homelessness helps.

>> MICHAEL MOLINA: Thank you. Next speaker please come forward .

>> Good morning commission and good morning everyone. My name is Eddy Flemming and I am from emergency and intervention. You hear me? There we go. My name is eddy FLEMMING with emergency intervention and director of community relations and I am here the to read the the letter from the community and address the disconnect between the department and the community. We have no direct connection to resources except for the agenda which might be six meetings a year and I heard something put off until June. People are having an experience now and I heard something about another consultant and that is the last thing we need. I have this letter from the community in SALT six to an attention. Sunlt complunt and trust and transparency. I am writing to address the matter of upmost importance concerning community trust and transparency concerning SALT six and funding allocations for mental health advocates and support we must uphold the account sxblt credibility in our initiatives and last SALT six meeting there was a break down in communication regarding funding allocation for community events aimed at mental health awareness many community members left the meeting (Indistinct). January 18th, 2024, dfs brought to the attention of t community and SALT six members at the service area leadership team allocated over a 130,000 for community based organizations and partnership with organizing mental health and events in the community. This information was clearly outlined in the agenda clarifying the intend use of funds and subsequent rel vags of the funds were not available many question the accountability and credibility of the leadership and absent of transparency and honesty caused significant harm and disappointment with the community. Stakeholder trust is compromised. (Indistinct) the emotional toll on our end user and consumers is profound.

>> MICHAEL MOLINA: I will give you 30 more seconds to finish excuse me sir I will give you 30 more seconds .

>> This is respect --

>> MICHAEL MOLINA: I am being respectful sir give you 30 more seconds .

>> This is important. We have consumers dying out here. Whenever you want to talk you come to the community this community has been building and building and the disconnect is leaving us in despair .

>> (Indistinct).

>> Address the real issues which is the community.

>> MICHAEL MOLINA: You are welcome to leave your letter with us so we can take a look at it. Anybody else in the room wishing to be heard?

>> I will do it.

>> MICHAEL MOLINA: Thank you sir. All right moving back to online public comment please?

>> We have no one queued up at this time?

>> Wonderful.

>> MICHAEL MOLINA: We will close the first round of public comment. Comments general in nature and we will move onto our agenda. The next commissioners is consent agenda and three items on the agenda. Any commissioner like to take the items off of the consent agenda seeing none I will entertain a motion and a second the to approve the consent agenda.

>> Moved .

>> Second.

>> MICHAEL MOLINA: Unanimously approve and had moving to item number five. Standing items this is the beginning of the discussion relative to the two-year plan for the MHSA and I will welcome Dr. Horn and Kayleen Gilbert

to come forward and we are beginning the public hearing that will include an additional round of public comments and participation and questions and statements by our commissioners reminder commissioners this is not the end of the MHSA process. It is just the beginning and we will have two months to be able the to provide comment. This kicks off the process relative to our commission. We will have time for questions and clarifications. Welcome Dr. Horn and Kalene please begin .

>> Thank you very much commissioners and thank you for taking the time to hear our presentation today on our two-year plan and this is a culmination of the years work. I feel like we are in a different place not only to the team and Dr. Horn but also the participation of the stakeholders and my name is Kalene Gilbert and mental health services act coordinator and here the to cover an overview of the two-year plan. Program and expenditure plan. Commissioner Molina your comment is correct. Not only is this the beginning the conversation continues for the next two years and this is where we start and we will continue to monitor and bring updates back.

Just as I am getting to start I do want to note, again, the work that went into this. Particularly that of the stakeholder rs and I do see a number of familiar faces here in the audience. It was intensive work. Oftentimes we are look at three hours a meeting and twice a month and held a number of conversations specifically focus conversations to identify the needs of the community. And I want to acknowledge the time and the participation and the appreciation for our stakeholder rs to bring information and also appreciation for their kander. They will let us know certainly what the needs are and let us know when we are getting it right and where we need to make improvements and we learned quite a bit from the first round and learned more this round and anticipate a collaborative process. The forums for us to work together and talk together are going to be so important as we do look towards implementation in proposition one. We are going to need the relationships. The communication and this involvement.

I am going to go ahead and ask that we go on the to the first slide. Yeah? Okay.

Just to give you an of view of what I am going to be covering today. One of the first things p I want to share is that our two-year plan. Typically it is a three-year plan and it is different this year because COVID threw us off skemgual and covers three separate -- I want to share up front it is clear what is in here. Whatever annual plan will cover the needs assessment. Programming. And outcome frs the fiscal year prior.

This particular plan will cover the needs assessment. The outcomes and programming for fiscal years 22\23. It also covers the stakeholder process for the current year. Finally it covers the programs and program recommendations for the years to come. For the next two years.

This is really the outline and this is our blueprint for the work ahead and that means that is any recommendation that when you come in we talk with the stakeholders about items wes are able the to move forward with now and any item in here we talk with our needs and what comes up. This is the blueprint we have to work from. And I will cover for the purpose of the plan an overview of the LA county population and some of the needs assessment information and overview of MHSA components and overview of the community planning process and Dr. Horn will provide that and planning team work groups and priority areas and proposed changes.

I hope most folks are aware been talking so much about proposition one. I hope folks are aware the mental health services act passed in November 20:04. This was a tax on personal in over a million dollars in the state of California. State collects the tax dollars and identifies it is amount to provide to counties based on population size. LA county get it is largest share often 25 percent plus of the MHSA dollars. And the mental health services act was intended today build on the scaffolding of the existing system. And idea is that the existing system post institution was not sufficient and never fulfilled the promise of community mental health and MHSA was mixed to provide an expansion to that and we have grown significantly since that time.

We have seen a significant expansion in the amount of intensive filled services. Prices services. Outpatient services and new services like prevention and early intervention. Next slide.

Just a couple of notes on LA county population. We have predominantly I think adults at 48 percent. We do 20 percent of LA county population is older adults. T 18 percent children and 14 percent transition age youth. LA county serves approximately 10 million residents of which 48 pack t are Latino. 25.9 white. 15.1 API. Those are the top in your opinions we are going to talk about MHSA populations a little more shortly.

There are more details for you here at the table and those in the aud scombrens they should be post and had we have highlights with more details and it is an executive summary of the plan and also post nd Spanish and Korean if folks are interested in more of the needs assessment details the thorough details are in the itself which is also posted.

One of the things I want to do this year and plan to continue to do going forward not just look at the demographics and understanding the needs of t populations. Language and culture which is a top priority and I also understanding, identifying top priorities for the county and are where the needs are across the county and this is part of the work we are starting with equity and making sure we deliver the right resource to the right place where they are needed most and we identified three areas and what you see are highway t maps frs the equity tool. By the CEO and available the to the public.

We look at foster youth placement and removal. And here you can see removals are outlined in red. Darker the colorer is higher number of removals and bubbles represent replacements and the larger the bubble the larger concentration and if you want we can go in and look at actual numbers. --

>> MICHAEL MOLINA: Can I interrupt. We have a commissioner asking few if there is an opportunity to reference it is big book by chapter of what you are talking about she would appreciate that. Thank you .

>> If you don't mind giving me a moment I can do that. Our needs assessment begins on page eight. You will see we go through a bit around language and demographics and this is a needs assess mment chapter that begins on

page # # and I believe it ends on, excuse me. Eight and should end on page 16 or 17. That is where the community planning process starts.

This let's us know that we have highly concentrated needs in service areas 1, 6 and 4 and certainly you can see that there are needs throughout Los Angeles county. Next slide?

We also look ted at the Jenny which is a justice equity need and it is a composite score or index that looks at vulnerability and impacts of justice involvement in communities which we know is another area in which we are try to go increase and improve access the to mental health services.

Here the darker the area. The tashg ker the color the greater the concentration of need. Again we see more service area one and service area 6 and 7. If you go to the next one. This is, um, unsheltered and shulterred homeless rank and we included some detail a little more on homelessness. Here again the darker the color the greater the concentration. And this is based off of the homeless count conducted by LASA that tells us where we have concentrations of individuals unhoused and service area 4 and 6 seems the to be where we have the highest concentrations. Populations enrolled in medical. That is important. We are here with all of LA county and DMH in particular serves individuals and responsible for individuals beneficiaries of Medical and we serve individual who is have no other needs for service. And it is a broader population than that. And I want to make a note. We always look closely at data around the Medical population and specifically around ethnicity and language.

Here we have approximately 40 percent of the LA,population that I noted earlier makes up the eligible medical population and 40 percent are Hispanic or Latino. 25.9 percent white. 15.1 percent API -- percent African American. 3.1 percent not recorded.

These are indicated by folk who is are served. We ask them what is your primary language and doesn't mean it is necessarily their only language and we have 57.6 English. 33.6 percent Spanish and 1.9 percent Armenia. And you see in the report we have the full list this is the top ones for the summary report and I will go onto the next slide. We are looking at the population of unhoused specifically and we took a look at count number frs 2018, 2019, and 2020 and I asked my team to include the most recent number frs 2022. Reason you see the numbers here this is what is included nd the needs assessment as discussed with the stakeholders in July. This is what we used for the discussions and I want to acknowledge there is more updated information available to us now and we note that most folks are individuals we have 51,000 individuals now. County. Family members. And youth at over 4,000 who are unhoused. And I want to say the highest service areas with individuals homelessness that would be service area four. Greater than 17,000 individuals experiencing homelessness. That is the highest of all of the service areas. Significantly higher because the greater than 5,000 have been identified in spa six which would be the next one. Next slide.

All of this to say we look pr many r broadly at demographics as I noted and this is a high level summary of some of the key demographics we look at and we have more detail in the report and want to know cultural needs and language needs and where are the concentration of specific priorities we have throughout the county. And moving onto mental health service act components the MHSA requires that we spend our dollars in a specific way. They have us break out the MHSA dollars in categories and the largest category is called CSS or community services and supports. That is some 76 percent of the total pot. And it is, half of the pot needs to be FSP. This is patient and linkage and crisis services and includes our FSP services. Next up is prevention and early intervention and includes early intervention services held in clinic settings with one on one services and also includes prevention efforts and anti stigma efforts and includes are all of the community based preventions that we have throughout the community with the sister departments and this is where we have most if not the great majority of our investments with community based organizations. This allow us to deliver services up front in the community by the community. And in an effort to mitigate or the impacts of trauma and hopefully reduce the number of individuals needing mental health services down the road.

With this we serve individuals and children and families through a variety of programming.

The next component is innovations at five percent. And innovations is something like a, gives us an opportunity to test new ideas and we basically have to set funding aside into that pot. And work with the state to identify project that is we can do and spend these dollars on projects for up to 1 to 5 years.

They need to be approved by the culture and the state and the idea is if we complete them. A good example bhieth the promoters we call innovations too. We have community ambassador network and identify the outcomes from that which we saw as positive and that has now been rolledd over into prevention funding. Where we see positive impact ins the community we will have to find dollars within the rest of the MHSA funds to continue the programing and that is the most recent example. We have work force education and training and CFTN. Which is capital facilities and technological needs and these do not have specific allocations if we want to fund we utilize each of the categories and wet is in particular is key for addressing the issues wes have with work force and work force availability and building a work force and identifying work force members who are link wisically and (Indistinct). These are p pots if we want to fund they have to come out of the community services and supports category.

Next slide. Let's take a look at the community services and supports. As noted CSS includes our outpatient. Crisis. A broad array of programs and I am going to talk about full service partnership and alternative crisis and housing is another area covered here separately. Overall the largest component as noted with 76 percent the number of unique clients served with dollars is 178,083 and that number is representative of the number of folk who is have come in to our services where we have opened a case and delivered a specific service. It doesn't necessarily count the nonmental health services that are deliver and had the number is higher when you consider prachls like housing for example or linkage if we did not open a case and did additional work with folks.

Of the 178,000, 50,000 were new. Just under add third of folks are new to the system. These, this data or metrics are available not only in a report but there is a live version in the dash board online. In if individuals are interested

in looking at the services to the various populations that is available to you at any time and you are able the to break up by service area and you can see where we have delivered the number of clients serve and had number of new clients within each service area and where we have the most services delivered and that would be service area four. Followed by service area eight.

Full service partnership. So for FSB. We are looking at, we have served this pavs year, again r, unique individuals and served 8815 adults and 5704 children and youth and found of those who leave FSP some 32 percent left due to successfully meeting goals and 49 percent left due to meeting goals and we have data on the remainder and often time going into other programming or other settings. And for the impact of FSP on post partnership rez den ken shl outcomes for adults we see a percentage by client ps. The number of clients who experienced changes and saw a 39 percent reduction in homelessness. 66 percent reduction in justice involvement. 51 percent reduction in psychiatric hospitalization and 6 percent increase in independent living. Chifrn and youth. Five percent increase in independent living but 33 percent increase if you consider the data by number of of days. Next slide? Here is information on alternative crisis services.

We just featured two of them here and have several programs and thls psychiatric and urgent care and indicates eight percent of the clients had a psychiatric emergency assessment within 30 days of UC admission and 92 percent, this is eight percent of clients returned to the UCC within 30 days and 29 percent did not return to UCC services and we did make note. It is not an outcome but a tracking of who we are serving some 20 percent of the clients are homeless upon admission to the UCC.

With law enforcement teams and this is our partnership with law enforcement we have 11312 incidents. We did note 25 percent involved individual who is are unhoused. 56 percent required hospitalization. Six percent resulted in arrest and goal here is to divert any kind of jail or legal involvement and increase access the to services. To avoid or mitigate any kind of incidents. We want to reduce that crisis. Mitigate crisis.

Community services and supports for housing. We have 75 of the 15 # two permanent supportive housing development finish construction resulting in 1680 units to be available. Of the individuals housed we have 1464 adults and adult family members and 1630 minor children and a 90 percent housing retention rate for the capital investments this is investing in building of homes.

Housing for mental health. We have 424 clients in housing during 22, 23. Most referred by DMH contracted providers and some newly referred to the program through the community and we have a 93 percent retention rate for the program.

The federal housing subsidies unit is where we work with the housing authority and supported 27 a three tenant based. With 3018 house and had that includes adults and some with minor children. Finally the ERC. Enriched care program which is where we have served add total of 1238 this is where we work with residential facilities and provide additional funding for -- not only additional supports on site but also we pay for rent in most of the cases as well. Next slide.

Still on housing. Interim housing for adults and these are often short term beds. Shelter beds. MHSA we contracted with 618 interim housing beds across 21 sites and this past year we served 1419 and 75 families as part of the program.

Acknowledging we have youth and -- we have our enhanced emergency shelter program for TAY and we were able the to open two additional shelters this past year to raise the capacity to 110 beds and serve 592 TAY during the fiscal year. In addition we have home which is homeless out reach mobile and engagement team. This is the street teams out there working with individuals and they do their engagement on the streets and the teams that are working with some of the most difficult to engage with services and that work can take months and month pss and they are just so fantastic. If you have a chance to see some of the work that they do. This year recognizing the impact of the program. They increased capacity by adding 67 new position across LA county and went from 10 to 16 teams.

Going onto the next slide. Prevention and early intervention. Second largest component. Notice that I noted earlier early intervention is clinic base and had prevention is community based upstream services. Suicide prevention. Stigma and discrimination reduction is the fourth category. And we really, again, focus on providing the preventive care. Early intervention strategy and with the prevention dollars we fund a lot of school work as well.

>> MICHAEL MOLINA: Kalene can you give us p chapters within the big book so we can --

>> Thank you so much. For CSS that began on page 63. For our PEI programs I am on the next slide please. I will talk about prevention first. It is the community based programses and these are a little more challenging to capture since they are community based. We have some time to identify how many individuals are served. Outcomes are required for all of the programs and oftentimes what we do as survey. Sampling surveys and get a sense of how many folks showed up to a community meeting or event and those are some of the ways we have to note what we have done. Here is an example throughout the slide and gives information on just some examples of a prevention programming. Large zest partnership with LAUSD in which 1 million surveys were collect frd LAUSD based on the work and programs and services they provided.

We have a great array of programming from the veteran peer access network which we collected 13,600 surveys from participants. My health LA behavioral expansion program that is a r partnership with DHS and providing wellness services on site. That is 27,000 surveys received and had we also have in her our incubation academy and this is our effort to develop our community based organizations to become LE down the road and it is training and support and includes grant work and served the grants they receive from us as part of the training and they were able to collect 4,000 survey from individuals.

The surveys oftentimes are looking at prevention types of or impacts of trauma and we use several instruments and what is challenging is it depends on the program and most often we use a tool called the bubs and that is a tool that looks at impacts on trauma. Are we increasing the factors for trauma or decreasing risk factors. A simple tool in the community and I gave examples like parks after dark. People don't want to stop and take a five page survey and we try to do the best we can to collect key information. Next slide. Community ambassador network. Some 4,449 participants received a total to have 27,000 referrals and that stands for the brief universal prevention program survey and this program overall we saw protective factors. There is a skoer and we want to see it go up showing a positive impact from 23 to 23.6 and also use it had well being. The world health organization well being sub scale and saw increases from individuals from that program from 16.5 to 17.4 and this program looks at engaging community members and linking community members into services. Manufacture specifically we worked hard to ensure we are reaching cultural and ethnic communities and this program evolved this past year in the united promoters program. We look at community members and engage with community members here.

Prevention after care is another one we want to reflect and that is a partnership with the department of children family services where CBOs are contracted to work with families who have been referred or at risk for being referred and there we have also seeing some increases in supports or positive outcomes. Parent, caregiver resilience the scores go from 2.6 to 3.1. Social connections. Knowledge of parenting increasing and stoeshl and emotional competence increased. And we were able the to collect 3437 survey frs tevents in addition to some of the increases and some of the outcomes we want folks also felt that in terms of stigma they felt they were connected with others and learn something different and something new to add. Next slide.

>> This is Kenya and I don't know if anyone is listening online. Aparentally there is an issue going on with the live broadcast. We are try to go figure that out. Keep going for now.

>> Moving onto prevention and early intervention services and these are clinic based services delivered by clinicians or peers or professionals or partners and these are clinic based services so the cleent here. We served 36,206 unique clients received prevention and early intervention services and these are often in clinic settings with almost half of those new clients who are new to the system. And I will speed up a little bit and I know there is a lot of information and let me hit the next slide. You are there already. Early intervention outcomes and some examples of many evidence based practices we have for seeking safety which has served children, TAY. Adults and older adults and saw a 51 percent reduction from trauma symptoms and -- managing and adapting practice. This is a specialty of MHSA practice for children where we saw a 55 percent reduction in depression. 48 reduction in trauma. 44 percent reduction in symptoms relate today anxiety. Trauma focused and cognitive behavioral therapy. This is used with children and I think focus on foster youth. 51 percent reduction in trauma related symptoms and the mental health integration program. This is (Indistinct). And we saw 57 percent reduction in symptoms related to depression before related to anxiety. Next slide.

Prevention and early intervention programs. This is our stigma discrimination programing and this is our prom tors program from the last year and these are combined with the (Indistinct) program. And this is the departments prom tors program that is running for some time and they were able to serve far more folks and collect some 16218 surveys with the educations and services that they have provided nd the community. Most often the to the Latino community.

Suicide prevention. And this is the program that provides services through multiple strategies. We have our suicide prevention programmings where we have a team that a couple of teams that go out and deliver suicide prevention trainings for community organizations. For groups and anybody who asks for them and they are intended for community as a means to provide support. And, they, um, served or they trained more than 752 folks with those trainings. And in addition we also have the school threat assessment and response teams. These teams do presentations at schools and work with schools on the crisis planse and respond to consultations and referrals and receive 991 referrals of which 787 percent received screenings ask and they were able the to work with those individuals.

I am going to pause here. Because we have gone through the majority of the prevention, early intervention and community services and supports and full service partnership programs and I want to shift over into our community planning process for this year and I will ask Dr. Horn the to pick it up. For the community planning process I -- [away from microphone] .

>> Okay the fun stuff is community planning process and I am always energized to have the opportunity to speak about our community planning process it is where the rubber meets the road and it is where we want our stakeholders and our communities to know that they have a voice and an influence around how we plan and what we plan to meet their needs and we really, r for this round of community planning. We did a lot of work and presented here a few times before how we enlarge it had community planning process with the community planning team. We have over a hundred seats and recommending seats as a r part of the teem. And those seats represent our service area leadership teams or our SALTs. We had a lot of discussion earlier in the meeting about SALTs and creating capacity within the SALTs. Underserved cultural communities have a seat as part of the planning team and we work with our department and sister departments like the first responder and fire department and DCFS and public health and we have seats on the community planning team for those persons as well and all of our community planning meetings are definitely open to the public.

At any given point we will have a lot of community at large members or stake holedder at large is what we call them and they do participate and we do serve and get their recommendations as well.

I do want the to highlight as ar part of the community planning process our p push to be more robust in our ADA accommodations and for every single one of the meetings make sure that we have the full ADA accommodations available that includes sign language and that includes all of the documents and are translated in both English and Spanish and any other language that is requested. But we do definitely do English and Spanish on just a regular basis.

We also have the, it needs to be recorded and we also make sure any other interpretation services are available.

We ensure that if one pants to participate we accommodate them and are able the to do that. As Kalene mentioned earlier for this planning process have two meetings every month and one on Tuesday and one on Friday. All meetings are definitely able to be observed virtually. And of course the meetings are definitely in-person at saint Anns conference center. Starting with the planning process is is phase one. And we had to recruit and open up the seats from just the SALT and USCC from the DMH framework to this robust open accommodating over a hundred seats and that took the best part of the summer in June and July and we did recruit individuals to sit on those recommending seats and what we did in the first phase. The first three months was due what Kalene presented a little bit earlier is go over a needs assessment and we would like our stakeholders to be informed and we start out each planning process with presenting them data as we presented here. For them to know who has been serve bid our MHSA funding and both through the direct service and indirect service programs and that of course can our CSC planning and we do provide direct services through clinics and in our prevention related programs those are more community based services and we try to correct to where services are need and had provided and where there is gaps and we realize we have some gaps.

Over the first three months of planning. Once we recruit and provide data and information we begin to work with the stakeholders around what are the community needs. For the planning process we divvy the stakeholders in four work groups.

Look at phase two on the slide you will see the work groups are community support continuum and that is outpatient services. And we have our housing services and housing resources work group. We also have our prevention and early intervention work group and then b work force education and training work group. Those work groups have met separately. They look at the data for the programs that fall within those categories. They identify service gaps in service areas or underserved cultural complunts and make their recommendations on what should be included in our next plan.

Those recommendations are then recorded, they are written in draft plan. We do and have other multiple meetings gone over what is in the draft plan with the stakeholders sometime in January and we post it had plan in February, on February 28th and that plan. That 30-day posting period culminates today. And so we are here doing our public hearing and then receiving your feedback towards hopefully the adoption of passage of the new plan.

That is our process over our three periods. We came out of the meeting with the four work groups and the next slide hones in many on how many recommendation we received and there was a total of 713 recommendations and that is total across all four of the work groups.

Below you will see how that 713 recommendations (Indistinct). Over the 713 recommendations you will see across the four work groups how many. 133 belong to the CSC work group. 118 to the housing and 288 to PEI and 174 for work force. I want to clarify recommendations those are the direct comments that were recorded. Unphaseded and uncollapse and had it is the direct recommendation that was recorded as the person in the work group setting. Right?

Then we take those very large numbers of recommendations and then we look at themes. So, of course. 123 people may have a similar or same recommendations and so it falls upon us to look at is this the same recommendation and can we combine and the numbers that you see below the larger numbers and if you look at CSC, for example, you see four categories and 52 recommendations. Over the 103 total comments that we received for CSC we called out four categories and those recommendations fell into those four categories which is emergency response. Psychiatric beds. FSP and access the to quality of care. And amongst those 133 that fell into those four categories we identify 52 unique recommendations. They could not be collapsed any further in terms of themes and that is the way those recommendations were pulled together over the four work groupses and for housing you will see that 118 recommendations fell in five categories. Eviction prevention. Street outreach. Housing options. Service quality and specific populations.

Nine # seven unique rengss for that work group. For PEI. Three category. Populations. Access and ef effective practices. And those fell into 136 unique recommendations and then finally for work force you have four categories. Mental health career path ways and resident season internships and p financial incentives and training. 52 unique recommendations and I want to point out something that is unique for the wet category that is not the same for the other work groups. The four categories for WET are the funding streams under WET and they stuck to how the WET funding is categorized and made the recommendations within the four. Verses the other flee they were just recommendations that were called out based on needs. Next slide.

After receiving the recommendations because, again, you know, this is human work and human error. After recording the recommendations and making sure they were listed in their entirety we then re-shared and we shared out with our stakeholders the recommendations and surveyed them and did a good job on reflecting what you recommend to us. We don't want to misrepresent what the recommendations were and of course since we do condense and categorize them we want to make sure they are reflective of the input we receive. We sent out a survey and it went out sometime in November or December. Because that as holiday we carried over to January to capture as many as we could.

The number of stakeholder thars completed it had survey were 41. Of that 41, 18 were community planning team members and our stakeholder process includes seats for folks that have a formal recommendation based on who they represent. We have representatives of the SALT. Other county departments and so forth and so on. Those are considered formal community planning team members.

Then we have stakeholders at large. It is open to the public and with do include everyone's recommendations and those stakeholders at large were 17 that completed it had survey and we have six other. Other means they did not identify whether or not they represented a group or whether or not they were a stakeholder at large. We still captureded their feedback. Next slide.

Of the survey we captured we ask did the recommendation we had in the draft plan address the recommendations that you share in the work group. Did we capture the recommendations the way they were mention and had we see for the most part of the survey 66 percent strongly agree or agreed that their recommendation was captured in the spirit it was given and amongst our CPT members which represents those who have a formal recommendation 87 percent agreed that we did capture their recommendations correctly.

We did also the recommendation were addressed in the plan. Did they see a connection between what they recommended and what actually came out in the plan and we see, again, of the total number of folks surveyed they strongly at 69 strongly agreed or agreed that their recommendations were address and had 78 percent of the recommendation group or formal CPT members agreed or strongly agreed. Next slide.

Now to dig a little bit deep. I mention the work groups and mention the priority areas and we will dig a little deeper and I will keep it as brief as possible. For the prevention priority areas again, the focus was on population. Access and effective practices. Populations there was a strong priority around children. Early childhood birth up to five years of age and underserved communities. And we spent a lot of time and I I have a slide later on. I want to say early on all of the recommendations were anchored in the focus on equity and looking at services and looking at them from an equity standpoint and (Indistinct) went off of earlier. Points to that and so you will see very thematic and look at underserved cultural xhoonts and looking at where we can address gaps gr an equity standpoint and I want to point that out.

In terms of area for prevention. We look at access for kids in kindergarten and up to 12 years of age and not only that but older. Kids in college and attending university. And trade and technical schools. And community engagement. Very strong in looking at how our community based platforms are doing and what are the gapses in providing outreach and engagement services and in effective practices which points to suicide prevention and of course our evidence based practices that are provided within our clinic walls.

In our work force education and training work group. There were four priority areas and to note WET relief followed the WET plan and they stuck to their categories in the way they allocate funding and first is mental health career path ways. And look rg at having strong partnerships with schooling. One of the things we are focusing on what is upstream efforts and how do we get our kids who are in grade school interested in careers in mental health. We want to start there. By the time you are recruiting from colleges and people have already selecteded their path and there was a focus. I am looking at kid as little more upstream. Whether they are in elementary school. High school. Really having partnerships with the colleges and university. To develop early on a work force pool.

Look rg at residency or internshipses and increasing opportunities for folks to be a part of the system as they decide the career path. Financial incentives that work to recruit folks in the system. And also retention to make sure we are a xetive employer and we are attracting and keeping the right folks that we need in our system.

Training and technical assistance. And making sure DMH work force receives training. And have skill building and stunts to really hone in on our craft. Next slide. Looking at housing work group. What services are need today keep folks houseded. Street outreach. Service quality. Improving quality that we provide within our housing resources. Creating a more variety type of housing.

Whether it is short term housing, long term housing, permanent housing, we want to ensure we increase housing options and then identifying specific populations we need to target within underserved communities or underserved populations to ensure that we have housing resources and supports available to those communities.

Finally our continuum of care work group. They have four focus or priority areas. Emergency response. And improving our work with our first responders and ensuring that folks that need immediate care receive those emergency responses timely. Increase or expanding psychiatric beds. For individuals that need that level of care. Full service partnership. And looking at the efficacy of full service partnerships. One of the thing that is I know with prop one. There will be a focus on the levels of care wb full service partnerships and the work group did have a focus there.

Access to quality of care sxen suring that the services that we provide are quality and do provide what folks need to address their skills.

Next slide.

I brought this up a little while ago. The theme across all of our work groups of course is starting with equity and we made a very intentional effort to look at equity mapping tools and getting, share a little bit about where the kids are placed and had where we have the highest level of need within communities and really identifying equity concerns across our work groups.

Looking at access. Ensuring awareness of service availability. Going back to make sure our outreach is really good. With the prom tors and our community based platforms and prevention that people know where services are available the to them. Working to increase access for non English speaking communities and making sure those supports are there. And always making sure the services reflect the accountability and we are looking at outcomes and quality and we are collecting data to inform us where service gaps are and that we are accountable for addressing those service gaps as we can.

After going through the three phase process with our stakeholders and ensuring we come out with a set of recommendations our draft plan did best reflect some proposed changes and I want to highlight that we are now moving into a territory of implementation and before I go through the proposed changes and I will be brief on that. I do want to share with the commission and those listening that our stakeholder process is now looking into that implementation window and the meetings from this point forward will focus on the the, the proposed recommendations in this mrap and what is the department strategy and process for making sure those recommendations get implemented in a the timely fashion. We do know we have two years and so we really looked at programs that could be implemented within that

two-year time frame. Especially with the looming prop one changes and so we are doing a dual thing now with the stakeholders and implementing and also looking at how prop one will impact us going forward.

Some of the recommending changes working by work group. Again, CSC and looking at lower levels of FSP and how can FSP not just serve folks that are critical but looking at how we have stepped down opportunities or efforts of care within FSP. Wrap around -- FSP? Lower levels of care within FSP. So FSP has always been our very intense level of service and we are now looking at what are some step down options and still keeping folks enrolled in FSP.

Wrap around having FSP as a wrap around program, again, a lot of work around FSP and levels within FSP. Expanding PH square Kalene mentioned that program earlier and working with that program to expand opportunities for clients to get services through that option. Adding peer support. Programming across programs. The use of peer support across programs. And access network. Integrating mental health services into existing programs and that was a recommendation. Information to access for culturally and linguistically appropriate service ins a timely manner.

And then investing in metrics. A lot of work around data and improveing and providing more detailed data to the stakeholders and we do want to invest in equity matrix measures that allow us to report out on that. Focusing on health, income and education. And disparities.

Also for our CSC work group. Proposed changes including expanding navigating teams. Our service area navigators investing more in expanding that program. Investing in media campaigns and awareness. We heard a lot from our service areas and our SALTs that we need to do more around having more advertisement and letting people know we are here both in outdoor media and we know we do well and also looking at social media. Awareness web sites. And expanding in that area. CSC recommendations also include our housing and cap facilities on the housing front. There is a recommendation to increase the flexible housing subsidy pool. Those are the dollars that we can use to pay rent subsidies for folks that need that while they are in permanent housing resources. For capital facilities and tok logical needs there is a recommendation around the children's community care village. Investing in capital facilities for the unhoused and IT investments. Being able to report out and collect data and improving our reporting of outcomes.

Our final housing our continuum recommendation is around expanding peer RESBIT programs to support individual who is are at risk of losing housing.

In the prevention work group the recommendations that came out of the work group would be to contract with a third party intermediary to facilitate CBO funding for prevention projects and I can share, we have done already a lot of implementation work around that recommendation to, in addition to, the support that is we give CBO through the incubation academy to have a third party that we are able to bring in and work with more CBOs to provide them funding to do the services that they do best in the communities.

Also within prevention implement child and family teams to help maintain stable placements with family and to fund CBO to do the work. Another recommendation explore how to increase awareness and communities through promoters. Focus on outreach. Awareness campaigns and media and social media. Provide wellness centers that offer community support for people who have substance use occurring, mental health and substance yufs disorders. There is a recommendation to increase work there. Expand our services to TAY who are not enrolled in colleges and university. If they are struggling with school and want to have the opportunity to extend their education. Opportunities. There is a recommendation to expand services in that area. Increase accessibility for training individuals with disabilities to ensure that we are meeting their needs and that service delivery staff do, are able the to meet their needs to ensure access.

Finally our work force and education work group had four recommendations. Explore developing strategies and this is the recommendation to provide more upstream recruiting our educating individuals when they are in middle school and high school about potential careers in the mental health field and reaching out to after school programs to do the upstream recruiting and education. Explore marketing and career campaigns that focus on high school aim kids and exploring opportunities for community colleges and creating better more clearer path ways for them to be a part of the mental health system. And finally, again, the focus on loan repayment and financial incentives to not only recruit but retain our work force.

Those are the recommendations that lu see reflect nd the draft plan. We are moving into a focus with a stakeholders over the next month to June to get feedback about implementation, time lines and what are the avenues for getting these recommendations out. We look forward to your support of the plan and feedback and recommendations and then, of course, we have our board hearing on June 4th.

>> MICHAEL MOLINA: Great. Thank you Dr. Horn and thank you Kalene. Go ahead .

>> I want to make a couple of notes on the observation throughout the process. You will see we started with a large number of recommendations. What you see in this final list here are thing that is are different than what is already in the plan. One of the things that we realize is we have a lot of service that is folks aren't aware about. We got a lot of recommendations that came forth that could be reflected in work that we are doing for example training or working with law enforcement teams. Or having sometimes some of the specialty services. One of the big recommendations that came out of here and what we came out with is understanding we need to do a lot of awareness raising around our services and not just the high level but figure out how to work with communities and help them identify and access services and not just mental health service but the community services that are available to them. This list of proposed changes isn't the only thing we are doing there is a number of recommendations we identify either we are already doing or are thing that is we can do without additional funding or changes to the plan.

An example might be a recommendation around training landlords with working with people with mental illness. Doesn't necessarily cost us p funding and that is something the housing leads and it stayed as a recommendation. And it isn't necessarily a proposed change in the plan. This isn't the full extent of items we heard and are moving forward with. And that is one thing I wanted to share.

In the process of bringing down, you know, I think condensing a lot of these. We did lose a lot of the specificity and I want to acknowledge that is significant to stakeholders who express concern. We as a group identify specific community that is we want to see served and had we want to see Spanish language work or immigrants and there were a number of programs we saw, when we brought those altogether the specificity needs to come out the other side as we do the analysis and implementation piece. It is our job to put t that p back in. What we are looking at is expansion of full service partnership and when we start to look at the expansion it is the where and who of it. And that is the analysis work we need to do now as we, we have just finalized this list. What is going to be important is working with stakeholders to identify metrics. That we are going to work on. How do we know we are successful and we are getting there and that is going to be part of the implementation work and we will take the time in the next year to look at existing programs in more depth as well. Not just add to go FSP but what we are doing already. And I want to make one comment on proposition one. And I know there is question how it influences with what happens to proposition one with this plan. As proposition one has passed implementation date is July 1st, 2026, and this plan is in place until June 30th, 2026. While we don't have to shift our categories as part of the plan. Knowing prop one is likely coming did influence our discussions and did influence the programs we consider what we can add funding to. The proposed changes we are look at using unspent dollars and we have to think about what do we have funding to continue post July 1, 2026. Are we going to start a program we might not be able to continue. We have to be mindful as we identify some of these and sometimes that was the decision maker for things that we might have identified and we wanted to I a line these recommendations with department priorities and board priorities and priorities we identified in the data and also think about feasibility and on going sustainability. And that is where you see something like peer RESBIT we know we have a housing category. Expansion of FSP where we know we need to expand FSP. I want to put that out there.

>> MICHAEL MOLINA: I am glad you did. Thank you to both of you. It was a terrific presentation. Very detail and had that is what we need and had such a difference to what it was six years ago when I first started on this commission and reason why it is so different it is because of the input of t community planning team. So many people and stakeholders participated including commissioner Stevens. Commissioners my thought is we go to public comment now and that may inform the questions or comment that is we make. Let dos public comment and before we do that. And I think especially for the newer commissioners if you wouldn't mind if we turn to page 241 so we understand the magnitude of the program in front of us and Dr. Horn or Kalene can you answer for 24\25 how much income are we going to have and number two how much are we going to spend? Page 241 exhibit A the budget. I think it is important to get a sense of when we talk MHSA what are the dollars we are talking about. First question what is the available funding for 24\25 .

>> Available funding for the report is 1,226,000,800. I a m sorry I am looking at just CSS. Sorry. One moment I need to find the right line. It does not look like we have a total listed here. They are added up. In community service reports we have 1.2 billion. Prevention and early intervention. 363 million. Innovations 281 million and then we have under work force education and training 36 million and facilities and technological need ss 127 million. Forgive me for the length of time it took for the response.

>> MICHAEL MOLINA: All added up is a grand total of our funding for the next year.

>> Correct.

>> MICHAEL MOLINA: And in the second column what would be our expenditures? Projected expenditures of that money?

>> Projected expenditures are listed under community services and supports and includes outpatient and FSP at 757 million. Prevention and early intervention 271 million. Activation 76 million. Work force and education training 24 million. Capital facilities and technological needs at 76 mm.

>> MICHAEL MOLINA: I want to highlight the page it identify it is magnitude of the program and reason why it has taken a year to get to this moment and now it sits within the commission for the next couple of months as we look at the various recommendations that are so well described in appendix C I think in this draft plan and that way we are all encouraged for the next month or so to use this as the nightly bedtime meeting to look at each of the pages and craft our response the letter we send to the board of supervisors attached to document. Thank you Dr. Horn and Kalene and we are going to move to public comment.

>> This plan is available online and it is available on the mental health commission web site and available on the DMH general web site and we also send out bulletins where this plan was also shared. And it was afls shared on the live broadcast link.

>> MICHAEL MOLINA: Great. We get the ATT operator queueing up folks online. In the meantime anyone in the room present that would like to provide public comment specifically on the MHSA draft plan? Public comment on item number 5B. MHSA draft plan specifically. Public comment on this item.

>> So thank you for having us hrl today my name is (Indistinct) I am a native American latina mother of seven grandmother of four and provider for the past 16 years today I stand or sit before you to advocate for the inclusion of parents anonymous an amazing organization with rich history of services and impact in our communities since 1969. Parents anonymous has been a becken of hope for diverse parents children and youth offering evidence based programs and supportive services that have positively transformed countless lives. Parents anonymous evidence based approach is not only recognized locally but supported at the federal level through the inclusion in the federal clearinghouse for evidence based practice. This acknowledgment underscoreses the effectiveness and legitimacy of parents anonymous programs. Which have been evaluate and had proven to deliver tangible result ins improving family dynamics. Mental health and overall well being. Despite the proven track record and unwavering commitment to servicing our community. Parents anonymous was unjustly excluded frd the recent mental health services act with MHSA 24\26 plan that decision not only overlooks the valuable contributions of parents anonymous and undermines the integrity of the decision making

process within the community planning process CPP. As a CPP member who attended almost every single one except one because of my brothers passing due to mental health. I was appointed to be on CPI subcommittee and USCC and parents anonymous has served diverse parents children and youth since 1969 despite the on going commitment and submission of proposals by the deadline established by DMH there has been no contact or follow up. Further more parents anonymous was unjustly eliminated from the MHSA 24\26 plan despite knowing, having a three-year contract with DMH to provide services via a master agreement starting in 2019 for seven years. The importance here that I am saying to you all is parents anonymous be put back in the green and doing so if it is not you are failing hundreds of thousands diverse parents, children and youth. And I wanted to throw in there because of this organization I stand here today celebrating 18 years clean. Maintaining my mental health and stability and it saved my sons life. My daughter who was held hostage and her mental health. It saved her life and not only that it made the cycle of mental health within generation of my own family and those that I know completely break that chain and we are strong advocates here today because of it.

>> MICHAEL MOLINA: Thank you for the important message. Thank you anyone else in the room wishing to speak? Please come forward. Good afternoon .

>> Good afternoon. I am senior research and development research with parents anonymous and also a member of API USCC and I a tended the CPP meetings and I am here to address serious concerns regarding the community planning process for the MHSA 24\26 plan and impact on organizations like rn parents anonymous and let's talk about the methodology or lack thereof. Throughout the process there is absence of any methodology. Instead of diving into the specifics of each recommendation decisions were made based on whether stakeholders agreed or disagreed with categories of recommendations. This blanket approach (Indistinct) each recommendation. The dollar or the dollars on the table. The budget that usually asked about today that wasn't discussed in the beginning and we didn't know about in any of that. Leaving stake hold every rs in the dark about the data and evidence behind all of the recommendations. This process is meant to be more than just going through the motions. It is b about listening to the voices of all of the community members regardless of background or experience. And yet CPP failed to do just that. Let's talk about parents anonymous. Despite having a master agreement with the DMH the organization was inv deemed eliminated in the current plan. Proposal submitted by the deadline established by the DMH and it was acknowledged asked and there is no contact or follow up since. Parents anonymous was eliminated saying it didn't meet the guidelines which isn't possible since there is a three-year contract with the DMH to provide services by a seven-year master agreement since to 19. Organizations like parents anonymous have been supporting the empowerment of diversion parentses children and youth since 1969 and has been support nd the federal clearinghouse and I would recommend that MHC take a look at all of the points and make changes.

>> MICHAEL MOLINA: Thank you vchl. Next speaker please?

>> Hi again. (Indistinct). Primary focus on my unlawful detainer. And landlord awareness for mental health is awesome. (Indistinct) and domestic violence and in my minutes at court they said, the court at the the hearing that my evidence was not going to be allowed. I had a voice recording at two in the morning from my landlord saying get rid of the cat or get out. The cat is is my best friend and towed four of my vehicles. I was asked to sit down and mote with his attorney I didn't have legal representation and I was by myself and I met with the attorney and she said because you didn't file the documentation you are not table to admit any to the court. In the minute order it says request continued made by the defendant was heard. Motion to continue by defendant is denied. I have been in a mental health crisis since the induction of my 15-year-old son who is a gang leader arrestd with a loaded firearm. I was dealing with this by myself and lost my apartment and couldn't get a continuance in court. Path ways of hope is my service provider and defendant walks out of the kourtd and states dos what you have to do. And court state as default hearing. And this is on my record and I want to thank the planning commission for hearing my statement the last meeting and providing landlord awareness. (No audio). (Audio disconnected).

>> Thank you for letting me know the no audio.

(Audio is connected).

>> We are back on.

>> MICHAEL MOLINA: We are back on? Three more minutes .

>> We are take ago five-minute break and we will be back 1:14.

(Break until 1:14).

>> MICHAEL MOLINA: We are reconvening the meeting after a short recess. And we will continue with public comment. Anyone left in room in-person that wish to make public comment? Daniel you have someone? Come forward please so we can continue with our comments.

>> Goods afternoon everyone I am with NAMI urban LA. Just appreciate you having this space today. I had the pleasure of p being a part of the community planning team for this stakeholder process. And I want to, just share some reif flexion that is the process was really powerful in a lot of ways and just the time invested; the effort, I just want to uplift that RIGO rod regez was an exceptional facilitator for the conversation. We had a diverse group of people who got together discuss proposal ideas and I want to share in look at the presentation today it was great to see some of the recommendations presented here and also it is a very limited work at what happened in that space. I just want to urge the commissioner to consider all of the proposals that all of the recommendations that were shared in the fuller, I am sure

you have the big one that you are referencing. Just to keep in mind that the ones shared today, while there is a lot of consensus that went into representing those. They are not fully representative of what some of the robust discussions and em passioned conversations that were had on the team and some of the ones that didn't make it to the limited look and I want you to consider those and as Kalene mentioned a lot of specificity is lost when consolidating to the recommendations here and some are where the most pressing needs are. I can't say that enough. We see the gap between the ARDI need areas and that is just a very limited look and then the services that were provided. I think a lot of that. A lot of those needs are not going to be addressed until we get specific and name the population most impacted by some of the gaps and I think taking a deep look at the recommendations you are seeing some of the community members it took a lot for a lot of us to be at the table so consistently. And, you know, we did that for the community that is we represent and I want to encourage you to consider those and lean into the specificity and make room for that. Until we name the populations that were impacted we are not going to see the gaps closing.

>> MICHAEL MOLINA: Thank you very much. For your level of commitment and the time you shared with us. Let's move the to online. Kenya anyone with the ATT operator ready to make a public comment?

>> If you have a comment press 1 and 0 at this time. We will start with line 44 please go ahead .

>> Thank you my name is Hector ra mir ez and I am LA county consumer and mental health clinic here in chats worth and my comments are as a consumer and I participated in this project since the succession and I think one thing to take away from this it was a good attempt and it shows perhaps it is failure. Up until a couple of minutes ago many of were having joining through Microsoft teams and we couldn't join. We call and had couldn't e-mail the department and we didn't get a response. While the department and staff could say they have accommodations and services for us to participate. The fact is that many of us don't have access to them because of the technical difficulties we are forced to deal with through Microsoft teams and then definitely some of the attitude issues we had with the facilitator particularly for people with disabilities and our Spanish speaking communities who felt very much not only mafrj liezed but discriminated and had unfortunately in our access for all. Our consumers have stopped participating in those groups and two of the cochairs resigned because of the retaliation and hostility. Not only towards disability but some of the members try to support and advocate for some of the other priorities that is are not included nd here and for those that are new. Think that this particular document is an example of why prop one was kind of passed forward and while it talks about equity and (Indistinct) and doesn't have accountability and is lose sight and had doesn't show the contributions that the community did or mention the deficits it encountered in the process and other they think it is missing sg specificity in the to how to clearly articulate some of the things that are going to be worked nd implementation. Particularly given the fact that the recommendations from people with disabilities in our access for to, and -- not included in here to resolve and follow up with that really look forward to making sure that is include and had (Indistinct) an example of how this report, similarly another community. The access for all USCC which is represented here and I am cochaired of is not title correctly. To say the community and you don't write about the community group the way it is. It shows a significant disconnect.

>> MICHAEL MOLINA: Please wrap up sir.

>> Thank you. And as a consumer I ask for more transparency and hope that moving forward things are corrected. This has been happening only since Dr. Sharon left and we don't understand why the department has taken that particular bias towards disable and had Spanish speaking communities.

>> MICHAEL MOLINA: Thank you for sharing your concerns. Operator next speaker please? Next go to line number line. Please go ahead .

>> Good day my name is (Indistinct) representing black Los Angeles county client coalition Inc. Key struggles for the plan include concerns over homelessness. Funds to help capitalize and reinstate the housing trust fund advisory. DMH to support development of supportive housing today to keep pace with the crisis in our communities we need immediate ready for occupancy dwellings. Housing and investment not 2 or 3 years. Housing units down the road. The importance of reestablishing the housing trust fund to support the development of homelessness. Transitional and permanent housing for the homeless and unhoused. The critical need to produce dwelling in our restored buildings immediately and substantially without delay. On site support services for special needs to leverage we must explore long term commitments and investments for the housing. For the unhoused for the challenges facing us today thank you.

>> MICHAEL MOLINA: Thank you very much. ATT operator next speaker please?

>> Next line 21 please go ahead .

>> Thank you this is dlchlt Lisa pine in per listen and parent and CEO of parents anonymous. Thank you for listening and I am sorry I couldn't be in-person. I object to the utilization of the model and CBP process for several reasons you look at page 56 and parents anonymous for example was included by the PEI committee in the plan and the discussions we have been around 55 years providing evidence based mental services to diverse parents children and youth in this county. All of a sudden after a meeting in February the department decided to red line it and say by their definition we do not mee the MHSA guidelines that is impossible since we currently have a $600,000 3-year MHSA contract with the department. So the application of red lining parents anonymous out is not factual and not fair. It meets the guidelineses and by the way we have a seven-year master agreement we are already approved to do MHSA PEI work. We do not know, for example, in this complicated process what the rational for this. We asked for several meetings and we got no response and we also put in a proposal on 1\15\22 as required by the department and never scheduled a meeting to have a conversation at all. The process we believe is very truncate and had the CPP process never moved it had meetings around. How do you engage a county that is 55 miles long and wide and force them to come to a location downtown. You are not looking to get the community involved. To ask parents, children and youth to appear Monday morning is impossible. Many advocates not just us are asking why don't you move the meetings around the county which

is done over andover again. Get t the input and ask the community what you need. Last part I want to make about accountability. Thank you ka lean for talking b about the amount of money. But the 365 million for PEI or 255 million or over 1.5 billion in the reserves that Los Angeles has. No other county has reserves like Los Angeles and that is online you report and people are suffering and we do not know how much of the proposal is going back in the coppers of the county and how it is going through the community based organizations in the community. Thank you very much .

>> If I may Alex can you check the Spanish line please?

>> I will check that right now. This is Lucy your interpreter. O other interpreter will take over now.

>> MICHAEL MOLINA: AT operate ere next caller please.

>> Line 50 .

>> Good afternoon my name is Sidney SALT seven and new cochair and along with YVONNE I attend it had mens mental health picnic in nor walk and I will say I will be attending my next future meetings in-person everyone have a nice day and a bless Easter. Good day. Bye-bye.

>> MICHAEL MOLINA: Thank you very much. You too. Operator next call please?

>> We have no one else in queue wanting to speak.

>> MICHAEL MOLINA: Thank you very much one final speaker in the room wishing to be heard. Go ahead ma'am .

>> Hi again the MHSA report is great and it is a report that has been established by a mental health commission on October 7th, 1957. It is a repeat unfortunately. You are just brushing it up. You are not really implementing what was established back then. The discharge plan. Hospitals and discharge patients. There is no safe discharge plan. My daughter is a good reason. I am sitting right here you don't have to go farther away. Landlord. Law enforcement you mentioned they need to be educated. How about our businesses. How about you yourself the mental health employees themselves are out of touch. How about restaurants and all businesses who do work with people. They need to have some kind of mandatory required training like diversity.

As the one speaker who experienced about her hearing and her voice was not heard because of her son and all of that stuff. Guess what it is because of lack of patient advocacy. We need new advocates and not the patient right frs the mental health department. No that should be off of t table. Right t now I reported about two months ago. What are you doing still? They should be off of the case. But sadly the relationship that is excludeing patients from participating in probate hearing. I was deny and had I pushed it. It should be, they should be removed immediately. If you didn't do it. Housing issue. If when loved ones are not allowed and had my daughter as sick as she was, she was not allowed to be added on the list. If (Indistinct) doesn't have a heart. Maybe you should bring here. They should be educated.

>> MICHAEL MOLINA: Thank you very much ma'am. One Mr. Speaker? Come on up sir.

>> My name is EZEKEIL and community member and to speak on the proposal they are great. If not many people felt like they were heard and lots of things got done and we pushed through lots of arguments while we were at the meetings and I went to every one of them. And I felt like I was a r part of it and it was a great experience. I hope there is more of things such as this because it really gets the community involved. Everybody can nitpick and when you nitpick at something you will find something wrong this was something that was brought together by the community at large thank you very much.

>> MICHAEL MOLINA: Thank you very much. Great to hear that. Thank you. All right I think we are -- anyone else? All right. We are going to close public comment and move on the commissioners comments and questions. Commissioners again especially for the newer commissions our job is the following this plan is transmitted to board of supervisors accompanied with a letter from this commission. Our goal is to generate that letter. It could be as simple as board of supervisors fine as is love the commission or includes as series of recommendations. Concepts. Concerns. Relative to this plan. Our job in the next two-month ss to generate that letter. With that in mind, keep that in mind as you ask questions or seek clarifications. Instruction to the commission is the following is o we don't violate a Brown act talk to go each other. If there is recommendations concerns or exclusion you would like. Send to Kenya and we will start to generate a draft letter that is distributed so everyone can read it. Rather than you sending to me and I send to you and we all start talk to go each other. It is better if there is a clearinghouse and that is the executive assistant Kenya and we will talk today if there is issues Kenya is the taking know ts and it is found in the letter. Subsequent to that as you are reading the plan over the course of the next month and have other issues that you would like included please address the issues to Kenya so that we can adequately and in a timely basis prepare our draft letter. Commissioner?

>> I want to be clear that all of our recommendations will be sent to Kenya. Is it possible that it would be sent to Kenya and? Would you be included? Brittany included? Someone else included in the e-mail that is going directly to Kenya. I don't think it is fair to just only to send it to Kenya. I think you should be included in the me mail.

>> MICHAEL MOLINA: If you wish to include me that is fine I ask you not to include any other commissioner rs because I don't want to break any Brown act rules .

>> Not a problem I think that is clear. Can I keep talking?

>> MICHAEL MOLINA: Are you ready to start asking questions?

>> Yes.

>> MICHAEL MOLINA: Commissioner Stevens go right ahead .

>> Thank you for the presentation and I mainly want to address then community. Those who are online. Those who are present here today and also those who have exited the building. For showing up today and being a part of the process. I will say I had some expectations this morning upon coming here that the room would be packed and I am somewhat disappoint and had on the other hand not necessarily so because being a member of the CPT I think one area I will ask the commission to consider as a recommendation is understanding not just the number of people that had seats

at the table for the process but how many people participated that had those seats. I believe that even that was, there were a lot of gaps there. And attendances and commitment in that process and in addition to that. I do see there was a disconnect regarding the service area groups and I can't speak for all service area grouches and I don't attend all of them. And I am certain some are, you know, we are different. There was clear broad communication about the process and getting input. Too oftentimes we are and I am speaking as a commissioner and service area chair at the same time because of the experience I am currently having. That too oftentimes that the communication is, there is such a huge gap tlp, because we are not really educateing and informing but in addition to that collecting feedback. If I am representing a group. I shouldn't just be the only person who is showing up and speaking up. I should be also having conversation. Collecting information from the broader community that I am representing and then bringing that voice to the table. But also encouraging others to attend.

Moving into this beautifully, colorful, what is it called again? Summary. There are some concerns I have in how data is collect and had sent out. For instance we do know in DMH we tend to operate by way of service area groups. However, even on the very first page where we look at and I will just uplift and highlight. Service area six and poverty. And service area four and homelessness. We know that across the county of Los Angeles there is great need and disparities. It is this somewhat problematic for me and I would hope we look more at regional. If we look reejly you are going to find the second vooup I have sor yal district has the largest number of unhoused residents despite what is happening on skid row and it is important as a community to be educated and informed that homeless is no longer concentrated in skid row or bottom of service area four it has grown across the entire county. We want to highlight service area groups and we should also address the region. And I think the region, I believe the board of vooup visors would also appreciate that. The other is when we are look at high needs in reference of the needs assessment for spa 1, 4, and 6. What are we doing creatively and innovatively to address those particular service area groups by way of education and by way of looking at how we change that. We can't change it if you are not in space. And I would hope that your representatives would be more actively involved nd the service area groups to ensure that this data actually changes.

>> MICHAEL MOLINA: Can we, we will come back to you. That was three for you right now. Let's come back. Commissioner FRIEDMAN?

>> Thank you very much for the presentation. I know it shows a lot of hard work. And I wanted to ask Dr. Horn. Do you feel that you had a representative community? Are you happy about the number of so called, the people who contributed to this whole thing. Do you feel you had a represent I have group of people? I remember in years past before the pandemic we would meet in a huge room and there were hundreds of people there. I expected like Reba this room would be filled today and maybe the department is not communicating to the general public what is going on. How are people educated about what is going on and why do not we have more people here?

>> To answer the question whether I am happy with it. I am happy with the intention and the effort to broaden it. You am not very happy about what mentioned which is the pafrpgs. It has been a really and I can say the department, we have blessed that there is about 1300 people right now on the e-mail blessed list which is amazing and we just started that maybe not even six months ago and we have pushed it and pushed it. Please get on the list and go to the SALT and tell them about the meeting and say please participate and from the deputy office reach out to sister departments and please have folks come and represent your interested departments. From the standpoint we make the push and consistently done that. We have done that and it has been hard getting people to the table. COVID and not just for the stakeholder process and I think we all have experience, it has been hard to get people back sxout back to many different tables and so we are working on that. There was a lot of talk about the SALTs and the push for the SALTs and being more intentional b about getting out there in the community and creating the ground swell. That is really where it happens. And where, if they can commit to that they will then commit to this.

I don't have a good answer to that. I am happy with the intent. But there is a lot of work to be done.

>> Remember we use today meet at saint Anns.

>> Yeah. Hundreds of people. Even this room for a public hearing would have been filled .

>> If I can make a comment this is Kenya. The commission has a bulletin that goes out and these are people that sign up on their own to be on your mail list and that is about 4,000 people it goes out to. As a commission you are also making that effort to get this more out. We also have people that are watching the live broadcast. It could be a matter of some of them having that access. I want to let you know commissioner DALGLEISH has her hand up.

>> MICHAEL MOLINA: Commissioner MANALO .

>> Thank you very much Mr. Chair Dr. Horn and Kalene I want to congratulate you on completing what has been a very complex and challenging ask and difficult process. The report that you presented I thought it was very clear. And although I still, I would love to kind of delve into the weeds with you at some point in terms of data collection and looking at some of the issues and I know we can do it at a later time and I will not bring that up, right now.

I want to ask you and obviously today and over the last year, you have some sense of what has worked well in the process and what hasn't worked well. Kalene you mention about the potential impact of prop one and I assume there may be a similar process that may be occurring as we get closer to July 1st, 2026. And how DMH is going to implement. Obviously I am not giving a lot of time to think about this. Have you thought about things you are taking away from the process that are going to help to form a similar process that may occur in the future when it comes closer to implementing prop one?

>> My first piece of feedback is we will have to start to use this structure and planning process if for prop one in 2025. When we begin to plan for the next three-year plan it will be under the prop one rules and the expectation is that we will start this expand planning process.

It is something that we need to be thinking about right now. As I noted in my comments earlier. I am really grateful for the structure. I think that we have set up. The representation piece and as Dr. Horn has noted there is work to be done to make sure we have if got better representation at the table from various communities, agencies and needs. That is an area of need and I really do think that this structure of walking through data and what is important in LA county and having the opportunities for smaller conversations and almost work groups to dive into certain areas has been effective for us. I think approaching all as one as a group. There is several technical pieces to proposition one. We need folks with various backgrounds, interests and passions to help talk through these things and what I think we are doing right now and learning from the process. The technical and logistical stuff. What works and what doesn't. This is such a tremendous accomplish sxment I want to acknowledge Dr. Horn and here her team that is now fully staff and had I think that is one area too we see a lot of improvement in participation. I think that will be the overarching. Here is the data and here is context and here is background. What are priorities as a group and the major metrics we want to look at and start toe dive in and invite people the to the table for those discussions.

That has been an effective formula for us and I think there is more to think about that is off the top of my head. Anything you want to add?

>> Key take away from what works and doesn't work is doing the ground work. As Kalene mentioned I am es static and my team is fully on board and had many of you have already witnessed and they have only been around for a little while and they are connected today each and ere SALT. And connect today the faith based initiatives and round tables and they are connected for that reason they will monthly be able to keep the conversation going. It is not just you coming to the stakeholder meeting once a month. If you made it to saint Anns to join into the conversation that is wonderful. However we will get that feedback on a regular basis at that very local level to be able to inform the conversation.

That is where we are if going and my take away from the process .

>> Thank you very much and I appreciate you identifying those things and seems that you have a very active, committed group of stakeholders and team members already involved and we need to kind of maybe survey them and say what makes you show up? Why can't with eget other people the to show up and maybe they have answers for us as to what we can do to do better and more effective outreach. Especially to some of the groups that need to be represented. Thank you very much and I appreciate you keeping that in mind.

>> MICHAEL MOLINA: Thank you commissioner. We will go commissioner Austria and to commissioner DALGLEISH.

>> I want to thank you for all of the hard work and I know you worked on a lot of improvements and improvements have been made although there is some gaps and one of the questions is around, you are dividing by equity quite a bit and I know that is a priority of the second district. I can't read the equity here. It is not really, the funding isn't divided up. And recommendations are not necessarily divided up from where they will be implemented.

While they are, it is wonderful recommendations and I don't know where they will be and I know you are still in the process and we need to know where things will be implemented. Where they are going to be planted. The seeds. Is o that we can tell and, again, it is not by spa or SALT it is region and there is overlap and we have to look at the whole county and district and we need division budget wise and location where the recommendations are implemented and had where things are currently now. My other question you have a color designation green red and yellow nor the ones in the red that didn't fit MHSA and there are quite an if you reds and I think parents anonymous felt they were under the red although they may not be. And I am asking and it is a gap and MHSA can't fill all of the gaps but the mental health budget doesn't have quite a few other line items and are people refer to the right area of the budget they should apply for or contracts or to the incubation academy and I don't want people to show up and feel like I am not being listened to after all of that. Which would decrease participation.

>> With regards to putting folks on path ways. That is very confusing. What path am I taking if I am a CBO and I come to the department and I want services. You are all familiar with incubation which incubation academy which is meant to be around small grass roots CBOs that need training and capacity building on how to provide their service and they were already connect nd their community and give them some stipend money and train them. That is a temporary path way and not mnt to be a permanent path way.

We are at this point creating interim path ways and I mention earlier when I was speaking about the CBO path way and we are going intermediary and work with the CBO that are not necessarily as small and gras roots as we intended for the CBO that went through incubation but more CBO that can provide a service and have a contract and can work with a fiscal intermediary to do that work. We have our legal entity path way and most CBO will come and say to us I want a legal entity agreement. The issue with that the legal entity agreements are about Medical providers and reimbursement services.

I think they want a contract and they are not clear on, that may not be the path for your agency. We are working more with CBOs to clear up what door, what funding, you know, where they best fit so they don't feel they are spinning their wheel sxings unfortunately many thought incubation was the right way. T they were more advanced than what incubation was design to provide.

You will see more of that commissioner. And you all will. As we bring on the fiscal intermediary board and we begin to offer the opportunities to CBOs that are farther along and have a different path and maybe not a Medical provider path and we plan to do it in the future. I will turn to Kalene to talk about the --

>> This was, I will start by sharing with so many recommendations one of the first things we want to do is make this system pl to follow. The colors had multiple meanings and not just one. I want to be careful about a narrow specific

interpretation of each. In some areas we need to acknowledge we might share things verbally and making clear in writing is where we could have done something better here.

Green typically meant we are already doing it and maybe we will expand it and maybe we will tweak it. Green is more of a, a reflection of things that we are continuing or already doing. Yellow is a reflection of things that, and thing that is we may consider doing. It is possible. It is in the, within the realm of us and some of the considerations that went into making something yellow verses red. One is MHSA. Is it eligible as an MHSA program? It is not the only one. Also is it a priority with the county? Is it a program we can launch in sunset or sustainability past July 1, 2026. There is a number of program ins the early intervention area and we don't have enough information going forward and in this case and many cases for folks in the red it was more about what we can sustain and not that a program was not capable of being funded or couldn't be fund and had this process was very specific to not just the plan as whole but to the excess funding. This is a one time dollar fund we are talking about. We are not talking about the whole base bumth as a whole. Some of the officers and I am not just referring to the one speaking today. Some of the organizations also have roots to be funded just as a PEI provider with evidence based practices and all of those paths are still open. I think that is clarity we can do a better job next round .

>> I think that is important people know if I can't go this path there is another path. And the last comment and I would like to know how areas were pick and had the Microsoft teams issue people identify as a barrier to accessing the meetings I think that is something that needs to be addressed and had I know the county picked that overall and I know it was a county employee it was easier for me to get on team than it is on Zoom. Now I am not a county employee it is easier to get on Zoom and Team ss a barrier and I want to point that out.

>> MICHAEL MOLINA: Thank you commissioner and we will go to commissioner DALGLEISH online and after that commissioner Sandoval.

>> Hi. I appreciate the reports as you know. I said to Dr. Horn and Ms. Gilbert in the past and I think this is the best we have had. Some of my concern about how we are getting this message out include if you go to the landing page of the departments web site. There is no mention there of the budget. And in order to get to it, and I have tried on numerous times to make sure I am correct. It takes several clicks to get through and you have you to know where you are on the site and how to navigate to it. When I went around and looked at other counties around the state I noticed in many situations it is on the landing page. Or, it may not be at the top of the landing page but it is on the landing page and I think that makes a big difference.

Also, I don't know who the 4,000 people are on our list. That is great to hear and I was unaware of how many people were on the list until today and thank you for that information. I know it for myself in the past. I always received a hard copy of this document. Either in if a three ring binder or bound. This year instead I requested it several times and I still haven't received it. I did receive a box with the document in loose paper. For those of us who want to have a hard copy to work with. It needs to be provided and I nor anyone should have to keep having to beg for it and not receive it in time to be able the to look at it and review it thoroughly.

Another thing that I think it is important for us to think about moving forward is I have have attended several of the SALT and USCC meetings where I have seen their frustrations. Especially with with the SALT and with the USCC it is less so. I don't know why. But the SALTs have struggled to spend this money. I know for SALT six they had a meeting where many programs were approved and then suddenly they were deny and had if we are making people feel that they can get money out of the MHSA budget and then they go through the work to apply and than are turned down with a deadline looming. Just as happened last year. We can't really expect people to not be frustrated and just give up. Is so I am not really surprised there arenn't as many people in attendance and I really hope that we can figure out a way to make this better for the people that we are all trying to help.

I guess the last thing I would say is I am curious to know how many people are on the live broadcast since that was mentioned I don't know if this is something we can assert tan. I do know we did manage to push out a lot of the contract agencies a few years ago when we emphasizeed having stakeholder involvement instead of having more of the contract agencies.

So anything that we can do to codify making people want to I a tend and making sure that when this he do attend that we follow up on what they are concerned about and especially obvious hadly in terms of the MHSA budget. Thank you very much.

>> MICHAEL MOLINA: Thank you very much. And at this point 3 hours in how many people are on live?

>> 26.

>> MICHAEL MOLINA: 26. Thank you.

>> If I may say there is also other consumers logged into the internet which would be, could be DMH employees who are listening in. That is additional audience that is part of the constituency.

>> MICHAEL MOLINA: Commissioner .

>> Community input was asked about your guys planning. Right? I want to know if the PEI was higher than your guys I believe CSC, CSS. How come there is less funding for the PEI than that?

>> How much is the budget? Is that the question?

>> I want to know since you asked for the communities input there was more concern raised on prevention. They wanted more prevention than anything else you guys asked for but it is not the highest in your guys overall component.

>> Components and expenditures are identified nd regulations. That is the way we were directed to spend those funds whereby 76 percent is CSS and 19 percent is PEI. Sometimes it feels like we have more dollars. Sometimes we focus more on PEI because historically it has been more challenge to go spend overall it is a smaller component.

>> MICHAEL MOLINA: Commissioner ROACHE?

>> Seems like there is a general concern that maybe -- thank you for the work on this. There is some concerns about the number and diversity of representations of the workers themselves. That is fine. Seems like what recommendations had made their way into the report is consensus built upon the rp participants in the work groups. Is that correct? That is my question. Where are the other filtders. You mention sustainability over two years was a concern. What are the other filters that had any recommendations on there pushed to the wayside?

>> That is a great question. The first cut of the 17 we had identified with each of the stakeholder groups had their subject matter expert lead. The housing group is led by deputy of housing and continuum of care is led by senior over outpatient and they took those back to the unit and did compare them to. We had a list of word priorities and departmental priorities and identified which things they are already doing and they identified any of the mandate wes might have and I talked with them specifically about considering one, the amount of funding we have available for specific categories and considering then as well plop sigs one and this is, we only had two years to spend those dollars. They began to cultivate a list based on that and that is the list that went forward and basically this easy are the items that the leads say we think we can do this and might be able to put more money into this and we put that forward to the stakeholders verses consensus building on that .

>> Do you have the raw recommendations available?

>> They are in the appendix .

>> Question I have for you. The word specific comes up a lot. In your comments and as well as other folk that is spoke. Some specifics are lost. I heard that over and over again. Can you give examples of what that mean bs in concrete terms?

>> I don't have an example off of the top of my head. When you read the raw comments you will see. For instance there is different agencies or CBOs that submitted proposals. And say there was a proposal for providing ADA services. We know that the department and there was a proposal for providing ADA services. The specific proposal and maybe what they are specifically asking that is something that the department is investing in and doing is and supporting. As a concept we need to provide more ADA services going forward but you may not have a specific proposal or proposer that submitted that in reflecting. There were specifics and they were captured in the concept. Can we move forward and can we not? I think might have a specific one you want to call out?

>> One of the things that I can share you and this is one where underserved cultural community groups submitted a list of recommendations from their groups and we got recommendation frs the Latino group and recommendation frs the indigenous American group. Each of those oftentimes do say expand these p kinds of services for the Spanish speaking community or for the API community. It is the same service level and same funded service and that might be and that is a very big example and this is one of the ones that is passionately debate and had making sure we ensure cultural linguistic congruency for all of the programs and what we didn't do is breakout every single population that identified with that. And it would go along the lines of the priority or priority groups that we have .

>> Sounds like a lot of groups are still and it makes sense to me and we are already doing all of these things and groups are coming forward and saying you are not doing for my community well enough. Is this another communication problem?

>> I think we can do a better job there and I also feel like this is where we talk about the work ahead with implementation and identifying metrics and how do we agree together as a group and r start to measure where we are moving the needle on this and I think that is the next step in this discussion and especially with implementation not only new programs but the ones we have running now too.

>> MICHAEL MOLINA: Thank you commissioner. Commissioner SCHALLERT?

>> Thank you very much. And thank you very much for the report and it is amazing. I can't imagine the amount of work that goes into preparing this sort of thing and pulling it off and thank you to commissioner Stevens for attending all of those meetings and I can't imagine that either and I don't want to thank you for all of the homework that you gave us. Oh man.

I notice and I like that you are getting FSP in position to manage prop one by expanding the services it could do and that is good thinking and you can you see what is going to happen and that is great. In had terms of p people that show up. You know? I don't know how specific you want to get. If people want to show up and then I hear parents anonymous comes to our meeting and they are not satisfied. I don't know if you want to talk specifically because we are going to have two months to think about whether we want to recommend parents anonymous to the thing. But I am just needing clarification.

Are you saying that a program like that is able to use other resources out of PEI but PEI is MHSA. Can you clarify what happened there? I don't want to put you on the spot or anything. We just heard from three people about it. Four people. What happened there? That is one question. And the other question that strike me is we have 60 or 70,000 homeless people in Los Angeles county and we are serving, we are just a drop in the bucket of what we are able to, 400 here. Maybe even a thousand there and it feels like we are coming way shore t and I know there is 5 or 6 other programs. In the county. Federal programs. State programs. County programs to deal with the homeless. Just seems like we are falling real short here and I don't know if you want to talk to that or not. That is good for now and thank you again and I am not criticizing and this is fabulous what you have done .

>> Thank you commissioner and it may help and I will try to sum this up. When we requested proposals from anyone. The world. Everyone. We are running the MHSA process please submit your proposal if you want a proposal. Part of it is was we are looking at concepts and maybe not funding individual agencies. We are look at wlofrnt it is a service, program or project that could be supported and I think Kalene went through the process. We are looking at all

of the recommendations and consents and proposals. And there is many organizations and not just the organization we speaking about here. Following the process and recommendations going forward with the plan now we look at implementation. Is it a concept we can now implement based on the limitations that Kalene mentioned. That could mean that implementation falls to one of those agencies.

However it is not at an implementation phase. It was never meant to fund individual organizations. However, I would welcome a conversation with you and the commissioners b about the activities or what has happened surrounding that particular agency. There has been a lot of work and, so, I don't necessarily think that is appropriate maybe to talk about it here .

>> I appreciate that and certainly we know that parent training and there is some PEI programs for parent training and triple P and bring back more community mental health stuff. Parent and parent spovrt is obviously huge in and our new commissioner can probably talk a lot about that. Thank you for that.

>> MICHAEL MOLINA: Thank you xhegser. Commissioner Stevens to wrap it up?

>> There is a couple of things and one is I believe it is pretty consistent around the lack of real clear communication. And how huge the gaps are. Not only with this process but throughout efrlg that falls beneath you. Such as the service area groups. It is huge that gap and that gap is not just around, I don't know what your office is called. Someone call the MHSA office. Not only the MHSA office how it trickles down to the service area chief and to the liaison that supports staff and then to us or even when it is together.

I don't know if we need to be chairs in the service area groupses and maybe it needs to be the service area chief and the line staff. Or the community process. It is not a real clear community process. It is a mess. It is a mess.

What I will say is that I think what is really important is for us to look at being very creative and innovative in how we address mental health. As an example. Parents anonymous. I believe in all anonymous programses and fellowships. Why? Because they have principles and they have traditions and a foundation that is very safe for those who are participating in these anonymous programs.

It is an opportunity, especially when we are talking about participants, to be able to have real conversation and feel trust and had feel supported. There is probably some sponsorship connected to it so people don't feel alone and they are helping each other. That is a creative and innovative approach how we address mental health and our mental well being and I think it is important that we stop and p pause.

Last thing I will say and I will be quiet. I forget this thing is being recorded but who cares. What I am finding is that is most concerning is just the mere fact that proposition one just hovering. Sort of reminds me of my first initial experience with mindfulness and recognizing that depression was coming near me. That it was going to, at some point land on me and nothing I can do about it and I had to learn tools to brace myself for the impact it was going to have which positioned me the to not fall down or drown.

It is shameful because proposition one has interfered based on what I am seeing and happening all around me and I am concerned about the department of mental health and how well you are taking care of yourselves and what is that process and that looks like chlth what are some of the other challenges that you you are facing we are unaware of. Maybe there is a downsize even in this department. I don't know what those challenges may be and I am greatly concerned about your well being. Overall the whole entire department of mental health. Because when you are affected in any form or fashion it does trickle down to those beneath you. I am not saying that is what is happening and I do want to expraesz concern and also say I am having wonderful warm thoughts that we will all get through this together.

>> MICHAEL MOLINA: Thank you commissioner. Commissioner Stevens concern is all of our concern for sure as we move forward in the next year. This is a great discussion. Thank you commissioners and everyone who asked questions and participated. If there is --

>> Last one. As we look over the data you provided in the next couple of months and thankful. Sorry about the tough questions. This report is wonderful and in some respects. We have 13 thousandish new clients served through FSP and etc. I had no idea what that means and I don't know what the market is. Or what the need is. Is that data available to us as well? And if not maybe just here for the record you can say in looking over the report and looking over activities for the past year what do you consider to be the biggest success and maybe the biggest weak point of the activities last year.

>> I think what you are speaking the to is penetration rate. And data we are reporting out to the penetration rate. And we use pa report called the CHIZ and shifting away for something more appropriate to the population we serve specifically and there aren't a lot of great resources for that and I think we have consensus built into that. That starts to give a benchmark how many people need our services and from that tl it be determine what level of care is needed. We do want to get into thinking ab we are going to have to start to do thinking already because we are expanding FSP and talking about lower level. How much of that are we going to need? We have to do the analysis and what is the right number of slots or units or whatever it is how we want to describe that. It is a good observation and something we anticipate going forward and the state will give direction how they want that reported out to. Prop one is going to be -- there is 375 pages of accountability here and they have more they want ups to look at as well and they want the local communities to identify some of the metrics.

To speak this quickly too to commissioner Stephens and one of the previous questions we have an online dash board that is live and it is updated weekly and it does look at each of programs and how many people have been serve and had breaks it out by service area and also by district and we can look at language and et in misty and can only do two components at a time.

>> MICHAEL MOLINA: We look forward to receiving your e-mails and letters to come that are transmitted with this report.

Moving on folks I am happy to report it is election time again and I know you are excited about that. The bruises have healed from last year and here we are again doing one more time. Wen ya will be sending out in the next week or so a form to all commissioners asking -- you already receive add form asking you to serve on the nomination committee. Please take a look at that and if you wish to serve on the nomination committee please respond back to Kenya by? Soon .

>> You already have one response?

>> MICHAEL MOLINA: Wonderful we have one response.

>> Yes. Commissioner MANALO wants to be a part of that. If anyone else wants --

>> MICHAEL MOLINA: Thank you very much we are looking for at least one more. Fantastic. Moving on. Item number eight. Announcements. Next month we are gathering in carson at the carson community center for the next mental health commission meeting on April the 25th beginning at 10:30. That is the service area eight town hall. Final announcements? Kalene?

>> I have one more and I noted you are talking about the date that is feedback for the letter. We need to submit the full plan report with the letter to the board at least a month in advance of the hearing which is on June 4th. We don't have the full two months and I will need to get back to you with a specific date. It is longer than the weekend we had last year.

>> MICHAEL MOLINA: Terrific if it doesn't (Indistinct) we have contact ins the supervisors office and we can talk to chair and see if with we can do something and I appreciate that. Thank you Kalene.

I would like to ask commissioner Cooperberg to please un-mute she would like to have the commission adjourn in memory of someone important today.

>> Good afternoon. Many people my realize Gene Harris is not there today. Unfortunately her husband has passed away this past weekend and many of us as mental health advocates have a silent partner or quieter partner by our side as we are the more vocal ones and Ron Harris as quiet as he was, he was still a mental health advocate for many years and I would like to ask that we adjourn in memory of the wonderful Ron Harris.

>> MICHAEL MOLINA: Thank you commissioner cooper berg we will do that and add jourp in his memory and keeping in mind our thoughts and prayers for Gene. With that it is 2:20 and we are adjourned. Thank you everyone.

(Meeting adjourned).

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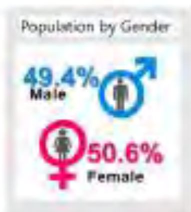
E.5. HIGHLIGHTS: MHSA TWO YEAR PROGRAM AND EXPENDITURE PLAN, FY 2024-25 THROUGH 2025-26

LOS ANGELES COUNTY POPULATION

The Los Angeles County (County) Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. Serving as the local mental health plan in an area with **over 10 million residents.**



POPULATION ENROLLED IN MEDI-CAL

This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, and age.

Approximately **40%** of the Los Angeles County population makes up the Medi-Cal Eligible population.

LOS ANGELES HOMELESS SERVICES AUTHORITY

2020 GREATER LOS ANGELES HOMELESS COUNTS

The following information is taken from the Quality Assessment and Performance Improvement Evaluation Report 2021 and Work Plan 2022.

The Los Angeles Homeless Services Authority's (LAHSA) results of the 2020* Greater Los Angeles Homeless Count showed

66,436 individuals

in Los Angeles County were experiencing homelessness.

The 2020 Homeless Counts were conducted in January 2020, before the impacts of the COVID-19 pandemic.

Highest Service Area with Individuals Experiencing Homelessness CY 2020

SPA 4	SPA 6
had greater than 17,000 individuals experiencing homelessness, the highest of all SPAs.	had greater than 5,000 individuals experiencing homelessness who are sheltered.

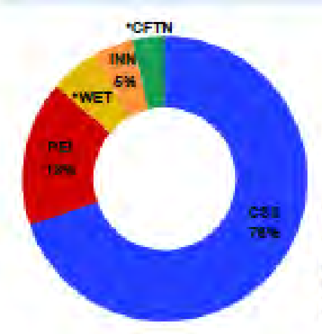
*2022 Homeless Count: 65,111 individuals, 45,878 unsheltered, 19,233 sheltered

MHSA INTRODUCTION AND REQUIREMENTS

The MHSA is funded by Proposition 63 and was passed by the Carlifornian 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.

MHSA Components

- Community Services and Support (CSS)
- Prevention and Early Intervention (PEI)
- Innovation (INN)
- Capital Facilities and Technological Needs (CFTN)
- Workforce Education and Training (WET)



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

Three-Year Program and Expenditure Plan and Annual Update

The Los Angeles County must prepare and submit a Three Year Program and Expenditure Plan (Plan) and Annual Update (Update) for MHSA programs and expenditures to Mental Health Oversight and Accountability Commission (MHSOAC) and Department of Health Care Services (DHCS). Los Angeles collaborates and engages stakeholders throughout the planning and development process of the Plan and the Plan must be adopted by the County Board of Supervisors.

*MHSA CLIENTS SERVED FY 2022-23

192,656
Unique Clients Served

32,254
New Clients Served

Client Served by Age Group

49% Adult (Ages 26-59)
23% Child (Ages 0-15)
18% TAY (Ages 16-25)
13% Older Adult (Ages 60+)

Client Served by Race/Ethnicity Group

39% Hispanic/Latino
18% Black/African American
16% White
18% Unreported
5% Asian/Pacific Islander
3% Multiple Races
1% Native American

*Only includes a direct mental health service

COMMUNITY SUPPORT SERVICES

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 (FSP), Outpatient Care Services, Alternative Crisis Services, Housing Services, Linkage and Planning, Outreach and Engagement.

178,083

Number of Unique Clients Served

Full Service Partnership (FSP)

12,941

Unique Clients Served

Client Served by Age Group

Age Group	Clients
Adult (Ages 26-59)	6,563
Child (Ages 0-15)	2,807
TAY (Ages 16-25)	2,273
Older Adult (Ages 60+)	1,692

Race/Ethnicity Group

Race/Ethnicity	Percent
Hispanic/Latino	3%
Black/African American	24%
Unreported	18%
White	17%
Asian	4%
Multiple Races	3%
Native Hawaiian/Pacific Islander	1%
Native American	1%

Highest Service Area

SA 8	SA 4	SA 6
2,531	2,518	2,501

Outpatient Care Services (OCS)

121,537

Unique Clients Served

Client Served by Age Group

Age Group	Clients
Adult (Ages 26-59)	65,286
Child (Ages 0-15)	20,534
TAY (Ages 16-25)	20,415
Older Adult (Ages 60+)	18,288

Race/Ethnicity Group

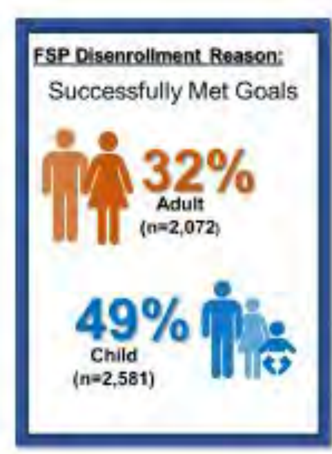
Race/Ethnicity	Percent
Hispanic/Latino	39%
Black/African American	20%
Unreported	15%
White	16%
Asian	4%
Multiple Races	4%
Native Hawaiian/Pacific Islander	1%
Native American	1%

Highest Service Area

SA 8	SA 4	SA 2
22,579	21,156	19,979

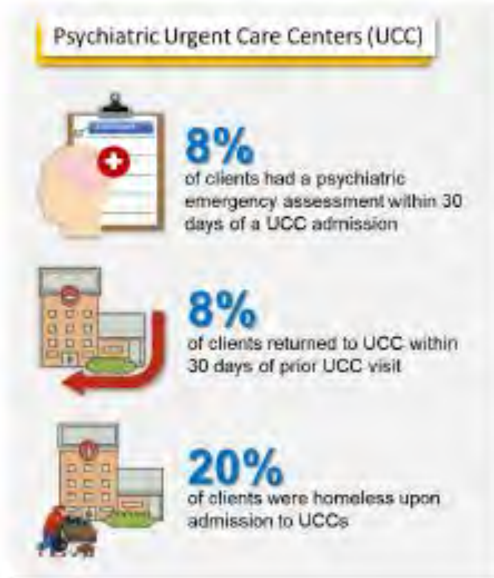
COMMUNITY SUPPORT SEVICES – OUTCOMES

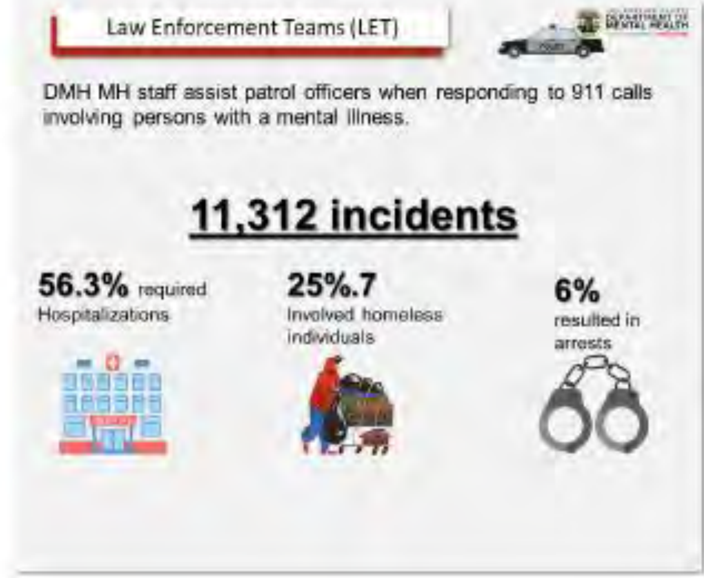
Full Service Partnership (FSP) Outcomes



Outcome data for clients with open outcomes in FY 2022-23 with a data cut off of 6/30/2023. Clients had a baseline sometime before 6/30/2023 and no disenrollment Key Event Change before 7/1/22 unless they also had a reestablishment that was active during FY 2022-23. Figures represents cumulative changes, inclusive of all clients through June 30, 2023

Alternative Crisis Services Outcomes





COMMUNITY SUPPORT SEVICES – OUTCOMES

Housing Outcomes

Capital Investments Program

75 of the 152 Permanent Support Housing (PSH) developments finished construction, resulting in **1,680** units available for occupancy.

Individuals Housed
- **1,764** adult clients and adult family members
- **190** minor children

90% housing retention rate for the Capital Investments Program

Housing for Mental Health (HFMH)

424 DMH clients were in permanent housing at some point during FY 2022-23.

- Of the 424, **335** were referred by DMH contracted providers and **89** were referred by DHS Office of Diversion and Reentry (ODR).
- **77** individuals were newly referred to the program
- **41** individuals newly moved into housing

93% housing retention rate for the HFMH clients

Federal Housing Subsides Unit

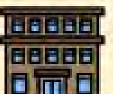
DMH Housing Authority contracts supported **2,753** tenant-based Permanent Supportive Housing (PSH) units.

3,018 Individuals Housed
- **2,361** adults
- **657** minor children

96% housing retention rate for DMH clients residing in these units, with the average length of stay totaling 5 years.

Enriched Residential Care Program (ERC)

As of June 30, 2023, the ERC program was serving a total of **1,236** clients.



- **361** clients were referred to the program and
- **358** clients moved into an Adult Residential Facility (ARF) or Residential Care Facility for the Elderly (RCFE) with ERC financial support

81% housing retention rate for the ERC program

Interim Housing

Interim Housing Program (IHP) – Adults
MHSA funds enabled DMH to contract for 618 IHP beds across 21 sites.
- **555** beds for individuals
- **63** family units

IHP served **1,419** individuals and **75** families throughout the fiscal year

Enhanced Emergency Shelter Program (EESP) – TAY
2 additional shelters were opened, expanding the total EESP capacity to **110** beds.

1. Male shelter comprised of **14 beds** in Service Area 2. (first EESP shelter to be located in North County)
2. Female shelter comprised of **12 beds** in Service Area 6

EESP served **592** Transitional Age Youth (TAY) during the fiscal year.

Linkage Outcomes

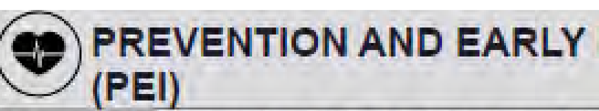
Homeless Outreach and Mobile Engagement (HOME)

The Homeless Outreach & Mobile Engagement (HOME) program provides field-based outreach, engagement, support, and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness.

FY 2022-23

The HOME program increased their capacity by adding **67 new positions**.

- Rightsized existing teams to align the team staffing pattern across service areas;
- Expanded the number of HOME teams from **10 to 16 teams**;
- Expanded the administrative infrastructure to support the program expansion;
- Expanded psychiatry services by adding Nurse Practitioners and Psychiatrists in each service area
- Created a HOME Operations and Navigation Team
- Involved in Inside Safe and Pathway Home

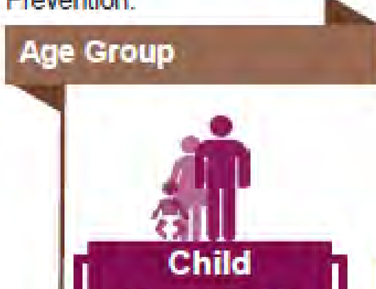


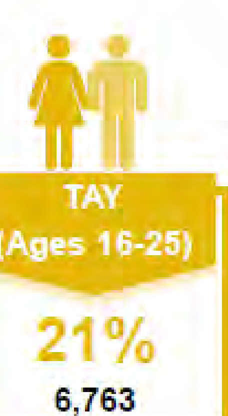
PREVENTION AND EARLY INTERVENTION (PEI)

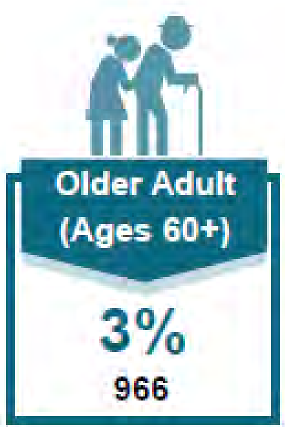
The goal of the Prevention & Early Intervention (PEI) component of the MHSA is to help counties implement services that promote wellness, foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members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

32,206 Number of Unique Clients Served

Age Group

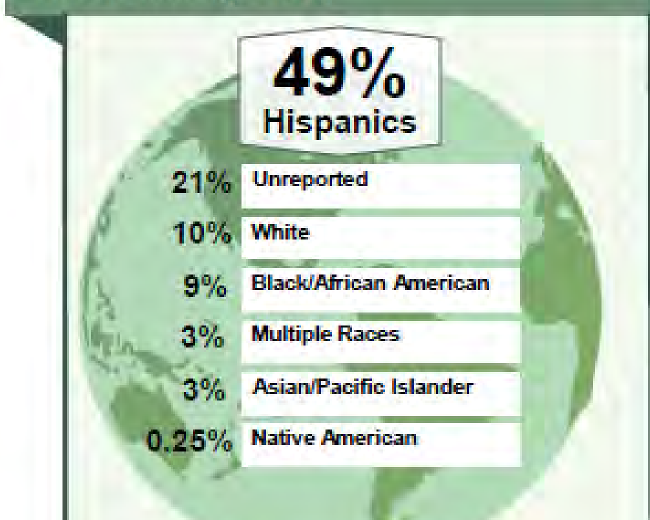






Child (Ages 0-15)	TAY (Ages 16-25)	Adult (Ages 26-59)	Older Adult (Ages 60+)
61%	21%	14%	3%
19,646	6,763	4,508	966

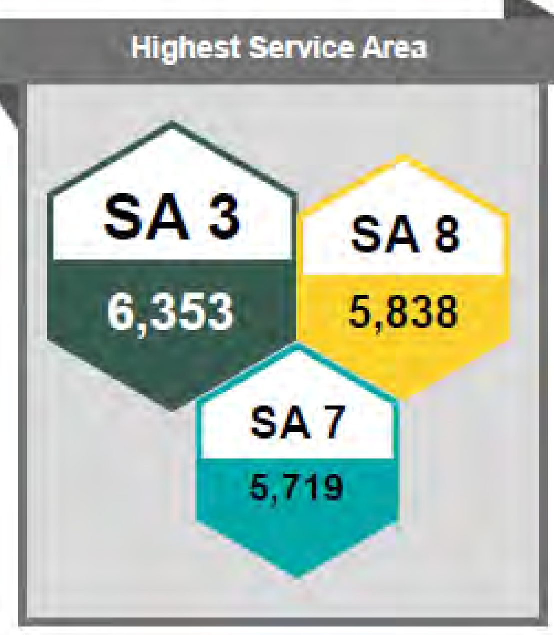
Race/Ethnicity Group



49% Hispanics

%	Group
21%	Unreported
10%	White
9%	Black/African American
3%	Multiple Races
3%	Asian/Pacific Islander
0.25%	Native American

Highest Service Area



Service Area	Clients
SA 3	6,353
SA 8	5,838
SA 7	5,719

PREVENTION AND EARLY INTERVENTION (PEI) - OUTCOMES

Stigma and Discrimination Reduction (SDR)

FISCAL YEAR 2022-23 SDR DATA AND OUTCOMES:

16,218
surveys were collected

93% of participants agreed or strongly agreed with the statement: "As a direct result of this training, I am more willing to seek support from a mental health professional if I thought I needed it."

87% of participants agreed or strongly agreed with the statement: "As a direct result of attending this training, I am more likely to believe anyone can have a mental health condition."

97% of participants agreed or strongly agreed with the statement: "The presenters demonstrated knowledge of the subject matter."

97% of participants agreed or strongly agreed with the statement: "The presenters were respectful of my culture (i.e., race, ethnicity, gender, religion, etc.)."

Suicide Prevention

FISCAL YEAR 2022-23 SUICIDE PREVENTION DATA AND OUTCOMES:

Suicide Prevention Programs

752 surveys received for suicide prevention trainings

- **95%** of participants agreed or strongly agreed the SP programs were quite successful in meeting their program goals.
- **98%** of participants agreed or strongly agreed with the statement: "*as a direct result of this program I am more knowledgeable about professional and peer resources that are available to help people who are at risk of suicide.*"
- **99%** of participants agreed or strongly agreed with the statement: "*The presenters demonstrated knowledge of the subject matter.*"

School Threat Assessment Response Team (START)

93 presentations were conducted

991 referrals were served

- **87%** received screenings and/or threat assessments
- **13%** received consultations
- Primary focus of **interventions** centered on:
  - **34%** Initial Screening/Threat Assessment
  - **27%** Outreach & Engagement
  - **21%** Crisis Intervention

Appendix F – Acronyms

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

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

Adult Age Group: Age range is 26 to 59 years old.
Child Age Group: Age range is 0 to 15 years old.
Older Adult Age Group: Age range is 60+.
Transitional Age Youth Age Group: Age range is 16 to 25 years old.
Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Not inclusive of community outreach services or client supportive services expenditures.
Unique client means a single client claimed in the Integrated Behavioral Health Information System.
New Community Services and Supports clients may have received a non-MHSA mental health service.
New Prevention and Early Intervention clients may have received a non-MHSA mental health service.