MENTAL HEALTH SERVICES ACT

ANNUAL UPDATE

FISCAL YEAR 2012-13

County of Los Angeles
Department of Mental Health

Marvin J. Southard, D.S.W.
Director

June 28, 2012

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-2013
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EXHIBIT A

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FY 2012-13
COUNTY CERTIFICATION

County Mental Health Director	Project Lead
Name: Marvin J. Southard, D.S.W.	Name: Debbie Innes-Gomberg, Ph.D.
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I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations, laws and statutes for this annual update/update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This annual update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2012-13 annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan be updated annually and approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

The costs of any Capital Facilities renovation projects in this annual update are reasonable and consistent with what a prudent buyer would incur.

The information provided for each work plan is true and correct.

All documents in the attached FY 2012-13 annual update/update are true and correct.

Marvin J. Southard, D.S.W.
Mental Health Director (PRINT)

Signature

6/28/12
Date

EXHIBIT B

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FY 2012-13

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

30-day Public Comment period dates: May 30 to June 28, 2012

Date: July 9, 2012 **Date of Public Hearing (Annual update only):** June 28, 2012

The following is a brief description of the Community Program Planning and Local Review Processes that were conducted as part of this annual update/update per Title 9 of the California Code of Regulations, sections 3300 and 3315.

Community Program Planning
1. Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2012/13 annual update. Include the methods used to obtain stakeholder input.
The Department's process for developing the FY 2012/13 Annual Update included: ▪ Review of the overall structure with the Mental Health Commission Executive Committee November 3, 2011 and with the SAAC chairs on December 13, 2011. ▪ Stakeholder Meeting - Presentation to Systems Leadership Team (SLT) on April 25, 2012 ▪ Presentation to the Mental Health Commission on April 26, 2012. ▪ Presentation to the Mental Health Commission Executive Committee on June 14, 2012
2. Identify the stakeholder entities involved in the Community Program Planning (CPP) Process. (i.e., name, agency affiliation, population represented, age, race/ethnicity, client/family member affiliation, primary language spoken, etc.)
System Leadership Team (SLT) The role of the SLT is to support the Department in system transformation and monitoring MHSA implementation. This includes the following responsibilities: ▪ Develop process and structural frameworks to support overall system transformation (e.g., performance measures; budget dilemmas). ▪ Monitor progress on implementation of MHSA Plans (e.g., track performance, identify design issues, initiate workgroups, etc.). ▪ Provide feedback to Department on proposed MHSA Plan extensions or revisions. ▪ Work with Department and consultant to develop agendas for Delegates meetings. ▪ Comment on workgroup recommendations before Department makes final decisions
3. If consolidating programs or eliminating a program/project, please include how the stakeholders were involved and had the opportunity to participate in the decision to eliminate the program/project.
Not applicable
Local Review Process
4. Describe methods used to circulate, for the purpose of public comment, the annual update or update.
LAC-DMH obtained stakeholder input through various review and comment sessions allowing all stakeholders, providers and the general public the opportunity to express their questions and concerns and provide their feedback on the MHSA Annual Update. Opportunities for stakeholders to provide their input and express their concerns included: ▪ Engagement in a presentation and comment session at the Department's System Leadership Team (SLT) Meeting on April 25, 2012. ▪ Engagement in a presentation and comment session at the Mental Health Commission Meeting on April 26, 2012. ▪ Posting on the LA County Department of Mental Health website from May 30 to June 28, 2012.

EXHIBIT B

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FY 2012-13

COMMUNITY PROGRAM PLANNING AND LOCAL REVIEW PROCESS

5. Include substantive comments received during the stakeholder review and public hearing, responses to those comments, and a description of any substantive changes made to the proposed annual update/update that was circulated. The County should indicate if no substantive comments were received.
▪ See attachment for comments at the April 25th presentation at the Systems Leadership Team meeting. ▪ Mental Health Commission comments include the following: o Make clear the reasons for Full Service Partnership disenrollment and what disenrollment means. o Post the Annual Update in a location that's easier to find on the DMH website. o Send the Annual Update directly to the Service Area Advisory Committee (SAAC) Chairs for distribution to SAACs for comment and review. o Allow the Mental Health Commission time to review any public comments DMH obtains prior to the Public Hearing. ▪ Public Hearing comments are attached.

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM MEETING
Wednesday, April 25, 2012 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To give an update from the County of Los Angeles Department of Mental Health.
2. To present and discuss the MHSA Annual Plan Update.
3. To distribute proposals to strengthen the SLT's role.

MEETING NOTES

Agenda Item	Presentation, Feedback & Agreements
Department Mental Health Update	*Marvin J. Southard, Director,* County of Los Angeles, Department of Mental Health, provided an update from the County of Los Angeles Department of Mental Health, which included information over the Assembly Bill 109, implementation of the 1115 waiver, MHSA and governance, and the prudent reserve. FEEDBACK 1. Question: Is there an update about the other realignment of MediCal dollars? a. Response: In regards to realignment, there is a much better growth formula for behavioral health being worked out. The growth will be allocated to the 1991 realignment and the new realignment. The Department hopes that the Medicaid benefit for alcohol and drug will be better. 2. Question: Will the funding source be tied to the initiative in November 2012? What is the Department thinking between now and November 2012 before knowing whether the funding source will be available? a. Response: EPSDT is a mandate that includes substance abuse services. Counties are concerned about whether they will have sufficient money to fund EPSDT. 3. Question: Is AB 109 underfunded? a. Response: Unfortunately, the Department does not know because the service utilization for the new population is unknown. 4. Question: What is the status of the Healthy Way LA program? a. Response: It depends on the metric being used. For example, if enrollment is the metric used, then the program is doing really well. The Health Department is focused and working to help increase access. On the mental health side, the enrollment process for Tier 1 clients has been an issue. The Department is tracking the enrollment process in each service area. 5. Question: In regards to AB 109, out of 2,000 individuals identified as needing mental health services, only 1,000 received services. What happened to the other 1,000 individuals? a. Response: Unfortunately, the majority of those 1,000 individuals declined services. Between October 2011 and January

	2012, mental health and substance abuse treatment was not mandatory. However, after January 2012, the Probation Department included mental health treatment as part of individual's community plan, which resulted in a significant increase in the acceptance for treatment rates. 6. Question: Is there an update on the challenge grants? a. Response: Unfortunately, no information was known over the status of the challenge grants.
MHSA Plan Annual Update	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation Unit,* County of Los Angeles, Department of Mental Health, presented the MHSA Plan Annual Update, which included information over the CSS Plan, the PEI Plan, and the WET/CAP – FAC/INN Plan. For additional information, please refer to the handouts titled, "Mental Health Services Act (MHSA) Fiscal Year 2012-13 Annual Update Summary, April 25, 2012." FEEDBACK 1. Comment: Measuring efficiency and effectiveness was underlined. 2. Question: How do we capture the discontinued population when the provider makes the decision? a. Response: The disenrollment categories are State-defined categories. Discontinued refers to when a client wishes to discontinue the partnership due to reasons other than re-locating to another geographic area. b. Action Item: More information will be provided in the future on disenrollment's from FSP, including better understanding the process and reasons for disenrollment and increasing intentional and successful disenrollment. More information and more focus on reasons for positive and negative outcomes reported. FSP program elements that contribute most positively to success will attempt to be identified. A plan to address poor outcomes will be developed. 3. Question: How are the reasons for disenrollment captured? a. Response: The reasons for disenrollment are State-defined categories and reported on the request for disenrollment form completed by providers and transmitted to the Service Area Impact Unit Coordinator and then to the Countywide FSP lead for the particular age group. Enrollment as well as disenrollment information from these forms is captured in the Department's Authorization Tracking database. 4. Question: How can desired metrics be developed, such as age groups, etc.? a. Response: Need more information to be able to answer this question. If there are recommended metrics that are not being captured, these recommendations should be sent to Debbie Innes-Gomberg or discussed within the SLT. 5. Comment: A concern pertaining to OA funding was voiced. 6. Question: Does the leverage percentage equal the total? a. Response: The allocations presented are non-leveraged and do not include EPSDT or non-EPSDT FFP. 7. Question: Is the decrease in homelessness due to the housing program?

a. Response: While it is not possible to ascertain which elements of FSP may contribute most greatly to reducing the number of clients homeless and the number of days these are homeless, utilizing Client Supportive Services funds for housing is a critical program element that contributes to those reductions.

8. Question: Is the Department engaged in data cleaning?
   a. Response: Yes. Representatives from all 4 age groups meet twice per month to review data and identify where data does not appear to be accurate. Ensuring the Key Event Changes (KECs) are completed by providers at the beginning and end of psychiatric hospitalizations, incarcerations and as clients enter education or employment is critical. This is a continual process.

9. Question: Why are so few TAY using drop-in?
   a. Response: The annual targets for the Drop-In Centers are have been met or slightly exceeded for the past two fiscal years. FY 10/11 Target = 832, Actual – 834; FY 11/12 Target = 832, 78% met at the 3rd quarter.

10. Question: Why are there few service extenders?
    a. Response: There are currently 31 Service Extenders, which is more than double the amount two years ago. The Older Adult Systems of Care Bureau actively recruited volunteers for Service Extenders from clinics, NAMI, and from current Service Extenders. In the summer of 2011 we held a 9-hour Service Extender Training "Academy," and from this group we placed eight Service Extenders in both directly operated and contract provider agencies. Their placement was the result of OA staff regularly encouraging our providers during site visits and provider meetings to bring Service Extenders onto their team. Additionally we advocated for the $150/month stipend to be increased to $240 – on par with ASOC's WOW program – and this increase was effective 2/1/2012. We continue to support our Service Extenders in quarterly meetings with the OA District Chief and Administrative Supervisor. These meetings provide peer support as well as brainstorming opportunities for Service Extenders in on-the-job issues that may arise.

11. Question: What about FPS urging termination of clients?
    a. Response: While efforts occur locally and at a countywide level to review clients that have been in FSP programs beyond a certain time and whether treatment goals can be met at lower levels of service, neither DMH nor the providers should be urging clients to terminate from FSP. Any concerns should be forwarded to Debbie Innes-Gomberg for review.

12. Question: How many new clients are there each year?
    a. Response: This will be included in future Annual Updates and is an excellent recommendation.

    b. Action Item: New clients entering services will be reported on and not just unique clients served. Looking at new clients each year was considered an excellent idea.

13. Question: Why is improvement happening? Is improvement connected to programs?
    a. Response: FSP programs employ a Whatever it Takes, team-based approach that includes the use of flex/Client Supportive Services funding to assist clients in paying for certain elements of their recovery (housing, clothing, furniture, etc.). DMH has not had the resources to identify, which elements of FSP contribute most effectively to the outcomes attained so far. Dr. Innes-Gomberg recommends providers using PDSA cycles to determine this.

b. Action Item: With the assistance of SLT, the metrics used to evaluate MHSA programs will be reviewed. More focus will be paid to quality improvement practices.

14. Comment: A suggestion was made to add a category for step-down for less intensive services under disenrollment.
    a. Response: One of the changes, as a result of ICSC, consisted in that clients can meet their goals, not just through FSP but also through FCCS or a wellness program, and the Department now includes that as meeting their goals.

15. Comment: In regards to INN plan, a suggestion was made to move from a two-to-three year program.

16. Comment: A recommendation was made to introduce PIER to EDIPP into Los Angeles beyond UCLA.

17. Question: Why is the API percentage low?
    a. Response: Will review with the Department's Ethnic Services Manager, review the cultural competency plan and discuss at the MHSA Implementation meeting, as a start to better understand this (DIG).

    b. Action Item: Disparities in services to the API population will be reviewed and a plan will be developed across MHSA programs and across age groups to reduce disparities in service and increase engagement and services to the API population.

18. Question: Where will the Department use WET funds?
    a. Response: See the WET plan outlined in the Annual Update

19. Comment: There is a need for more certified peer workers to satisfy RFS needs.
    a. Response: Currently, there are various efforts to train peer workers. Due to the timing of the annual update, reports of programs that were implemented recently were not included.

    b. Action Item: A report will be issued of all the programs and number of people that were trained.

20. Question: In regards to COS billing, how can the new IBIS system capture the COS elements more effectively?
    a. Response: DMH is addressing this now in the build-out of IBHIS.

21. Comment: ASL is being overlooked. ASL is one of the top three languages referring to the CCS Plan.

22. Question: Can we drill down on clients leaving FSP services for reasons other than 'meeting outcomes?'
    a. Response: Yes and would like input on how to address this.
    b. Action Item: Yes, the Department will work on that and IBIS might have opportunities

23. Question: Can WRAP be added to the list of PEI Evidence-based Practices (EBP) and be coded to its use?
    a. Response: WRAP could be added to the IS EBP field for general use but not as a PEI practice (at the moment) since it is not part of our current plan.

24. Question: Is recovery-oriented training for MD residents who enter psychiatry as part of WET funding program?
    a. Response: While more information is needed to more precisely answer the question, all training does focus on recovery.

25. Question: How can county provider agencies be notified and informed about location of computers for consumer and family access?
    a. Response: Presently, access to these computers is limited to clients seeking services at DMH directly operated clinics and family members involved in their recovery. To access these computers, all users must have an LA County Library Card. DMH staff can issue a library card only to DMH clients who do not have a card. Family members must have a card issued by LA County Library. The Project Steering Committee will need to address the question of providing broader access to individuals who are not clients or family members associated with a directly operated clinic. Additionally, the steering committee will consider a means of making the locations of these computers readily available. More information on this project will be provided at the SLT meeting on June 20, 2012.

26. Comment: Under PEI for subgroups, the deaf and hard of hearing and ASL is missing for a population greatly affected by mental illness and suicide.

27. Comment: In regards to ethnicity and primary language, a concern was raised over the Spanish-speaking area?

28. Question: What goals are being met as a reason for disenrollment?
    a. Response: Whatever goals the client establishes for themselves, as part of their Client Care Coordination Plan.

29. Question: How did the FSP get a 60 percent increase in the number of clients in juvenile hall?
    a. Response: There are several reasons that could be attributed to the 60% increase in the number of clients in juvenile hall. One of the reasons is due to OMA errors in key event change (KEC) paperwork not being entered into the system when clients are discharged from juvenile halls. Another reason is due to under-reporting of Juvenile Justice activity at the time of intake, when the client and/or family are not comfortable disclosing such history in the initial stages of working with the FSP Team. The data team is focusing on corrections in OMA by working with providers and the implementation unit on any errors. To assist providers with treating this population, intervention-based trainings have been added to the FSP training curriculum for the next fiscal year, focusing on substance abuse and gang interventions.

30. Question: When the numbers are wrong, is the issue always data collection?
    a. Response: We start with data validation and often find that Key Event Change forms are not completed at the end of an episode related to a living arrangement change, however, more effort needs to be devoted to identify where practices are not effective or practices are not being implemented in the manner intended.

31. Question: In regards to the clients served by age category, how does this compare to the dollar distribution in the PEI plan?
    a. Response: While the State requirement was that 51% of PEI funds go to services for child and TAY, locally we agreed to 65%. For FY 10/11, 76% of the clients served in TAY were child and TAY.

32. Question: Is there a plan to include AB 109 front end and back end clients in MHSA services?

a. Response: The AB 109 services are an expansion of what the Department is already doing through MHSA. The Department expanded the intensive community-based services using largely FSP providers.

33. Question: Is the peer training for 2013-2014 the same or different from the current training?
    a. Response: The peer-training institute would augment already existing efforts to date.

34. Question: Is there any data about people being put on 'waiting lists' at clinical?
    a. Response: The Department has recently developed a strategy to track this.

35. Question: How many service extenders are serving older adults? Are these peers?
    a. Response: Currently there are 32 Service Extenders in both directly-operated and contracted agencies. The majority are peers, although there are a few who are interested in working with the Older Adult population and have not identified as peers/consumers.

36. Question: How many peer advocates have been trained in county? How many are employed?
    a. Response: Adult System of Care is researching this.

37. Question: Can more information be provided on the cost and accuracy of self-reporting versus unobtrusive selected sample with investigative follow up?
    a. Response: This warrants more discussion and information.

38. Comment: A concern was raised over the FCCS child baseline being very high.

39. Question: Are the right things being measured?
    a. Response: SLT should make recommendations about the approach to outcomes and evaluation. FSP outcome data elements are mandated by the State, others are not and were developed in response to program goals. More discussion is needed here.

    b. Action Item: 39With the assistance of SLT, the metrics used to evaluate MHSA programs will be reviewed. More focus will be paid to quality improvement practices.

40. Question: In regards to FSP disenrollment, is child and adult 'N' identical?
    a. Response: No, child reported 1,127 disenrollment's in FY 10/11 and adult 1,227.

41. Question: Are FSP homeless adult and older adult percentage clients and days identical?
    a. Response: Yes, and this was double-checked.

42. Question: In regards to the $18 million shortfall, will that come from the prudent reserve and how will that be used?
    a. Response: The money will come out of the prudent reserve specifically for CSS. The $18 million shortfall is only for one year.

43. Comment: There is a need for employee assistance for hired customers, including onsite training support and job coaches within the Department and within contract agencies.
    a. Response: The department has an employee assistance program. This is a good recommendation in terms of supporting people in the workforce.

44. Question: How can ethnicity and language be measured better in the CSS plan?
    a. Response: The unknowns are really a function of the reporting limitations of COS.

    b. Action Item: 44DMH will identify better ways to capture ethnicity and language of clients served in programs billed to COS (outreach and engagement, housing linkage, jail linkage and Service Area Navigation).

45. Question: How are system failures measured?
    a. Response: Need more information to answer the question. A robust evaluation approach should address client, program and system level outcomes.

46. Question: Do urgent care centers get MHSA funding when they are designated LPS?
    a. Response: Urgent Care Centers are funded through MHSA but only as an outpatient alternative to a psychiatric emergency room or inpatient psychiatric facility.

47. Question: Can the FSP data demonstrate the ethnicity breakdown and age groups?
    a. Response: Yes. Each month each age group creates a report on those authorized for FSP that includes the focal population and ethnicity associated with each client.

48. Question: In regards to CSS, how are the family support services for children used?
    a. Response: Currently, Providers are using Family Support Services (FSS) to provide mental health services to family members/caregivers of children with open FSP episodes. These are typically clients who do not have their own insurance, or those who do not fully meet "Medical Necessity" and therefore are unable to qualify for services in a Directly Operated DMH outpatient clinic. The Department is currently exploring options to expand FSS to include Respite Care services.

49. Question: How is it determined which wellness centers are client-run?
    a. Response: Wellness Centers and Client-Run Centers were bid out as distinct services. Wellness Centers are defined as having at least 50% of staffing as peer staff and Client-Run Centers are staffed 100% by peers.

50. Question: How much money will be allowed for CAPPS?
    a. Response: $3,520,402

51. Question: In regards to PEI, how can primary language results be reported better?
    a. Response: primary language is reported for all Mode 15 services (direct services, not COS)

52. Question: Will new computers go to wellness centers and who will determine which centers they will go to?

a. Response: Presently, access to these computers is limited to clients seeking services at DMH directly operated clinics and family members involved in their recovery. To access these computers, all users must have an LA County Library Card. DMH staff can issue a library card only to DMH clients who do not have a card. Family members must have a card issued by LA County Library. The Project Steering Committee will need to address the question of providing broader access to individuals who are not clients or family members associated with a directly operated clinic. Additionally, the steering committee will consider a means of making the locations of these computers readily available. More information on this project will be provided at the SLT meeting on June 20, 2012.

53. Question: Why are there no stipends available for doctoral students?
    a. Response: Instead of stipends for graduating doctoral students, postdoctoral fellowships would be offered. These are currently being offered through Harbor UCLA, but additional fellowships are being explored that might be spread through the different age groups or programs.

54. Question: Why is American Sign-Language not listed?
    a. Response: It is considered a "disability" in the IS and not a "language."

55. Question: What do the numbers truly represent?
    a. Response: The answer depends on which numbers the question is referring to (outcome data vs. clients served). All data is interpreted only through the lens of expectations and goals.

56. Comment: A recommendation was voiced to provide a synopsis narrative with outcome measures.

57. Question: What is the state of peer run crisis centers?
    a. Response: The Innovation Peer-Run Respite Program's bidders' conference is April 26, 2012.

58. Comment: There should be an analysis highlighting trends to develop strategies as opposed to just reporting the numbers.

59. Question: Who is asking the questions?
    a. Response: Need more information to answer question.

60. Question: How can peer advocates and community workers be counted on as a power source to social workers in clinics?
    a. Response: It sounds like the question is about the influence of peer specialists within a clinic or treatment team and how to measure a peer's impact.

61. Question: How is education being reflected?
    a. Response: Need more information about whose education relative to what information.

62. Question: What is the Department doing to service incoming veterans and veterans that may not want services from the VA hospital?
    a. Response: The Department is expanding services to returning war veterans and their families. The Department is moving the veterans program into Patriotic Hall for additional visibility and the ability to support other veteran programs.

	63. Question: Why are INN funds being used for the prudent reserve as opposed for their intended use? a. Response: Those funds were going to revert back to the State. In order to avoid reversion of those funds, they are being placed into the Prudent Reserve. Each year 5% of PEI and CSS funds must be used for Innovative programs, per the MHSA. 64. Question: Is the Department really funding and fostering innovations? a. Response: MHSA requires that 5 percent of CSS and PEI be reserved for innovative programs and the Department has met that requirement. 65. Question: Where is the Department with PEI? Is the Department on target with the realignments? a. Response: The Department has implemented 26 evidence based, promising and community-defined practices since inception of PEI services, as well as has implemented suicide prevention, stigma discrimination and school violence reduction services. 66. Question: Is there a formal mechanism for obtaining viewpoints and information from service providers? a. Response: Yes, practice networks are starting with about five or six EBPs associated with PEI. These networks will serve to bring together providers implementing common practices to facilitate provider-to-provider learning and data-informed learning. 67. Question: In regards to the service providers, is the Department referring to the executive managers or practitioners/line clinical staff? a. Response: Both. 68. Question: How much money will be taken from the prudent reserve over a two-year period? Will the prudent reserve need to be rebuilt at some point? a. Response: The Department is putting money into the prudent reserve from the CSS and PEI plans. In addition, DMH is putting funds into the PR. 69. Comment: There is an opportunity to create a statewide approach to data collection for MHSA. In a combination with OAC and whatever happens with SB 1136, the Department will have a better idea of what may be required in the future to collect data. Currently, this data does not explain why things are improving. There is an opportunity for the SLT to take a greater role in quality improvement related to MHSA.
Public Comments and Announcements	1. Question: A concern about mental health treatment in the Twin Towers correctional facility was underscored. Is there any allocation to train the deputies about mental illness and getting more feedback from inmates? Who can be contacted? 2. Comment: A concern about services for veterans was underlined. 3. Question: A concern was voiced about the lack of services for older adults. What is the department doing to serve older adults,

	the fastest growing population? 4. Announcement: An announcement was shared pertaining to 19 new apartments at the TAY group. 5. Question: How does a client transfer from one service area FSP program to another FSP program if they move to another service area? a. Response: FSP clients should talk to their service provider to discuss transferring services. 6. Question: How can family members give feedback to MHSA, etc.? a. Response: Family members can provide feedback directly to the provider or to DMH. 7. Announcement: Next Meeting Wednesday, May 16, 2012 9:30 am – 12:30 pm St. Anne's Auditorium

System Leadership Team

	Org. Affiliation	Name of Nominee	Phone Number	E-Mail
1	Latino Client Coalition	Zulma Acevedo	(818) 714-6149	zacevedo85@gmail.com
2	LAC-CEO	Vincent Amerson	(213) 974-4363	vamerson@ceo.lacounty.gov
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4	LAC-DHS	Karen Bernstein	(213) 250-8644	kbernstein@dhs.lacounty.gov
5	LACCC	Catherine Bond	(424) 288-6483	cbond702002@yahoo.com
6	LAC-CEO	Elizabeth Boyce	(213) 974-4673	eboyce@dhs.lacounty.gov
7	Consultant	Diana Concannon	(310) 625-8483	dmconcannon@sbclinic.org
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11	Community of Friends	Dora Gallo	(213)480-0809X230	dgallo@acof.org
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14	City of Los Angeles	Helmi Hisserich	(213) 808-8662	helmi.hisserich@lacity.org
15	SHARE	Ruth Hollman	(213) 213-0109	ruth@shareselfhelp.org
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17	Heritage Clinic	Cynthia Jackson	(626)577-8480X115	ckelartinian@cfar1.org
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20	City of Long Beach	Patti LaPlace	(562) 216-1966	Patti.LaPlace@longbeach.gov

System Leadership Team

	Org. Affiliation	Name of Nominee	Phone Number	E-Mail
21	LAC-DMH	Anthony Leggitt	(213) 738-4616	aleggitt@dmh.lacounty.gov
22	LAC-MH Commission	Jerry Lubin	(310) 820-1181	jerry917@earthlink.net
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24	AFSCME	Teddy Mckenna	(213) 252-1382	L2712@afscme36.org
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29	Project Return	Keris Myrick	(323)346-0960X222	kmyrick@mhala.org
30	COJAC	Jim O'Connell	(626) 332-3145	jimo@socialmodel.com
31	GLAD	Jennifer Olson	(323) 478-8000	jolson@gladinc.org
32	Pacific Clinics	Emma Oshagan	(626) 744-5230	Eoshagan@pacificclinics.org
33	Hospital Association	Mara Pelsman	(323)644-2000X274	mpelsman@gatewayshospital.org
34	MH Advocacy	Jim Preis	(213) 389-2077	jpreis@mhas-la.org
35	Pathpoint	Christina Rajlal	(818) 773-9570 x21	christina.rajlal@pathpoint.org
36	LAUSD	Cecilia Ramos	(213) 241-0834	cecilia.ramos@lausd.net
37	NAMI	James Randall	(818) 610-6732	JRandall@dmh.lacounty.gov]
38	LA Child Guidance Clinic	Paco Retana	(323)766-2345X2326	pretana@lacgc.org
39	LAC-Public Defender	Joanne Rotstein	(213) 974-3036	jrotstein@pubdef.lacounty.gov
40	Junior Blind	Lisa Rueda	(323) 295-4555X218	lrueda@juniorblind.org
41	DMH-American Indian Counseling Center	Paul Sacco	(323) 769-6183	PSacco@dmh.lacounty.gov

System Leadership Team

	Org. Affiliation	Name of Nominee	Phone Number	E-Mail
42	ACHSA	*Bruce Saltzer*	(213)250-5030X103	BSaltzer@achsa.net
43	L.A. Gay & Lesbian Center	*Curtis Shepard*	(310) 276-0535	cshepard@lagaycenter.org
44	Commission on Children and Families	*Nina Sorkin*	(323) 661-6459	apsorkin@att.net
45	LAC-DMH	*Ana Suarez*	(213) 738-3499	asuarez@dmh.lacounty.gov
46	LAC-Public Health	*Wayne Sugita*	(626) 299-4571	wsugita@ph.lacounty.gov
47	UREP	*Romalis Taylor*	(323)999-2404X138	rtaylor@starsinc.com
48	MHALA	*Richard Van Horn*	(562) 284-1241	rvanhorn@mhala.org
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50	SEIU	*Marlon Young*	(323) 241-6976	myoung@dmh.lacounty.gov

I. County of Los Angeles MHSA Annual Plan Update Presentation

A. Presentation: *Debbie Innes-Gomberg, Ph.D., MHSA Implementation Unit,* County of Los Angeles, Department of Mental Health. Please refer to PowerPoint for more details.

B. Public Comments

1. Comment: The Asian population is the fastest growing population in the United States and they are underutilizing mental health services. If more agencies were culturally competent, utilization rates will increase. In addition, a concern was raised over the Southeast Asian population and trauma due to war.
    a. Response: Outreach efforts to API communities are one of the challenges that need to be taken more seriously.

2. Comment: A concern was raised regarding the decreased budget allocation for API clients. The budget allocation needs to increase in order to have more efficient services for API clients.
    a. Response: The budget allocation is not based on ethnicity.

3. Comment: In order to continue working efficiently, the budget for the 2012-2013 fiscal year needs to increase.

4. Comment: Cultural and linguistic competence should be used as criteria for fund allocations.

5. Comment: Respite care programs for mothers who have children with mental health needs is critical, especially in the San Fernando Valley.

6. Comment: A concern was raised over the community's access to mental health services information. A suggestion was made to have informational meetings, which make linkage to services more accessible. In particular, more public service announcements and information would help the Spanish-speaking community increase access to mental health services. Another issue was raised pertaining to identification of services to assist with the courts for conservatorship.

7. Comment: A model of peer integration was underscored in regards to the issue of Family Law in mental health.

8. Comment: More funding is needed to continue outreach efforts in the API community.

9. Comment: More TAY individuals should attend MHSA stakeholder meetings. In addition, a concern was voiced over the lack of information about recovery in MHSA. Moreover, there should be a funding stream for additional community outreach efforts with respect to developing comprehensive Dbd's that belong to various communities. Also, more Cb's are needed at conferences, schools, homeless shelters, men and women's groups, and TAY.

10. Comment: In regards to urgent care, how will the funds from the prudent reserve be allocated for the population in the MLK area?
    a. Response: The idea for urgent care is to have a contracted-out facility on the grounds of the new MLK hospital. The Department is allocating about $8 million over the course of two years from the prudent reserve to be used for that purpose. At the same time, there is also an expansion of services at the Olive View Urgent Care. The functionality of the Olive View Urgent Care will also be expanded using the prudent reserve money. The prudent reserve funds will be used over a two-year period for the implementation of those programs. The Board of Supervisors has yet to finalized the plan's approval.

11. Question: What will happen when one-time funding runs out?

12. Question: Can the Department allocate funds to groups, such as the Mental Health Advocacy, to provide legal and paralegal services in advising new families?

13. Question: There is an increase of children committing suicide in the Antelope Valley. How can the Department incorporate peer advocates to save children's lives in the Antelope Valley?
    a. Response: The Department has a plan that focuses on future services in the Antelope Valley. There are about six (6) different initiatives that will be implemented in the next fiscal year that center on improving services in the Antelope Valley.

14. Question: Why does the data demonstrate that 52 percent are unknown for language and ethnicity?

15. Comment: The hospitals recognized that in light of the volume of folks served under MHSA, it does not necessarily translate to the volume of individuals in emergency rooms in need of mental health services. Communication with hospitals needs to improve. A concern was raised over the lack of beds. Urgent care centers should be expanded.

16. Comment: The Department wants to create a Lesbian-Gay-Bisexual-Transgender client coalition.

17. Question: Will there be an Oversight and Accountability Commission-type of organization in Los Angeles County to oversee the mental health services?
    a. Response: In the new structure, the ultimate accountability group for MHSA in Los Angeles County will be the Los Angeles County Board of Supervisors. The Mental Health Commission will advise the Board of Supervisors. And, the SLT will represent the community's input in the process.

18. Comment: The service area advisory council should have opportunities to provide input to the SLT.

II. Public Comment Cards

1. Question: Where is the recovery model? Can a peer support task force be trained to work out a solution to many of the problems, such as suicide prevention, drug and alcohol abuse.? Can individuals have a choice to go natural or take medications?

2. Question: When the head of a household dies, other people in the household have to leave the house and be homeless. Can more information be provided on how these people can belong because their income is incorporated together in low-income housing?

3. Question: If presentations of the success stories were not shared, is it possible that maybe it was not a good idea and a waste of MHSA funds?

4. Comment: Moving forward, a suggestion was made to explore opportunities for improved coordination of services in terms of how to better connect people (who are in an ER) to outpatient services in order to reduce what hospitals report is an increasing patient volume and revolving door of people who require mental health intervention.

5. Question: Can the funds be used to train Employment and Education Specialists?

6. Comment: A suggestion was shared recommending that the MHSA Public Hearings be presented to every UREP group and all client coalitions to ensure consumers understand the information and provide constructive feedback.

7. Comment: Respite care programs need to be included in the Los Angeles County Mental Health budget, specially for mothers of children with mental health problems.

8. Question: Was there any data on children?

9. Comment: A suggestion was shared over the need to develop programs that better educate law enforcement officials to deal with mentally ill clients.

10. Comment: The Los Angeles County Department of Mental Health will need to increase the allocated budget for the 2012-2013 fiscal year in order for the Asian Pacific Islander Consumer Leadership Council to continue to grow, be effective and competent in the area of advocacy.

11. Comment: A concern was raised over the (APRTP) Adams Residential consumers. There is a need for The Ethnic English teacher and the Ethnic Social Skill teacher programs.

12. Comment: Asian Americans are the fastest growing minority in America. However it has been shown that Asian mental health services are underutilized. This is not only true for Asians but for other minority groups as well. This can be explained partly due to cultural as well as economically reasons. Asians in need of mental health care simply cannot afford it. Many of the Asian immigrants who are in need of mental health services do not understand the Western approach to psychiatry. Instead of being depressed many of the immigrants will say there "chi" or life energy is low. Many of the Asian immigrants have to face language barriers and cultural shock when immigrating to the United States. South East Asians have experienced war trauma as well as trauma encountered when trying to reach the United States (boat people). This results in a high percentage of South East Asians experiencing mental health issues and need to be helped. Nonverbal expression of feeling is more culturally acceptable. Therefore Asian-Americans people do not talk about feeling depressed or seeking mental health services. Many Asians believe that mental health can be achieved

through will power and by avoiding bad thoughts. Furthermore Asian-Americans often delay treatment until they are extremely ill. Consequently, they come into a mental health facility sicker than other patients and they tend to drop out early in the course of their therapeutic regime. Stigma is strong in the Asian community when dealing with mental illness preventing many Asians from seeking help when they need it. Therefore, please be sensitive to the needs of the Asian mental health community when making decisions and be sensitive to other ethnic groups as well.

13. Comment: A concern was raised over the budget cuts and increasing mental health service needs. The API CLC asks that the budget be increased to continue implementation of their mission and provision of services.

14. Comment: The DMH website is not conducive for the public to provide feedback. In particular, the website makes it impossible for non-English speakers to participate. In addition, the American Indian Counseling Center requires a facility or building that incorporates Indian culture and is near a metro line making it more accessible to any Indian consumers throughout the county.

15. Comment: There is a lack of funding for the Public Guardian's office to private conservators for indigent consumers. There is a need for a higher budget to increase services.

16. Question: A concern was raised over the lack of parent and caregiver representation. How are family members, parents, and caregivers supported? Where is the information on children and homelessness?

17. Comment: There is a need to get more TAY involved in the MHSA stakeholder process. Additionally, more money should be dedicated for recovery.

18. Comment: Consumer recovery and success stories should be highlighted, recognized, and shared with communities by developing a comprehensive series of DVDs, Cds, and newsletters. This would be a valuable tool for jails, homeless population centers, men and women centers, seniors, college students, vets, gay, and transgender. In addition, this should be included in the WET budget.

19. Comment: The Service Extended Program, through ongoing education and training of peers and staff, has helped enhance the roles of API CLC members in the community and in wellness centers. A concern was raised over the lack of culturally competent interpretation during meetings.

20. Comment: Was there any data collected on homeless families with children? Also, there needs to be a plan that bridges all age groups. Moreover, when transitioning into different age groups, there should be different ways of doing things.

21. Comment: A concern was raised over the CSS plan and the number of clients served by ethnicity and primary language FY 2010-11, which underlined that out of 169,697 clients served, 88,546 or 52 percent fell into the unknown category. A suggest was made to review this information to ensure that it never happens again.

22. Comment: Regarding the formation of Lesbian, Gay, Bisexual, Transgendered Client Coalition/as Black, Latino, Asian Client Coalition, an individual petition was made to chair and contact Black, White, Latin, Asian (East Indian and Samoan) members.

23. Comment: There needs to be a special institute or organization that helps individuals gain the skills in order for them to work.

24. Comment: Each wellness center needs to have a basketball court and a swimming pool.

25. Comment: A concern was raised over the lack of spaces and areas where individuals can exercise. In addition, a concern with the lack of simple jobs was highlighted.

26. Comment: The budget in the new fiscal year needs to increase in order to provide proper services for Asian families who have different languages and cultural backgrounds

III. Motion to close Hearing and Approve Mental Health Services Act Plan

A. Jerry Lasco, Mental Health Commission

1. Motion to approve Mental Health Service Act plan, with the contingent that the comments that were made at this meeting, whether in verbal or written form, be incorporated into the plan. Motion was carried unanimously.

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June 28, 2012

The Los Angeles County Mental Health Commission
Los Angeles County Department of Mental Health
550 S. Vermont,
Los Angeles California,

Dear Commission Members,

The Asian Pacific Policy and Planning Council (A3PCON) appreciates this opportunity to comment to the Los Angeles County Mental Health Commission on the MHSA Annual Update for Fiscal Year 2010-11. While the report indicates overall progress, we are concerned that the data reflect a disturbing trend of continued underrepresentation and underutilization by API consumers. Despite the increase of APIs in the County to 15%, these data indicate that there is an increase in disparity in mental health services between the actual number of people served and their representation in the general population when across all age groups and programs only 3% are API consumers. These data indicate that actual use is as much as five times less than what one would reasonably expect.

A3PCON notes that API underutilization is not due to a lack of bilingual bicultural multidisciplinary API providers in this county. As the Department of Mental Health knows, A3PCON and its mental health member agencies have developed a well -coordinated county-wide system of culturally competent care. In fact, according to MHSA outcome data for FSP, these agencies have reported relatively full utilization. Our internal review of data indicates that the API contract providers account for over 90% of the total number of API consumers being served through MHSA funding in the County (all age groups).

A3PCON contends that the widening disparity is the direct result of flawed funding decisions. While the CSS plan had specific numerical targets for each identified underrepresented ethnic minority population, in the case of API's, the allocation of funding to agencies did not take into account the demonstrated cultural and linguistic competence of the provider as a primary factor. DMH employed a service area based allocation strategy that assumed that all agencies could serve APIs based on the demographic presence in that service area. This failed to address one of the key challenges for APIs to utilize services – trust in a culturally sensitive, community based organization to provide services. DMH's service area strategy dilutes what was intended as a targeted approach to address underrepresentation for APIs.

Clearly there have been great strides in the implementation of MHSA programs but for our API communities, the DMH goal to increase API representation in MHSA services has fallen short of

even minimal goals. A3PCON believes that the central cause was the absence of cultural and linguistic competence as a criterion for allocation decisions. It strongly advocates for a more equitable allocation through a significant increase in MHSA resources to API providers that are culturally sensitive to achieve the system wide target of improved access of care for API communities.

Sincerely,

Mariko Kahn,
A3PCON President

Dr. Herbert Hatanaka,
A3PCON Mental Health Committee Chair

EXHIBIT C

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-13

EXECUTIVE SUMMARY

The purpose of the Annual Update is to provide stakeholders across Los Angeles County with information on the status of implementation of the County's MHSA programs for the prior Fiscal Year (FY) 2010-11 as well as to project service expectations for FY 2012-13.

The structure of this Annual Update was agreed upon by counties across the State of California through a workgroup convened by the California Mental Health Directors' Association and approved locally by the Los Angeles County Mental Health Commission Executive Board and their convening of Service Area Advisory Committee Chairs.

The Annual Update is structured in the following way:

- Descriptions of all MHSA programs by component including implementation challenges and barriers and strategies used to overcome those challenges.
- Any proposed changes to MHSA programs next Fiscal Year.
- A summary of key program outcomes by MHSA component, including key Full Service Partnership (FSP) living arrangement outcomes, Field Capable Clinical Services (FCCS) outcomes, Wellness Center and Client-Run Center outcomes, Urgent Care Center (UCC) outcomes, Workforce, Education and Training (WET) accomplishments and Prevention and Early Intervention (PEI) outcome data collection strategy and initial outcome reports by practice.
- MHSA funding for FY 2012-13
- Prudent Reserve investment and utilization

Clients Served
In FY 2010-11, 169,697 clients were served by programs within the Community Services and Supports (CSS) Plan and 47,231 clients were served by Prevention and Early Intervention Programs.

Within the CSS plan, 9,878 clients were served by FSP programs, including:
- 3,180 children and families
- 1,620 transition age youth
- 4,672 adults
- 406 older adults

Of the 47,231 clients served by Prevention and Early Intervention programs, 77% of clients served were either children or transition age youth:
- 26,621 children and families

- 9,667 transition age youth
- 10,156 adults
- 495 older adults
- 292 served through Healthy Way LA low income health plan, ages 19 and above

Program Outcomes

When evaluating the impact of **FSP** services for clients served, the reports contained in this Annual Update are developed by collecting living arrangement information on all enrolled clients for the 365 days prior to enrollment and comparing it to changes in living arrangements after enrollment. These changes include incarcerations and psychiatric hospitalizations. In order to create equivalency between data reported the year prior to enrollment to data reported after enrollment, an annualization factor is applied to the data and a percent increase or decrease is calculated. Overall, FSP programs have demonstrated sustained reductions in days as well as clients homelessness, incarcerations and psychiatric hospitalizations. Adult, transition age youth and older adult FSP programs have increased the percentage of their clients who live independently.

Across age groups, **FCCS** programs seem to have the greatest impact in the areas of increasing involvement in one's community and in increasing meaningful activities, as defined by the client.

Mental Health UCC continue to demonstrate their effectiveness in reducing the likelihood of a psychiatric hospitalization, with only 3.2% of clients receiving a UCC service having a psychiatric hospitalization within 30 days of the UCC service.

Wellness and Client-Run Centers obtain semi-annual feedback from clients through a structured questionnaire, with the following key results:

- Strong alliances are reported with various treatment team staff, including peer staff, psychiatrists and therapists
- The majority of clients reporting strong engagement in services and satisfaction with care
- Half of the clients surveyed report that they receive care for physical health concerns and two thirds of clients surveyed reported that their physical health was a concern
- The majority of clients surveyed reported that they are sometimes or usually able to cope when things go wrong and accomplish what they wish to
- The majority of clients surveyed report usually making progress in their recovery goals and being socially connected to others

Prevention and Early Intervention practices are being evaluated by comparing client functioning and symptom levels, as measured by specific instruments, at the beginning and at the end of the treatment. The first three practices to be

evaluated in this way are Triple P Parenting, Trauma Focused Cognitive Behavioral Therapy and Managing and Adapting Practice.

Finally, DMH employs many approaches to user support and communication with providers to aid in the entering of outcome data and the use of reports and data. Some of these communication strategies are displayed under Exhibit G, including the Outcome Measure Application (OMA) Newsletter, a sample Quick Guide that summarizes pertinent information for each of the PEI outcome measures/questionnaires and the summary of general and specific outcome measures for PEI practices.

Funding for Fiscal Year 2012-13

The State estimates an approximate 20% increase in MHSA funds for FY 2012-13 over FY 2011-12. The increase in funds will go to restoring the service decreases that occurred over the last 2 fiscal years as a result of the decrease in MHSA funds since FY 2009-10.

LA County estimates an increase of $ 11 million in **PEI funding** for FY 2012-13. The funding will be used to extend one-time funding given to providers implementing the following PEI practices for children, families and transition age youth:

Evidence Based Practices	
Aggression Replacement Training	Interpersonal Psychotherapy for Depression
Alternatives for Families/Abuse Focused CBT	Loving Intervention for Family Enrichment Program
Brief Strategic Family Therapy	Managing and Adapting Practice
Caring for Our Families	Multidimensional Family Therapy
Child-Parent Psychotherapy	Multisystemic Therapy
Cognitive Behavioral Intervention for Trauma in Schools	Parent-Child Interaction Therapy
Crisis Oriented Recovery Services	Promoting Alternative Thinking Strategies
2K-IMPACT-MHIP Total	Reflective Parenting
Depression Treatment Quality Improvement Intervention	Seeking Safety
Functional Family Therapy	Strengthening Families
GLBT Champs	Trauma Focused CBT
Group CBT for Major Depression	Triple P Positive Parenting Program
Incredible Years	UCLA Ties Transition Model

Prudent Reserve Investment and Utilization

In order to continue services at the existing levels, the Department will withdraw $18 million dollars in funding this fiscal year from the prudent reserve. The Department will also withdraw an additional $30 million for use in fiscal years 2012-13 and 2013-14 to fund critically needed services within the existing Community Services and Supports plan. Funding withdrawn from the prudent

reserve will be used by age group according to how it was deposited, accordingly:

- FSP expansion
  - 30 additional TAY slots, includes probation camp slots
  - 60 additional older adult slots

- FCCS expansion:
  - 627 additional children to be served
  - 60 additional TAY to be served for those transitioning from probation camps
  - 94 additional adult clients to be served
  - 100 additional older adult clients to be served

- Enhanced alternative crisis services to reduce psychiatric emergency service over-utilization:
  - 11,000 additional clients to be served by Mental Health Urgent Care Centers
  - 126 additional clients served in IMD-Step-down programs
- 3,529 additional shelter beds for TAY
- TAY Drop-In Center expansion to serve an additional 250 clients

Section I: Community Services and Supports

A. BRIEF PROGRAM DESCRIPTION

Plan, Plan ID	Program Description
Adult Full Service Partnership A-01	Adult Full Service Partnership (FSP) program is designed for adults who have been diagnosed with a severe mental illness and would benefit from an intensive service program for clients ages 26-59, who are homeless, incarcerated, transitioning from institutional settings, or for whom care is provided solely through the family. Services include a wide array of mental health services, medication support, and linkage to community resources, support, housing, employment and money management services and assistance in obtained need medical care. Programs target clients from all ethnic communities, with a collaborative focusing specifically on the Asian Pacific Islander communities.
Wellness/Client Run Centers A-02	Self-directed, community-based services staffed by peer and professional support geared toward physical/emotional recovery and increased community integration. Focal population is clients at higher levels of recovery.
IMD Step Down Facilities A-03	IMD Step-Down Facility programs are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), and in some instances, assisted living, congregate housing or other independent living situations. The program also assists clients transitioning from acute inpatient and institutional settings to the community by providing intensive mental health and supportive services.
Adult Housing Services A-04	The Adult Housing Services include 14 Countywide Housing Specialists that provide housing placement services primarily to individuals and families that are homeless in their assigned Service Area.
Jail Transition & Linkage Services A-05	Jail Transition and Linkage Services are designed to outreach and engage individuals involved in the criminal justice system and receiving services from jail or jail related services (e.g. court workers, attorneys, etc.) and successfully link them to community-based services upon their release from jail. The program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Jail Transition and Linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and supports upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.
Adult Field Capable Clinical Services A-06	The Adult Field Capable Clinical Services (FCCS) program provides an array of recovery-oriented, field-based and engagement -focused mental health services to adults. Providers will utilize field-based outreach and engagement strategies to serve the projected number of clients. The goal of Adult FCCS is to build the capacity of DMH to serve this significantly underserved population with specifically trained professional and paraprofessional staff working together as part of a multi-disciplinary team. Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, evidence-based practices, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support. FCCS will directly respond to and address the needs of unserved/underserved adults by providing screening, assessment, treatment, linkage, medication support, and consultation.
Children's Full Service Partnership C-01	Children's FSP program is comprised of resiliency-focused services created in collaboration with family/caretakers and a multidisciplinary team that develops and implements an individualized plan. Child FSPs deliver intensive mental health services and supports to children ages 0-15 who are high-need, highrisk Seriously Emotionally Disturbed (SED) children and their families/caretakers. Focal populations include children 0-5 with a serious emotional disturbance, children with a mental illness involved with DCFS, schools or the probation system.

Plan, Plan ID	Program Description
Family Support Services C-02	Family Support Services (FSS) provide access to mental health services such as individual psychotherapy, couples/group therapy, psychiatry/medication support, crisis intervention, case management linkage/brokerage, parenting education, domestic violence and Co-Occurring Disorder services to parents, caregivers, and/or other family members of Full Service Partnership (FSP) enrolled children who need services, but who do not meet the criteria to receive their own mental health services.
Children-Field Capable Clinical Services C-05	Children's Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented, field-based and engagement-focused mental health services to children and families. Children's FCCS programs provide specialized mental health services delivered by a team of professional and Para-professional staff. The focus of FCCS is working with community partners to provide a wide range of services that meet individual needs. The program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic based services.
Older Adult Full Service Partnership OA-01	The foundation of the Older Adult FSP program is providing services and supports to help clients ages 60 and above progress toward recovery and wellness. The FSP assists individuals with mental health and substance abuse and ensures linkage to other needed services, such as benefits establishment, housing, transportation, healthcare and nutrition care. Older Adult FSP program works collaboratively with the OA client, family, caregivers, and other service providers and offer services in homes and the community. Older Adult FSPs place an emphasis on delivering services in ways that are culturally and linguistically appropriate.
Transformation Design Team OA-02	Older Adult Transformation Team provides system support to develop the infrastructure of older adult services within MHSA. The team will: • Monitor outcome measures utilized in the FSP & Field Capable Clinical Services programs. • Utilize performance-based contracting measures to promote program services.
Field Capable Clinical Services OA-03	An individual must be either 60 years of age and above or be a "transitional age adult (55-59 years) and have a serious and persistent mental illness or have a less severe or persistent Axis I disorder that is resulting in a functional impairment or that places the Older Adult at risk of losing or not attaining a life goal, for example risk of losing safe and stable living arrangement, risk of losing or inability to access services, risk of losing independence. Services provided include: outreach and engagement, bio-psychosocial assessment, individual and family treatment, medication support, linkage and case management support, treatment for co-occurring disorders, peer counseling, family education and support. FCCS will directly respond to and address the needs of unserved/underserved older adults by providing screening, assessment, linkage, medication support, and geropsychiatric consultation.
Service Extenders OA-04	Service Extenders are peers in recovery, family members or other individuals interested in providing services to older adults as part of the multi-disciplinary FCCS teams. 40 individuals are targeted for providing these services.
Older Adults Training OA-05	Older Adult Training Program will address the training needs of existing mental health professionals, and community partners by providing the following types of trainings: field safety, elder abuse, documentation, co-occurring disorders, hoarding, geriatric psychiatry, gero-psychiatry fellowship.
Transitional Age Youth Full Service Partnership T-01	Transition Age Youth (TAY) FSP program delivers intensive mental health services and supports to high need and high-risk Severely Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) Transition Age Youth ages 16 - 25. TAY FSPs place an emphasis on recovery and wellness while providing an array of community and social integration services to assist individuals with developing skill-sets that support self-sufficiency. The foundation of the TAY FSP program is doing "whatever it takes" to assist individuals with accessing mental health services and supports (e.g. housing, employment, education and integrated treatment for those with co-occurring mental health and substance abuse disorders). Unique to FSP programs are a low staff to consumer ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers.

Plan, Plan ID	Program Description
TAY Drop-in Centers T-02	TAY Drop-In Centers are intended as entry points to the mental health system for homeless youth or youth in unstable living situations. Drop-in centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can, as the youth is ready and willing, connect them to the services and supports that they need. Drop-In Centers also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, mailing address, and a safe inside place to rest that is away from the elements. Generally, these centers are operated during regular business hours. MHSA funding allows for expanded hours of operation of Drop-In Centers during evenings and weekends when access to these centers is even more crucial.
TAY Housing Services T-03	There are three housing related systems development investments for the TAY population. These include: 1. Enhanced Emergency Shelter Program (EESP) (Previously, Motel Voucher Program) for TAY that are homeless, living on the streets and in dire need of immediate short-term shelter while more permanent housing options are being explored. The annual target for EESP is 300 cleints. 2. Project-Based Operating Subsidies for Permanent Housing to address the long-term housing needs of SED/SPMI TAY who, with sufficient support, could live independently in community settings. The targeted number of youth to secure units with TAY Project-Based Operating Subsidies is 72. 3. A team of 8 Housing Specialists develop local resources and help TAY find and move into affordable housing.
TAY Probation Camps T-04	Probation Camp Services provide services to youth ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED, SPMI, those with co-occurring substance disorders and/or those who have suffered trauma. A multidisciplinary team of parent/peer advocates, clinicians, Probation staff, and health staff provide an array of on-site treatment and support services that include the following: assessments, substance abuse treatment. gender-specific treatment, medication support, aftercare planning and transition services. TAY Probation services fund mental health staff at the following probation camps: Camp Rockey-Paige-Afflerbaugh, Camp Scott-Scudder, Camp Holton-Routh, Camp Gonzales, Challenger Complex and Camp Miller-Kilpatrick.
TAY Field Capable Clinical Services T-05	The Transitional Age Youth Field Capable Clinical Services (FCCS) program provides an array of resiliency-oriented, field based and engagement-focused mental health services to TAY and their families. The TAY FCCS program provides specialized mental health services delivered by a team of professional and paraprofessional staff. The focus of the FCCS program is to work with community partners to provide a wide range of services that meet individual needs. The TAY FCCS program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

Plan, Plan ID	Program Description
Systems Navigator SN-01	Service Area Navigator Teams will assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking would create portals of entry in a variety of settings that would make the Department's long-standing goal of no wrong door achievable. The Service Area Navigators increase knowledge of and access to mental health services through the following activities: • Engaging in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to clients in the mental health system. • Promoting awareness of mental health issues, and the commitment to recovery, wellness and self-help. • Engaging with people and families to quickly identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity if those seeking them. • Recruiting community-based organizations and professional service providers to become part of an active locally-based support network for people in the service area, including those most challenged by mental health issues. • Following-up with people with whom they have engaged to ensure that they have received the help they need.
Alternative Crisis Services ACS-01	Alternate Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration and linkage to community-based programs, e.g. Full Service Partnerships (FSP) and Assertive Community Treatment Programs (ACT), housing alternatives and treatment for co-occurring substance abuse. ACS provides these services and supports to individuals of all genders, race/ethnicities, languages spoken, and those 18 years of age and older.

Plan, Plan ID	Program Description
Planning Outreach & Engagement POE-01	**Project 50** is a demonstration program to identify, engage, house and provide integrated supportive services to the 50 most vulnerable, long-term chronically homeless adults living on the streets of Skid Row. Project 50 involves 3 phases: 1) Registry of homeless individuals; 2) Outreach Team to assess needs, define services and develop plan for service delivery; and 3) Integrated Supportive Services Team to coordinate interagency collaboration for comprehensive care and services. Populations to be served include: the most vulnerable, chronically homeless adults in the Skid Row area of downtown Los Angeles across gender and linguistic diversity. **Homeless Outreach and Mobile Engagement Team (HOME)**, formerly known as HOET, provides county-wide, field-based, and dedicated outreach and engagement services to the most un-served and under-served of the homeless mentally ill population. In this capacity its staff function as the 'first link in the chain' to ultimately connect the homeless mentally ill individual to recovery and mental health wellness services through a collaborative effort with other care giving agencies and county entities. HOME serves predominantly adults and TAY by providing intensive case management services, linkage to health, substance abuse, mental health, benefits establishment services, transportation, assessment for inpatient psychiatric hospitalizations and any other services required in order to assist the chronically homeless and mentally ill across gender, cultural and linguistic diversity. **Under-Represented Ethnic Populations (UREP)** Through the use of one time funding, the Department has been able to fund projects aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities. One such example is Training for and Services provided by Promotores de Salud. The purpose of the training is to support the development and increase the capacity of Promotores to perform specialized mental health work with the Latino community, including mental health outreach to the Latino indigent population and monolingual Spanish-speaking communities. Similarly, a mental health worker program has been designed to provide professional support for Latino students interested in entering the mental health field. This project will involve the enhancement of existing mental health paraprofessional training programs. MHSA programs such as the ones mentioned above focus on reducing racial/ethnic disparities and providing services to unserved, underserved populations and inappropriately served.

Section I: Community Services and Supports

B. FOR FISCAL YEAR 2010-11 DESCRIBE ANY CHALLENGES OR BARRIERS AND THE STRATEGIES USED TO MITIGATE THOSE CHALLENGES OR BARRIERS

Plan, Plan ID	Challenges or Barriers and Strategies Used
Adult Full Service Partnership A-01	Challenges Included: 1.Encouraging greater utilization of assigned slots Strategy: Use of data to provide feedback to providers on slot utilization, Service Area District Chiefs, and Navigators on a monthly basis to assist them with management of Full Service Partnership (FSP) slots in their area. 2. Weaving in service to military veterans who qualify for FSP and are in need of intensive services who, because of their discharge status, did not qualify to receive services from the local Veteran' Administration programs. Strategies: a. Collaboration with the new adult veteran's lead and Adult FSP providers who have expressed interest in serving homeless veterans to facilitate outreach and engagement, and ensure quality services to this specialty population. b. Presentation to Full Service Partnership providers on the Homeless Veteran's Outreach project. 3. Promote additional opportunities for volunteers in supporting individual client self-help and recovery plans. Strategy: Adult Systems Of Care developed specialized training for peer and community volunteers interested in promoting recovery and working with clients in community mental health settings. 4. Developing greater community-based service alternatives to promote movement of FSP participants to lower levels of care and their neighborhood resources for ongoing, long-term recovery support. Work with Field Capable Clinical Services providers to reinforce their role in transitioning clients from the FSP level of care to their program. Strategy: Exploration of potential strategies to improve graduation via specialized workgroups of providers and Department members.
Wellness/Client Run Centers A-02	Fiscal year 2010-11 saw continued expansion of Wellness and Client Run Centers. Challenges and strategies included: 1. Ensuring programs provided recovery oriented services. Strategies: a. Developed immersion trainings with successful wellness centers to aid newer wellness programs to observe, participate, and master this unique service delivery venue. Thus far, nine directly operated wellness programs have successfully completed the Immersion training. The remaining eleven Directly Operated Wellness programs will take part in Immersion training in FY 2011-12. b. Ensure focus on consistent and broadened communication through provider meetings. c. Developed and provided three Recovery Documentation trainings for staff to become proficient in the documentation of recovery-based services for Medi-Cal reimbursement. 2. Ensuring Peer participation in programming. Strategies: a. Developed a specialized training program to promote Volunteer, Peer, and Family participation in Directly Operated Wellness Centers. b. Encouraged use of volunteers, as well as people with lived experience, for involvement and use within the contract providers' network. c. Provided food handling and safety trainings to centers in order to promote development of healthy living and cooking groups to increase the overall health of consumers, utilizing peer and mental health nursing staff.
IMD Step Down Facilities A-03	During Fiscal Year 2010-11, IMD Step Down Facilities received an increasing number of referrals for mentally ill individuals involved with the criminal justice system. In response to this increase of referrals, DMH was able to expand IMD Step Down Facility services for individuals with criminal justice involvement. DMH also implemented an IMD Step Down Facility for hearing impaired individuals.

Plan, Plan ID	Challenges or Barriers and Strategies Used
Adult Housing Services A-04	The economic climate made it difficult to assist clients with finding affordable housing. One of the resources for affordable housing was Shelter Plus Care but many clients did not qualify for Shelter Plus Care because they did not receive enough services to meet the required service match. In order to mitigate this issue, the Department applied for more Homeless Section 8 vouchers which provide subsidized housing but do not require a service match. Also, some of the Countywide Housing specialists have other duties which prevent them from being dedicated full time to assisting clients with housing. For the MHSA Housing Program, the Expression of Interest was suspended for most of the Fiscal Year because the Department had committed almost all of the funds. The Department was only able to consider and commit to very few requests for funding. To mitigate this problem, more funding could be allocated to the MHSA Housing Program which would allow DMH to invest in more Permanent Supportive Housing for its clients.
Jail Transition & Linkage Services A-05	Challenges Included: 1. Inadequate resources of the appropriate service level available for clients seen in the Mental Health Court Linkage Program. Strategy: Mitigation was expansion of residential treatment beds at Olive Vista. 2. Difficult to get appointments for clients in the outpatient clinics because of waiting lists. The Department is currently working to reduce the wait time at outpatient clinics. 3. Lack of resources for difficult to treat/house populations such as those: charged with arson, charged with a sex offense and those dually diagnosed with mental illness and borderline intellectual functioning (not eligible for regional center) Strategy:Mitigation is the jail linkage staff are always seeking out new resources for this population. 4.Community providers hesitant or unwilling to take clients coming from the jail. Strategy: Become more interactive in the community; develop personal relationships with various agencies, community and faith based organizations, developing trust and opportunities to advocate for clients in the community. 5. Jail clients often receive harsh sentences in court that do not address treatment concerns. Strategy: Advocate for clients during the court process, develop closer working relationships with court staff. 6. Finding appropriate housing for clients. Strategy: Partnering with emergency shelters as a temporary housing location for clients until more suitable housing can be located. Physically taking clients to tour various facilities until more permanent housing can be found. Become more aware of Departmental housing resources for clients. 7. Difficult to establish connection with women at time of release. Strategy: Women's Community Reintegration Services and Education Center (WCRSEC) staff provide services in the Women's jail on a daily basis: WCRSEC staff provide more intensive work in-reach with clients while they are still incarcerated to facilitate rapport, explain the services provided at WCRSEC, and the ancillary services provided at the 8300 Vermont facility, and often transport clients directly from the jai to WCRSEC. 8. Clients at New Image emergency shelter unable to fully connect to WCRSEC. Strategy: WCRSEC staff provides expanded provision of mental health outreach and education to the entire underserved population at the shelter. Transportation to and from WCRSEC is provided for all clients staying at the shelter on a daily basis. 9. WCRSEC lacked structure for tracking and assisting indigent clients with benefit establishment. Strategy: Specific WCRSEC staff was identified who would be responsible for assisting clients with benefit establishment, to include Social Security, Medi-Cal, and Health Way LA.
Adult Field Capable Clinical Services A-06	Challenges Included: 1. Timely initiation and completion of training on the Field Capable Clinical Services (FCCS) model, in addition to ensuring outcomes completion by providers expanding delivery of FCCS services. Strategies: a. Adult Systems Of Care solicited feedback from service providers concerning improvement in supporting their efforts. Based on this input, provider meetings were redesigned in FY 2011/12 to focus increased attention on FCCS providers and the provision of the trainings for FCCS team leads. b. ASOC promoted available Outcomes Measurement Application (OMA) trainings, focusing specific attention on reviewing development of OMA baseline input data, and following up with providers needing additional specific support. 2. The promotion of recovery services. Strategy: To support delivery of more innovative services, ASOC collaborated with the Quality Assurance division and providers to develop Recovery Oriented Documentation training for staff. This training was designed to foster the ability to appropriately document a broader range of recovery-based services for Medi-Cal reimbursement.

Plan, Plan ID	Challenges or Barriers and Strategies Used
Children's Full Service Partnership C-01	Children's Countywide MHSA Administration (CW) analyzed Child Full Service Partnership (FSP) disenrollment data for FY 10-11 for all child FSP programs. CW decided to visit agencies that had a 35% or lower successful disenrollment rate in order to provide supportive technical assistance. An analysis of disenrollment data indicated that the countywide average disenrollment for goals met is 56%. Based on this criterion, five provider sites were identified. The successful disenrollment rates for these identified sites ranged from 0% to 33%. Disenrollment data gathered indicated the following challenges and barriers: • Limited or no case manager • No parent partner involvement • Inconsistencies in documentation • Confusion when a client has both private and Medi-cal coverage • Lack of permanent housing • Slot availability for uninsured and indigent clients Each year CW conducts a telephonic survey of children and families who are currently enrolled in FSP or have been in the past. A comparative analysis of 2009 and 2010 survey data indicates an increase of all categories surveyed in 2010 over the previous year. The increased satisfaction in key FSP performance criteria combined with an 88% overall satisfaction demonstrates a commitment to the FSP model. Resolution: • Provided documentation training, "Strengthening Families and Resiliency," to assist providers with using a resiliency perspective in documentation to meet medical necessity, to improve quality assurance and to decrease claiming denials. • Conduct a focus group with parents of enrolled FSP children to determine what is working and what needs adjustment. • Offer training to increase the capacity of parent partners and their skills. • Modify the FSP Exclusionary Guidelines II.C. to NOT exclude clients with other health coverage and Medi-Cal.
Family Support Services C-02	Data analysis indicated minimal delivery of Family Support Services (FSS) and a significant under utilization of FSS funding. Data indicates that the biggest obstacle preventing the majority of providers from implementing FSS was a general lack of understanding relating to FSS eligibility and billing. • Clinician's use of "collateral" code 90887 to provide familial support. • Providers have a lack of experience in treating and charting adult interventions, which made implementing FSS seem overwhelming – so they avoided completing it altogether. • Full Service Partnership (FSP) Child clients' significant support persons actually meeting criteria to receive their own services at Los Angeles County Department of Mental Health Directly- Operated or County-Contracted Adult outpatient clinics Resolution: • Allow agencies to shift funds to service dollars. • Use of Community Outreach Services to claim FSS. • Technical assistance and training regarding use of FSS.

Plan, Plan ID	Challenges or Barriers and Strategies Used
Children-Field Capable Clinical Services C-05	For FY 2010-11, Countywide Child MHSA Administration (CW) conducted a desk performance evaluation. Field Capable Clinical Services (FCCS) agencies completed a program specific self assessment. Agencies report the biggest challenges and barriers include: • Hiring and retaining parent partners and bi-lingual staff, which is not a requirement in the FCCS program model for children. While providers identified the above mentioned service barriers, expenditures have steadily increased since program implementation. In an effort to assist providers with successfully implementing FCCS and to address the above barriers, CW provides technical training and support. • A pilot training module was launched titled: Integrating Community Partnerships in Reflective Supervision. • Held quarterly Roundtable Meetings with providers. • Ongoing consultation & monthly meetings with Service Area Child Navigators. • Training curriculum on topics such as Cultural Competence, Field Safety, & various evidence based practices. • Provide agencies assistance with self-monitoring. Data: Field based services percentages; Outcomes Measurement Applications Compliance; IS Reports on FCCS Expenditures
Older Adult Full Service Partnerships OA-01	**Outcomes Measurement Assessment:** Providers previously utilizing CAMINAR as a database have begun implementation of the Outcomes Measurement Application (OMA) for both FSP and FCCS programs. Some providers have reported difficulty with completing or entering data on the OMA due to lack of staff or unresolved OMA issues. Also, Reporting Unit issues have also affected the ability for some providers to make corrections or complete OMA reports (baseline, 3M, KECs). The OA Administrative team has addressed and provided support to providers while at quarterly site visits to help decrease the number of issues/problems in the OMA reports (60 Day no service, Baselines, etc.) Training schedules have also been distributed to providers for further training. **Qualified bicultural, Bilingual Staff** There continues to be a large gap in the availability of qualified mental health staff to ensure that services are being provided in the client's language and/or are culturally congruent. Few providers with the financial resources have taken the appropriate steps to staff their agencies with qualified bicultural/bilingual staff. Efforts are also being directed towards increas **Slot Utilization in Specific Service Areas and Indigent Funding** The current OA FSP enrollment is at 94%. Enrollment has slowly improved in the last few months. Outreach efforts have been noted by providers. One provider sends staff to outreach in skid row, board and cares in the area, hospitals, and senior centers to increase slot utilization. In addition, collaboration with directly operated agencies and Adult FSP programs has proven to be effective in increasing outreach and an increase in OA enrollment.
Transformation Design Team OA-02	Three staff came into our Older Adult Systems of Care Bureau during FY 2010-11 as part of the Transformation Design Team: a Mental Health Analyst II, a Mental Health Services Coordinator II (MHSC), and a Secretary III. The Analyst has assisted in the oversight and monitoring of our MHSA programs by formulating data reports on claims and maximum contract amounts utilization by the contract providers. The MHSC is an integral part of the OA administrative team, serving as the key point person to approximately half of the Older Adult providers. The Secretary's organization skills have assisted in the administrative duties required for running a smooth operational team. Prior to their coming on board there were gaps in coverage of these areas due to staff transferring or promoting.
Field Capable Clinical Services OA-03	During FY 2010-11 there were 17 Older Adult Field Capable Clinical Services' (FCCS) contracted providers and 10 directly-operated FCCS providers. • The FCCS outcomes collection compliance remains a challenge for most of our providers, and at our regular program monitoring site visits our Older Adult administrative team reviews the outstanding outcomes to determine the best way to correct them. The team refers the provider to the data labs and/or has forwarded the list to the MHSA Implementation team for further consult to correct. • Two of our directly-operated providers regularly provide Outreach and Engagement through co-locations in nearby senior/community centers but have received very few clients due to most seniors having private insurance. • The teams in several of our directly-operated providers have had difficulty keeping fully staffed, particularly for the nurse practitioner item. • Overall providers continue to struggle with recruitment of bilingual staff. Often this helped by bringing in bilingual interns during the school year.

Plan, Plan ID	Challenges or Barriers and Strategies Used
Service Extenders OA-04	Throughout FY 2010/11, Older Adults (OA) had 22 Service Extenders placed in nine agencies county-wide. OA Administration continually strive to address training and recruitment of Service Extenders. In May 2011, OA Administration completed a series of six monthly workshops to enhance the skills of the Service Extenders which was started in November 2010. Topics included Coping with the Holidays; a two-part session on Growing Old: Understanding Life Span Issues; a two-part session on Coping with Challenging Situations; and Self Care & Summing Up. These workshops were opened to Service Extenders as well as those interested in becoming Service Extenders, and there were approximately 35 regular attendees. The feedback from these workshops was extremely positive. The ethnicities of the Service Extenders include Hispanic, African-American, Euro-American, Chinese, Filipino, Iranian, Russian, Cambodian, and South Asian/Asian Indian. The languages spoken by the Service Extenders include Spanish (4), Khmer (4); Mandarin (2); Tagalog (2); Vietnamese (1); Cantonese (1); Russian (1); and Farsi (1).
Older Adults Training OA-05	Challenges to training included preparing and securing training materials, such as PowerPoint, educational materials, pamphlets and other visual aids. Other challenges included securing Continuing Education Units (CEU), Continuing Education (CE) and Continuing Medical Education (CME) for various trainings and participants. Difficulty with marketing, when attracting outside DMH contract providers. Assessment and budget management in making sure training expenditures are within and not exceeding budget guidelines and amounts. Equipment management, making sure sufficient training equipment is available to deliver the type of training that Department provides for community. Barriers-locating affordable and within budget community venues, venues physically disabled friendly parking and access, overcoming training approval for consumers and community at large. Strategies-Devote resources and man power to employee development and assessing and reporting training effectiveness to upper management. Up to and including the impact of training on DMH and outside providers. Develop a calendar that not only details type of training opportunities being offered but as well as marketing strategies, service areas, community enrollment/participation, assessment of community training needs, what community expected to learn, improved communication and consultation with upper management and designing and developing training programs for staff and community with will be expected for Older Adult Population.
Transitional Age Youth Full Service Partnership T-01	TAY FSP Providers have made measurable improvement in reducing the Outcome Measurement Application (OMA) baseline errors during the first half of FY 10/11. • The TAY administration provided training to providers on error reports and worked closely with them to clear up the backlog of missing baselines, OMA errors rates decreased by 69.8%. • These efforts also addressed baseline errors which helped providers improve their compliance with reporting requirements. Need for feedback from TAY FSP clients and/or their families about the services and supports received, areas of strength, and where there is opportunity for improvement. • TAY administration is currently conducting a telephone Satisfaction Survey of disenrolled TAY FSP clients. Providers experience challenges serving TAY FSP clients. • Providers are struggling with transitioning clients, primarily the longer-term TAY FSP clients, to less intensive services • Per client costs have risen since the program's inception; the DMH has authorized shifting of a portion of the underutilized TAY FSP CSS Flex Funds to increase funding available for clinical services matched to Medi-Cal and unmatched for indigent.
TAY Drop-in Centers T-02	• Providers struggle with TAY diagnosed with co-occurring substance abuse disorders who are generally in early stages of change/recovery with regards to mental health and substance use. • Many of these TAY clients are difficult to engage in mental health services. • TAY Division Navigation staff work with Drop-in Center staff to help link TAY clients to appropriate mental health services as well as substance abuse treatment. • The TAY Division sponsors trainings in Evidence-Based Practices (EBP) Motivational Interviewing, and Seeking Safety for the Drop-In Center staff. These trainings are offered as "tools" to assist providers in their Outreach and Engagement (O&E) efforts for TAY who are willing to obtain services in Drop-In Center settings.

Plan, Plan ID	Challenges or Barriers and Strategies Used
TAY Housing Services T-03	**Enhanced Emergency Shelter Program (EESP): Fiscal year 2010-11** approximately 300 youth have been housed in the TAY EESP shelters; these youth were provided with linkage to mental health services, substance abuse, and housing resources. To address concerns about TAY clients with multiple and recurrent shelter stays and the difficulties with accessing more permanent housing resources, modifications were made to the shelter program services: • In FY 2010-11 increased the maximum number of consecutive from 29 to 45 nights. • Amended EESP contracts to better define supportive services and programming components: 1) Life Skills Counseling; 2) Healthy Living Groups; and 3) Transportation supports. **Housing Specialist Program:** Limited and/or lack of permanent housing options: • Designated a staff Housing Specialist to coordinate access to the MHSA Housing Program permanent housing units; • Designated clinically trained staff to coordinate supportive services components with property managers and their staff to ensure TAY has access to MH services and supports to be able to maintain their independent functioning in the permanent housing. **Project-Based Operating Subsidies (PBOS):** The TAY PBOS project had not identified additional MHSA housing projects to receive available funding. However, TAY administration is working with the DMH Housing Program lead manager to develop a streamlined process to make funding available to housing developments that already have other committed funding; and that are willing to designate additional permanent housing units for TAY.
TAY Probation Camps T-04	Operational and staffing challenges have been addressed to improve and increase services. • Probation Electronic Medical Records (PEMRs) facilitated information exchange between the Juvenile Halls and the Camps. • With the hiring of 88 additional clinical staff, 26 of which were MHSA-funded, services have been enriched, and mental health services are now available 7 days a week, including evening hours and there is an increase in the ability of clinical staff to respond to crisis. • Transportation vans are now available to transport families to attend MDTS and IEPs and to visit with their detained children.
TAY Field Capable Clinical Services T-05	During Fiscal Year 2010-11 there was an increase in the number of Field Capbable Clinical Services (FCCS)-contracted providers. • As a result the number of TAY clients receiving FCCS services grew significantly. • TAY Navigators where able to provide linkage to FCCS services with higher frequency. • Increased opportunities for FSP clients to receive step-down services from FCCS. Providers experience challenges serving TAY FCCS clients. • Providers are struggling with transitioning clients to less intensive services; especially for those 22 – 25 year olds. • Limited housing resources. Outcomes compliance remains a challenge for FCCS Providers. • TAY Administration will work with Providers to help bring them into compliance providing error reports and consultation on an on-going basis.
Systems Navigator SN-01	As new programs and services are planned and implemented, navigation becomes more essential. In particular, Fiscal Year 2010-11, Service Area Navigators have become involved in the referrals for Healthy Way LA as well as some navigation of AB 109 clients into services. Countywide support has focused on educating navigators about services and the distinctions between various programs.
Alternative Crisis Services ACS-01	During Fiscal Year 2010-11, Alternate Crisis Services (ACS) programs have served an increasing number of mentally ill individuals involved with the criminal justice system. In response to this increase, ACS expanded service capacity for these individuals. In order to meet the changing needs of Los Angeles County and its residents, DMH was able to expand services at the Eastside Urgent Care Center to be able to serve children and during this fiscal year, the Urgent Care Center at Olive View Medical Center moved into a new dedicated building in close proximity to Olive View Medical Center and was able to expand its service hours. Countywide Resource Management (CRM) became the point of contact for DMH for individuals being released under the Post Release Community Supervision (PRCS) program as part of Assembly Bill 109. As a result, CRM was able to implement the Community Reintegration Program where individuals being released by California Department of Corrections and Rehabilitation are screened and linked with community-based mental health services.

Plan, Plan ID	Challenges or Barriers and Strategies Used
Planning Outreach & Engagement POE-01	Challenges Included: 1. Lacking Outreach and Engagement (O&E) resources that are translated in the languages needed: handouts, brochures, and booklets with mental health information. There is no funding to purchase booklets and many of the existing materials are copyrighted. Strategy: Staff created resources by researching free literature available online and making photocopies of these materials to disseminate to the communities served. 2. Limited mental health services to link community members, specifically the indigent. Strategy: Facilitate linkage with Service Area Navigators. O&E staff also use We also tap into our lists of resources in each service area to find mental health providers that operate with sliding scales.

Section I: Community Services and Supports

C. LIST ANY SIGNIFICANT CHANGES FOR FISCAL YEAR 2012/13

Plan, Plan ID	Changes
Adult Full Service Partnership A-01	Emphasis will continue on the pursuit of improved utilization of assigned slots by utilizing Impact and Provider meetings to develop collaborative solutions. These meetings will highlight slot utilization history, accurate accounting of potential of engaged participants and other creative considerations. Greater effort will also be made during the coming fiscal year, working collaborative with the Veteran's Mental Health Unit, to establish service communications links and genuine networking to assure veterans can be enrolled into Full Service Partnerships (FSP) in their home communities near their primary family support systems. FSP programs will continue to be engaged in assisting Adult Systems Of Care with development of the creative options made available to FSP consumers. Existing staff will continue to promote acceptance by community social service resources of adult mental health consumers. For 2012-13, the objective of some of these challenges represents a further refinement of previously established program developments.
Wellness/Client Run Centers A-02	There are no significant changes planned for Fiscal Year 2012/13. This year the focus will concentrate on collaboration of health and mental health services in our community and for mental health consumers. Currently, Mental Health Care Navigator and Worker trainings are available to peer staff. This effort will increase the connection to and effective use of limited healthcare resources to our service recipients and improve creative collaborative work between community health and mental health resources.
IMD Step Down Facilities A-03	DMH will continue to evaluate IMD Step Down Facility services and adjust its capabilities to maximize service delivery for Los Angeles County residents. DMH will expand IMD Step Down Facility services to serve individuals involved with the criminal justice system.
Adult Housing Services A-04	To date, LAC-DMH has obligated $110 million of the $115 million, investing in 33 housing projects in various stages of development. Although 727 MHSA housing units will be built with the current funding, the demand for more Permanent Supportive Housing continues to be great. LAC-DMH proposes to allocate an additional $2 million to this program. The funding will come from un-spent CSS funds and will be transferred to CalHFA and will be placed in an interest earning account for LAC-DMH. LAC-DMH will continue to use the processes already in place to make funding decisions for the additional funds. DMH also proposes to transfer the funding allocated under MHSA CSS Systems Development for TAY Project Based Subsidies to the MHSA Housing Program and to delete the TAY Project Based Subsidies from the CSS plan. An annual amount of $424,000 is allocated for TAY Project Based Subsidies. **This funding will continue to be used for project based subsidies of TAY housing** and this action is consistent with the intent of the stakeholders when they included this in the original CSS plan which states, "delegates are also recommending significant investments in project based housing subsidies that will help establish permanent housing units available to transition age youth with serious mental health issues." This action will result in improved efficiency for allocating the funding and monitoring the program.
Jail Transition & Linkage Services A-05	Jail Linkage (JL) is increasing time spent with clients after release and in the community by providing assistance 30 days post release. JL plans to expand this provision of community services in several key areas: • Transportation and personal support for clients to and from various community agencies such as Departments of Public Social Services (DPSS) and Probation, and medical, mental health and substance abuse providers. • Linkage to Full Service Partnership (FSP) services in an effort to increase the number of clients from jail accepted into FSP and meets the target goal. • Direct linkage to other services: outpatient services, wellness center services, substance abuse treatment, co-occurring disorders treatment, and other aftercare services for clients' pre and post-release. • Expansion of benefit establishment to include Healthy Way LA. • More intensive work with clients while they are still incarcerated to facilitate rapport, explore motivation for change and engage the client and the family fully in the process of recovery. • Assist families with community supports and resources such as the National Alliance on Mental Illness (NAMI). • Develop an ongoing partnership with Homeboy Industries (HBI) interns, providing mentorship in case management skills while the HBI interns, in turn, mentor recently released clients about strategies for life changes that reduce recidivism in very practical ways. • Early intervention into the jail to engage clients while in mental health treatment by WCRSEC staff will be expanded. This contact will continue into the general population areas where mental health clients are often "stepped down" to once they have reached some stability. • Expand immersion training for all Women's Jail Mental Health Services staff at WCRSEC to build better communication and understanding of service provision.

Plan, Plan ID	Changes
Adult Field Capable Clinical Services A-06	No significant changes are pending for the coming year. However, the most significant challenge for next year is to strengthen the focus on working collaboratively with health care service providers to increase accessibility to supportive and needed healthcare services for the Field Capable Clinical Services population.
Children's Full Service Partnership C-01	No significant changes; however, Service Area Navigator meetings, Roundtable meetings, and Full Service Partnership (FSP) Provider meetings will continue to be held for program monitoring. Changes to be regularly communicated to providers as soon as possible to enhance outcomes and service improvement. Implement a standardized tracking form in all Service Areas to assist Navigators and providers in monitoring slot capacity and create a seamless referral system for all service levels, including FSP, Field Capable Clinical Services, outpatient and available Prevention Early Intervention Evidence Based Practices.
Family Support Services C-02	In the past, the Respite Care Program was offered as part of Family Support Services (FSS). It was designed to provide support services by helping relieve eligible parents and/or caregivers from the ongoing stress they may be experiencing as the result of providing constant care to a seriously emotionally disturbed child. The goal of the program was to preserve the family and prevent out-of-home care by creating an opportunity for the child to be cared for short periods of time by other family approved individuals so that the primary parents/caretakers have a chance to relieve the stress of their day-to-day care giving. During its first year of implementation, several unforeseen challenges became apparent, which, as a result, forced the Child Respite Care Services program to be suspended as of June 30, 2008. In an effort to increase utilization of FSS funding, plans and strategies are being developed to revamp and reintroduce the Respite Care Services program by implementing a pilot, which will include a way for agencies to invoice Respite Care Services, and an array of ancillary services through Family Support Services. Service Area Navigator meetings, Roundtable meetings, and FSP Provider meetings will continue to be held for the purpose of program monitoring. Changes will be regularly communicated to providers as soon as possible to enhance outcomes and service improvement. CW will continue to monitor the use of Family Support Services and Flex Funds and encourage provider use to ensure clients and families are receiving the full scope of services offered in FSP, incorporating the "whatever it takes" MHSA philosophy.
Children-Field Capable Clinical Services C-05	Countywide Child MHSA Administration (CW) does not anticipate any significant changes for FY 2012-13. In order to support Field Capable Clinical Services (FCCS) providers, CW will continue to monitor and provide technical support. • Continue Quarterly Roundtable Meetings with providers. • Ongoing consultation and monthly meetings with Service Area Child Navigators. • Continue the programmatic and data monitoring of Child FCCS programs. • Encourage and monitor the use of best practices and evidenced based practices (EBPs) in FCCS; survey and compare those clients to those with no EBPs delivered. • Continue to provide a training curriculum around issues relevant to providers. o Engaging Families in Treatment o School-based Mental Health Services o Field Safety o EBPs o Cultural Competence o Motivational Interviewing
Older Adult Full Service Partnerships OA-01	**Slot Increase** FSP Target Increase: • 20 additional slots in SA 1, 2, 3, 4, 8 (Center for Aging Resources-Heritage Clinic) • 7 new slots in SA 2 (Didi Hirsch-Glendale) • Current total number of slots countywide is 344
Transformation Design Team OA-02	The arrival of Prevention and Early Intervention programs into the Older Adult Systems of Care Bureau will broaden the job duties of the three members of this team. We are currently looking at how best to incorporate those duties into the already-existing framework.
Field Capable Clinical Services OA-03	We anticipate that the implementation of Prevention and Early Intervention will bring in additional clients to FCCS, either through the increased outreach for this new program, or for those who complete PEI but are then found to
Service Extenders OA-04	An academy for new Service Extenders was held in August 2011. This was a 9-hour training addressing all facets of service extender duties, including the how's and why's of cultural sensitivity. The prospective Service Extenders were recruited via partnerships with other community organizations including those that are ethnically-based, through our current Service Extenders, and through NAMI. Six new Service Extenders were placed as a result of this training, and eight more were hired through providers' direct recruitment. We anticipate that our Service Extender program will continue to grow through FY 2012-13 as we continue outreach. Additionally we have reinstituted our quarterly Service Extender meeting to provide a means of support and information for the group.

Plan, Plan ID	Changes
Older Adults Training OA-05	Increased demand for Prevention and Early Intervention trainings will be a significant change in FY 2012/13.
Transitional Age Youth Full Service Partnership T-01	1. Improve coordination of effort between TAY Administration, TAY FSP Providers, and other partners along the TAY continuum of care to ensure clients are able to access services at the level of their need. 2. Improve use of OMA data as a tool for evaluating TAY FSP program effectiveness; making recommendations for program improvement; and identifying areas where resources, when available, should be targeted.
TAY Drop-in Centers T-02	Fiscal Year 2012-13 efforts will focus on creating opportunities for Peer-to-Peer O&E activities; advocacy; and anti-stigma in the Drop-In Centers and their surrounding community settings.
TAY Housing Services T-03	1. Evaluate the outcomes of TAY using the Enhanced Emergency Shelter Program services; 2. Evaluate the TAY Housing Specialist program to determine program effectiveness and make adjustment where necessary to improve housing outcomes; 3. Finalize actions to manage the TAY Project-Based Operating Subsidies funds to ensure eligible projects are provided with funding commitments as early as possible.
	DMH proposes to transfer the funding allocated under MHSA CSS Systems Development for TAY Project Based Subsidies to the MHSA Housing Program and to delete the TAY Project Based Subsidies from the CSS plan. An annual amount of $424,000 is allocated for TAY Project Based Subsidies. This funding will continue to be used for project based subsidies of TAY housing and this action is consistent with the intent of the stakeholders when they included this in the original CSS plan which states, "delegates are also recommending significant investments in project based housing subsidies that will help establish permanent housing units available to transition age youth with serious mental health issues." This action will result in improved efficiency for allocating the funding and monitoring the program.
TAY Probation Camps T-04	Continue Pilot Program Multidisciplinary Team (MDTS) in order to facilitate release and link the youth to services in their community. The MDTS are attended by staff from the Los Angeles County Department's of Mental Health, Health Services, Probation and the Los Angeles County Office of Education.
TAY Field Capable Clinical Services T-05	Improving coordination of effort between TAY Administration, TAY Field Capable Clinical Services' Providers, and other partners along the TAY continuum of care to ensure clients are able to access services at the level of their need.
Systems Navigator SN-01	None anticipated.
Alternative Crisis Services ACS-01	Alternate Crisis Services and Countywide Resource Management are planning to expand mental health services for individuals released under the Post Release Community Supervision program to promote the successful reintegration of these individuals back into the community.
Planning Outreach & Engagement POE-01	Each Service Area (SA) based Outreach and Engagement team responds directly to their District Chief. Changes for Fiscal Year 2012-13 will be decided upon by each SA District Chief.

SECTION II: Workforce Education and Training (WET)

A. BRIEF PROGRAM DESCRIPTION

Plan, Plan ID	Program Description
1- Workforce Education and Training Coordination	This program provides the funding for the MHSA WET Administrative unit. WET Administration continued to be tasked with implementation and oversight off all WET-funded activities.
2- WET County of Los Angeles Oversight Committee	The WET County of Los Angeles had been active throughout the development of the WET plans and may continue to provide recommendations to the Department. The WET County of Los Angeles Oversight Committee is composed of various subject matter experts, representing many underserved ethnicities in our County.
3-Transformation Academy Without Walls	3A – Public Mental Health Workforce Immersion into MHSA: This program is designed to provide an immersive training for public mental health staff and focuses on the MHSA core tenets, such as hope, wellness, recovery and resilience. This three day training offers opportunity to witness and experience first hand the essence of MHSA.
5 – Recovery Oriented Supervision Trainings	The goal of the Recovery Oriented Supervision Training and Consultation Program (ROSTCP) is to increase the capacity of the public mental health system to deliver best practice recovery-oriented mental health services. The ROSTCP is designed for front line supervisors and managers for they are the primary individuals who assume the important leadership roles to teach, support, and elevate the recovery and resilience philosophies among direct service staff in the public mental health system. The ROSTCP will train supervisors and managers across all age groups and inclusive of all public mental health programs. Total Supervisors and managers to be trained = 240 annually.
6 – Interpreter Training Program	The Interpreter Training program is designed to enhance the communication skills of the monolingual clinician and the bilingual interpreter. Vital to this training was the defining of the clinical and interpreter role in the treatment process, while being aware of cultural sensitivities. Monolingual clinicians received a 4-hour training that teaches skills to properly utilize interpreters as part of the delivery of services. Bilingual interpreters received either a 3-day introduction to interpreting or for those had previously attended this foundational training, the option to attend a 1-day advance training.
7 – Training for Community Partners	3A – Community College Collaboration – This project is tasked with outreaching and engaging the college student, faculty and the community at large at various community colleges. As mental health has become a more evident issue in the community colleges, these events provide information regarding mental health services in the community and how to access them. Each event hosted approximately 150 individuals. The Community College Collaboration for FY 2010-11 includes Los Angeles Harbor College, Santa Monica College, Los Angeles Southwest College and Mount San Antonio College. 3B – Faith Based Roundtable Pilot Project – Designed for clergy and mental health staff to come together to address mental health issues of the individual and communities they mutually serve. This program has better equipped faith-based and mental health personnel to integrate spirituality into the recovery process. During this FY, this project was piloted in Service Areas 6 and 7.
8 – Intensive Mental Health Recovery Specialist Training Program	Mental Health Rehabilitation Specialist Training - This program will prepare people with a Bachelors degree, advanced degree, equivalent certification, or experience, including consumers and family members, to work in the field of mental health as psycho-social rehabilitation specialists. This 12-16 weeks program is delivered in partnership with mental health contractors and the local community colleges. Successful completion of this program ensures that participants are qualified to apply for career opportunities in the public mental health system as peer advocates.
9 – Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	Peer Advocate Training – This training prepares individuals interested in work as mental health peer advocates in the public mental health system. In FY 2010-11, certificated training included core peer advocate training, advanced peer advocate training, and Train-The-Trainer components. This Peer Advocate Training Program was designed to train no less than 60 individuals. The targeted population for each training component was: a. For Core Peer Advocate Training: mental health consumers interested in becoming part of the public mental health workforce as mental health peer advocates. b. For Advanced and Train-The-Trainer training, individuals who are currently employed in the mental health system in a peer advocate capacity.

Plan, Plan ID	Program Description
10 – Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System	This program is designed to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: the work of family support for mental health; supporting the employment of parents and caregivers of children and youth consumers in our public mental health system; and promoting resilience and sustained wellness through an emphasis on increasing the availability of a workforce oriented to self-help, personal wellness and resilience techniques that are grounded in parent advocate/parent partner empowerment. This program is envisioned to provide these services thru four unique trainings annually: Basic (50 participants); Supervisory and Administrative (80 participants); Advanced and Specialty (80 participants); and Train-The-Trainer (10 participants).
11 – Expanded Employment and Professional Advancement Opportunities for Family Members in the Public Mental Health System	The proposed trainings would prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings would include such topics as public speaking, navigating systems, and resource supports for consumers and families. Priority will be given to those family members coming from targeted communities particularly those culturally and linguistically underserved in the County of Los Angeles (i.e., Spanish speaking, Asian Pacific Islanders, etc.).
12 – Mental Health Career Advisors	This program will address the many barriers that exist for those attempting to become employed in the mental health field, most particularly consumers, parents and family members. These barriers include financial constraints, competing responsibilities, a lack of support and encouragement, poor information, and a lack of advocacy in general. Most organizations are unable to offer constant, coordinated career guidance and support due to cost constraints, competing priorities and frequent turnover. Although it may be true that increased skills and education make an individual more attractive to a competitor, upward mobility will lead to a higher overall retention rates in the overall mental health system. In an effort to help the mental health system employ a more global approach when it comes to workforce retention, we propose developing a group of advisors who will work with newly entering and/or existing mental health staff to help them as they enter and remain in the mental health workforce. Through the provision of ongoing advice, coordination of financial assistance, job training, mentoring, tutoring, information sharing and advocacy, the Mental Health Career Advisors will essentially function as a one-stop shop for upward career mobility.
13 – High School Through University Mental Health Pathway	The County of Los Angeles will focus on promoting mental health careers to high school, community college and university students, particularly in communities or areas of the County where ethnically diverse populations reside. A High School Academy model program has been successfully implemented and targets students in ethnic communities where a greater likelihood for recruiting bilingual/bicultural individuals into the workforces exists. Expanding such academic programs into the County of Los Angeles promotes the education and preparation of the next generation of ethnically diverse mental health workers, while normalizing individual and family attitudes about mental illness. The High School Academy - University track ensures that a significant number of students are identified, selected, supported and mentored through the process. In addition, a Cohort Model, where participates enter into an academic training program as a group and are followed from pre-entry to graduation to licensure/certification would be considered as part of this career pathway. Success rates for program completion for participants increase when there is camaraderie and a s
14 – Market Research and Advertising Strategies for Recruitment of Professionals in the Public Mental Health System	Market research and advertising strategies can assist in defining ways of attracting and targeting new professionals into the public mental health field. To this date, no formal market research has been completed to address these issues. This action would establish collaboration with an academic institution, research institute or think tank to conduct market research and then formulate advertising strategies based on that research. Studies would include designing research to target attracting more bilingual staff, as well as staff to serve ethnic minority communities, addressing cultural variances and access factors. Indirectly, these efforts may also support the retention of current staff or encourage their further professional development.
15 - Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System (Immersion of Faculty-MFT, MSW, etc)	College Faculty Immersion Training Program – Immersion training services update college and graduate school faculty on the current best practices and requirements for the human services workforce in real-world jobs. This program delivers in class presentation to student on the core tenets of MHSA. As the consultant works with faculty, they are guided on how to incorporate mental health issues into their curriculum. Participants are also offered an MHSA mini-immersion training session to witness first hand the benefits of MHSA on mentally ill individuals.

Plan, Plan ID	Program Description
16 – Recovery Oriented Intership Development	A wide range of quality internships and placements must be available to students and interns to gain the maximum benefit from these experiences. Ideally, these placements include supervision that is both welcoming and supportive of recovery based services. Unfortunately, many potential quality placements cannot be utilized because they lack a supervisor with a degree that meets the standards of the academic institution and/or their accrediting body. At the same time, many of the supervisors who meet academic standards in qualified placements are not well versed in recovery and at times are wholly opposed to recovery centered service philosophies and practice. This latter problem leads to situations where students are receiving recovery oriented instruction in the classroom, only to have it not practiced in the field. The proposed Recovery Oriented Internship Development Program will address these problems by working with degree granting institutions providing recovery oriented classroom instruction to develop relationships with nontraditional providers, amend restrictive policies related to supervision of interns, employ a supervisor(s) who can provide supervision to interns across multiple agencies, and work with existing providers to increase the number of internships available through in-house supervisor recruitment and support.
19 – Public Mental Health Workforce Financial Incentive Program	The Public Mental Health Workforce Financial Incentive Program represent a consolidation of WET Plans # 19 (Tuition Reimbursement Program), 20 (Associate and Bachelor Degree Program), and 22 (Loan Forgiveness Program). This new program is intended to deliver educational/financial incentives to individuals in the public mental health workforce, as well as a potential recruitment incentive. This program will target consumers, family members, parent advocates and professionals from both directly operated and contract agencies. This new consolidated programs to be delivered those services previously approved: **Tuition Reimbursement Program** The County of Los Angeles' needs assessment revealed significant occupational shortages of licensed and unlicensed mental health professionals and paraprofessionals. This program specifically targets individuals interested in pursuing careers in the mental health field including AA, BA and graduate level degrees. This tuition reimbursement program will provide up to $5,000 dollars per year for tuition expenses for those individuals interested in entering or enhancing skills for the mental health field who meet certain criteria designed to fill gaps of greatest need. This program will include consumers, family members and parent advocates and professionals from both directly operated and contract agencies. Tuition reimbursement students will be expected to make a commitment to work in the public mental health system. Additionally, those candidates who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority for the program. **Associate and Bachelor Degree** This program specifically targets individuals currently working in public mental health who are interested in advancing their career in mental health by obtaining an MA or higher level degree. The program will pay for a portion of their salaries in order to allow students to meet academic responsibilities by combining hours of work with hours of education (20 hours school/20 hours work or 10 hours school/30 hours work). Participating students must commit to a minimum number of employment years in public mental health (comparable to the number of years financially supported by the program) after successful completion of the respective program. Priority will be given to staff that are bilingual and/or willing to work with underrepresented communities in the County. **Loan Forgiveness Program** Striving to meet MHSA expectations of a linguistically and culturally competent workforce, Los Angeles County will explore loan forgiveness programs as a supplement to the State's or its own County loan forgiveness program. Based on specific geographic, cultural and linguistic needs unique to Los Angeles County, the Oversight Committee will review the need and efficacy for such a program, for which classifications of workers, and how best to complement and not supplant existing forgiveness strategies loan.
21 – Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians	The County of Los Angeles – Department of Mental Health provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to service the traditionally un- and under- served populations of the County.

SECTION II: Workforce Education and Training (WET)

B. FOR FISCAL YEAR 2010-11 DESCRIBE ANY CHALLENGES OR BARRIERS AND THE STRATEGIES USED TO MITIGATE THOSE CHALLENGES OR BARRIERS

Plan, Plan ID	Challenges or Barriers and Strategies Used
1- Workforce Education and Training Coordination	No challenges or barriers have been experienced in this program.
2- WET County of Los Angeles Oversight Committee	No challenges or barriers have been experienced in this program.
3-Transformation Academy Without Walls	No challenges or barriers have been experienced in this program.
5 – Recovery Oriented Supervision Trainings	This program was not implemented in FY 2010-11.
6 – Interpreter Training Program	No challenges or barriers have been experienced in this program.
7 – Training for Community Partners	No challenges or barriers have been experienced in this program.
8 – Intensive Mental Health Recovery Specialist Training	No challenges or barriers have been experienced in this program.
9 – Expanded Employment and Professional Advancement	No challenges or barriers have been experienced in this program.
10 – Expanded Employment and Professional Advancement	This program was not implemented in FY 2010-11.
11 – Expanded Employment and Professional Advancement	This program was not implemented in FY 2010-11.
12 – Mental Health Career Advisors	This program was not implemented in FY 2010-11.
13 – High School Through University Mental Health	This program was not implemented in FY 2010-11.
14 – Market Research and Advertising Strategies for	This program was not implemented in FY 2010-11
15 - Partnership with Educational Institutions to Increase the	No challenges or barriers have been experienced in this program.
16 – Recovery Oriented Intership Development	This program was not implemented in FY 2010-11.
19 – Public Mental Health Workforce Financial Incentive	This program was not implemented in FY 2010-11.
21 – Stipend Program for Psychologists, MSWs, MFTs,	No challenges or barriers have been experienced in this program.

SECTION II: Workforce Education and Training (WET)

C. LIST ANY SIGNIFICANT CHANGES FOR FISCAL YEAR 2012-13

Plan, Plan ID	Changes
1- Workforce Education and Training Coordination	No changes are expected for this program for FY 2012-13
2- WET County of Los Angeles Oversight Committee	No changes are expected for this program for FY 2012-13
3-Transformation Academy Without Walls	3A – Public Mental Health Workforce Immersion into MHSA – No changes are expected for FY 2012-13. The contract for these services will continue as it currently stands. 3B – Licensure Preparation Program (LPP) – The Licensure Preparation Program, implemented during FY 2011-2012 will carry over thru FY 2012-2013. This program is designed to prepare unlicensed MSW, MFT and Psychology staff for either Part I or Part II of the required State Licensure Examination.
5 – Recovery Oriented Supervision Trainings	The ROSTCP program was implemented during FY 2011-12. No challenges or barriers have been identified/experienced.
6 – Interpreter Training Program	No significant changes are expected during FY 2012/13.
7 – Training for Community Partners	3A – Community College Collaboration – FY 2011-2012 the following Community College Collaborations are planned and/or currently being implemented: College of the Canyons-Santa Clarita, Cerritos College, El Camino College-Torrance and El Camino College-Compton – No significant changes are planned for FY 2012-13. 3B – Faith Based Program – While there will be no change to the program model, the areas to be targeted will shift from SAs 6 and 7 to two additional Service Areas.
8 – Intensive Mental Health Recovery Specialist Training	There will be no significant change to this program. It will continue to train 160 individuals during FY 2012-2013.
9 – Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	No significant changes are expected during FY 2012-13.
10 – Expanded Employment and Professional Advancement	This program will not be implemented for FY 2012-13. However, this program is planned to be put out for bid during FY 2012-13.
11 – Expanded Employment and Professional Advancement	This program will not be implemented by FY 2012-13.
12 – Mental Health Career Advisors	Anticipate piloting this program during FY 2012-13.
13 – High School Through University Mental Health Pathway	Anticipate piloting this program during FY 2012-13.
14 – Market Research and Advertising Strategies for	This program will not be implemented for FY 2012-13.
15 - Partnership with Educational Institutions to Increase the	No changes to this program are expected for FY 2012-13.
16 – Recovery Oriented Intership Development	This program will not be implemented for FY 2012-13.
19 – Public Mental Health Workforce Financial Incentive	This program will not be implemented for FY 2012-13. However, this program is planned to be put out for bid during FY 2012-13.
21 – Stipend Program for Psychologists, MSWs, MFTs,	During FY 2012-13, the number of stipends to be distributed is expected to increase to: 52 MFT, 52 MSW, and 4 Nurse Practitioner students.

SECTION III: Prevention & Early Intervention

A. BRIEF PROGRAM DESCRIPTION

Plan, Plan ID	Program Description
ES-1 PEI Early Start-Suicide Prevention	The following components of the Early Start Suicide Prevention Project have been implemented to date: **24/7 Crisis Hotline:** Didi Hirsch provides 24/7 crisis hotline services in English as well as Spanish; support services to attempters and/or those bereaved by a suicide; and assistance consultation to law enforcement and first responders. It builds community capacity by offering evidence-based training in the Applied Suicide Intervention Skills Training (ASIST) and safeTALK models. **Latina Youth Program:** The Pacific Clinics Latina Youth Program provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to schools regarding suicide risk factors among teens. It also provides education and support services in the community about warning signs and risk factors for suicide among youth. **Web-based Training for School Personnel on Suicide Prevention:** DMH contracted with the Los Angeles County Office of Education (LACOE), Center for Distance and Online Learning (CDOL) design, develop, and maintain a website dedicated to provide critical online information and materials on suicide prevention, intervention, and postvention for school personnel, parents, and students in all 80 K-12 school districts Los Angeles County. Launched in January 2011, the website has been widely publicized throughout the County, State (through the Office of Suicide Prevention), and at national conferences and meetings of various suicide prevention networks/organizations (including a recent Webinar on "Responding after a Suicide: Best Practices for Schools," sponsored by the Suicide Prevention Resource Center). Targeted local outreach activities have included 20 presentations to approximately 1,500 Los Angeles Unified School District (LAUSD) school personnel as well as presentations to the LACOE Board and multiple LACOE divisions and programs to a combined total of over 1,000 participants. Nearly 3,000 website flyers and posters have been distributed throughout the County. During the second and third phases of the project, the staff will continue to analyze survey results and data obtained from other sources, then continue to refine, update, and expand the website content/resources, while developing more focused implementation strategies for selected school districts. **Suicide Prevention Services:** Starting in 2010, new countywide programs were created and administered under the authority of the Older Adult Program Administration (OAPA). The cross-age Suicide Prevention Specialist Team (SPST) also known as Partners in Suicide Prevention (PSP) Team was developed to offer community education to increase suicide awareness. PSP team has provided community education to a total of 285 staff since the inception of the program. Eleven ASIST workshops on "suicide first aid" were conducted by DMH staff for 300 caregivers, including not only mental health professionals but those that are frontline gatekeepers (e.g. clergy, parents, graduate students, paraprofessionals, survivors, etc). The Suicide Prevention Specialist Team has continued to plan a critical role in offering training to the community. Team members have trained under best practice models of Applied Suicide Skill Intervention Training (ASIST) and Question, Persuade and Refer (QPR).

Plan, Plan ID	Program Description
ES-2 PEI Early Start – School Mental Health Initiative	The following components of the Early Start Mental Health Initiative have been implemented to date: The **School Threat Assessment and Response Team (START**) is a collaborative program with educational institutions and law enforcement designed to prevent school violence by identifying students at risk and providing an immediate comprehensive response and case management. START has developed teams comprised of a law enforcement officer and a DMH clinician who partners with all levels of educational institutions (K-12 through higher education), school based mental health programs, substance abuse programs, and other social service providers in the community to prevent school violence. In FY 2010-11 DMH conducted 5,778 School Threat Assessments and provided intervention and case management services to those who meet criteria for the START program. DMH and the Los Angeles Police Department (LAPD) have developed a limited to the City of Los Angeles program designed to address the need for a comprehensive threat prevention and management program. Its success has already prevented several school tragedies. The START program provides: • Training and Program Consultation to increase situational awareness among school administrators, faculty, parents, students, campus security, and local law enforcement on the behaviors and characteristics typically found among school shooters. • Early Screening and Identification with case-by-case consultation on students or situations of concern. Educational institutions are supported in adopting a multidisciplinary/multiagency team approach consisting of internal and external experts. • Assessment to assist schools in completing a comprehensive assessment of the student, situation, support system, and other factors relevant to the perceived, implied, or stated threat. • Intervention with educational institutions and law enforcement to provide a response appropriate to the situation at hand including arrest or detention, involuntary psychiatric hospitalization, voluntary outpatient psychiatric treatment, residential placement, monitoring, and case management services. • Case Management & Monitoring to provide post-intervention services including case consultation, case management, linkage to mental health and substance abuse, follow-up, and periodic review of risk factors.
ES-3 PEI Early Start-Anti-Stigma Discrimination	The following components of the Early Start Anti-Stigma Discrimination Project have been implemented to date: **Family-focused Strategies to Reduce Mental Health Stigma and Discrimination:** The Los Angeles County Alliance for the Mentally Ill provides prevention services countywide with a focus on reducing mental health stigma seen among and discrimination experienced by consumers' families and parents/caregivers. Services include education about mental illness, treatment, medication, and rehabilitation as well as teach communication and coping skills. The program includes a family support bureau training program, parental support services, and consultative services. The **Children's Stigma And Discrimination Reduction Project** provides education to parents and to the community through two distinct curricula. The first is a 10-week course, developed specifically to reduce stigma, includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. The second is a 12-week curriculum, developed by United Advocates for Children and Families, is an education course on childhood mental illnesses and it also includes grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS. The parents and community members have responded highly to the presentations that have taken place around the county. **Older Adults Mental Wellness:** In FY 2010-11, 42 anti-stigma and discrimination presentations on mental wellness, depression and anxiety, and substance abuse were conducted at a variety of community centers, including senior citizens centers, housing sites, etc. in English, Farsi, Korean, Mandarin, Russian, and Spanish. **Profiles of Hope Project:** The Profiles of Hope project and the PSAs that accompany them aim show that anyone could be subject to the stigma a mental illness has traditionally carried and hopes to change their mind about how they support and view others with a diagnosis of mental illness. Profiles of Hope, a 60-minute film, promotes an anti-stigma message for those diagnosed with mental illness. The Profiles series made its broadcast debut on May 2, 2011, on local PBS television station, KLCS-TV, and was repeated throughout the month. KLCS featured the Profiles series on the cover of Viewer, its programming magazine for May. Videos: Six high-profile personalities, experienced and passionate advocates in promoting hope, wellness and recovery, donated their time and talent to create 10-15 minute videos aired on various television stations, including: Latina boxing champion Mia St. John; CSI-Las Vegas actor and musician Robert David Hall; actress and author Mariette Hartley; psychiatrist in recovery Clayton Chau, M.D., Ph.D.; Veteran General Hospital actor Maurice Bernard; and US Vets CEO Steve Peck, M.S.W. Public Service Announces (PSAs) have been developed and shown on television stations.

Plan, Plan ID	Program Description
PEI-1 School Based Services	The School-Based Services Project is intended to (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress. These programs provide outreach and education; promote mental wellness through universal and selective prevention strategies; foster a positive school climate; offer early mental health intervention services on school sites; and provide training in mental health evidence-based programs to school personnel and providers working with youth and children. In FY 2010-11, four programs were implemented by DMH directly operated clinics and contracted agencies: • Aggression Replacement Therapy (ART) • Cognitive Behavioral Intervention for Trauma in Schools (CBITS) • Multidimensional Family Therapy (MDFT) • Strengthening Families (SF) DMH also implemented the Olweus Bullying Prevention Program (OBPP), a universal selection program in 30 schools and trained 180 school staff. Outcomes regarding the impact on bullying over the next three years will be gathered from the participating schools.
PEI-2 Family Education & Support Services	The purpose of the Family Education and Support Project is to build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods. In FY 2010-11, five programs were implemented by DMH directly operated clinics and contracted agencies: • Caring for Our Families (CFOF) • Incredible Years (IY • Managing and Adapting Practice (MAP) • Nurse-Family Partnership (NFP) • Triple P Positive Parenting Program (Triple P) With NFP DMH entered into a partnership with the Los Angeles County Department of Public Health (DPH) to implement this program in multiple services areas, with a special emphasis on pregnant teens. DMH provided for training in MAP and Triple P to facilitate an expeditious implementation of these programs. For MAP, a total of 76 directly operated and contract agencies were trained, including 342 staff, while for Triple P a total of 40 directly operated and contract agencies were trained, including 735 staff. These training opportunities included in-person workshops as well as a series of telephone consultations. As an additional training resource and learning opportunity, DMH sponsored a Triple P roundtable featuring the trainer and clinicians who addressed challenges, successful strategies, and lessons learned in the implementation of Triple P.

Plan, Plan ID	Program Description
PEI-3 At-Risk Family Services	The At-Risk Family Services Project (1) provides training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) builds skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provides support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family. In FY 2010-11, ten programs were implemented by DMH directly operated clinics and contracted agencies: • Brief Strategic Family Therapy (BSFT) • Child Parent Psychotherapy (CPP) • Incredible Years (IY) • Interpersonal Psychotherapy for Depression (IPT) • Managing and Adapting Practices (MAP) • Mindful Parenting (MP) • Parent Child Interaction Therapy (PCIT) • Reflective Parenting Group (RPG) • Triple P Positive Parenting Program (Triple P) • UCLA TIES Transition Model
PEI-4 Trauma Recovery Services	The Trauma Recovery Services Project (1) provides short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provides more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims. In FY 2010-11, eight programs were implemented by DMH directly operated clinics and contracted agencies: • Child Parent Psychotherapy (CPP) • Crisis Oriented Recovery Services (CORS) • Managing and Adapting Practices (MAP) • Parent Child Interacting Therapy (PCIT) • Prolonged Exposure for Post-Traumatic Stress Disorder (PE-PTSD) • Seeking Safety (SS) • Trauma Focused Cognitive Behavioral Therapy (TF-CBT) • Veterans Systems Navigators

Plan, Plan ID	Program Description
PEI – 5 Primary Care & Behavioral Health	The Primary Care and Behavioral Health project develops mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral. Another purpose is to prevent patients at primary care clinics from developing severe behavioral health issues by addressing their mental health issues early on. Many individuals who suffer from mental illness face challenges in accessing care, and this is particularly problematic for individuals dealing with both physical illness(es) and mental illness. The co-location of mental health providers in primary care settings is intended to bring needed early intervention mental health services into settings that are non-stigmatizing to lessen the severity and duration of mental illness, while simultaneously improving health care outcomes. In collaboration with Los Angeles County Department of Health Services (DHS), DMH placed small teams of mental health providers on a full-time basis in DHS Comprehensive Health Centers and Multi-service Ambulatory Care Centers in order to provide early intervention mental health services. Beginning Dec. 30, 2010 through the close of FY 10-11, DMH has implemented four DMH/DHS Collaboration Programs in DHS. Multiple pre- and post-implementation meetings occurred between the departments to ensure a shared understanding of the services and process related to referrals and mental health service delivery. Frequent intradepartmental meetings have been beneficial to address implementation challenges, such as: a) consistent provision of demographic information to facilitate timely contact with referred person, b) reinforcing importance of primary care provider discussing intent to refer person for mental health services, and c) determining best method of contacting primary care providers to discuss mental health concerns that may have bearing on their health status. In spring 2011 DMH began training mental health and health staff in the Mental Health Integration Program (MHIP) formerly known as Improving Mood – Promoting Access to Collaborative Treatment (IMPACT). A total of 5 workshops were held, with 50 agencies and 180 persons trained.
PEI-6 Early Care & Support for TAY	The Early Support and Care for Transition-Age Youth Project (1) builds resiliency, increase protective factors, and promote positive social behavior among TAY; (2) addresses depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project. In FY 2010-11, four programs were implemented by DMH directly operated clinics and contracted agencies: 1. Aggression Replacement Training (ART) 2. Interpersonal Psychotherapy for Depression (IPT) 3. Multidimensional Family Therapy (MDFT) 4. Seeking Safety (SS) DMH released a Request for Information (RFI) to provide integrated treatment services of mental health PEI programs through the Co-Occurring Disorders (COD) project at the County's Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) Antelope Valley Rehabilitation Center in Action in Service Area 1. The program will serve TAY women with co-occurring disorders who are mothers of children at high-risk of emotional or behavioral problems. Special Service for Groups was selected in late 2011 and is in the process of implementing the program utilizing Group CBT and other EBPs.

Plan, Plan ID	Program Description
PEI-7 Juvenile Justice Services	The Juvenile Justice Services Project (1) builds resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promotes coping and life skills to youths in the juvenile justice system to minimize recidivism; and (3) identifies mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system. Services are to be provided at probation camps throughout the County, residential treatment facilities, health clinics, community settings, and other non-traditional mental health sites. In FY 2010-11, six programs were implemented by DMH directly operated clinics and contracted agencies: • Aggression Replacement Therapy (ART) • Functional Family Therapy (FFT) • Loving Intervention for Family Enrichment (LIFE) • Multidimensional Family Therapy (MDFT) • Multisystemic Therapy (MST) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) In May 2011 the Board of Supervisors approved new staff positions for the new Countywide Juvenile Justice Transition Aftercare Services Program. This directly-operated program will deliver integrated, comprehensive early intervention mental health and collaborative services with the Probation Department, impacted families, and local community partners.
PEI-8 Early Care & Support for Older Adults	The Early Care and Support Project for Older Adults will (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals. Services are directed at older adults, their family members, caregivers, and others who interact with and provide services to this senior citizen population. The program implemented to date for older adults has been the promising practice, Crisis Oriented Recovery Services (CORS).
PEI-9 Improving Access for Underserved Populations	The Improving Access for Underserved Populations Project is intended to (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals, blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies. To date two programs have been implemented for underserved populations. The Nurse-Family Partnership (NFP) serves the deaf and hard of hearing populations countywide, while the Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services (GLBT CHAMPS) serves TAY.
PEI-10 American Indian Project	The American Indian Project will (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness. The programs will provide outreach and education; promote mental wellness through universal and selective prevention strategies; offer early mental health intervention services at comfortable, non-stigmatizing localities; and involve multi-generations in the American Indian children and youth's lives. An important emphasis is on preventing suicide among American Indian youth, given the high rate among this population.

SECTION III: Prevention & Early Intervention

B. FOR FISCAL YEAR 2010/11 DESCRIBE ANY CHALLENGES OR BARRIERS AND THE STRATEGIES USED TO MITIGATE THOSE CHALLENGES OR BARRIERS

Plan, Plan ID	Challenges or Barriers and Strategies Used
ES-1 PEI Early Start-Suicide Prevention	High turn over rates as the result of limited positions available for advancement.
ES-2 PEI Early Start – School Mental Health Initiative	A significant challenge is the lack of staff resources to manage the increasing number of referrals concerning students who have made or who pose a threat. Highly resistant students and their parents complicate the referral and linkage process to mental health providers. Thus, the School Threat Assessment and Response Team (START) provides the ongoing case management or monitoring until a comprehensive safety net, including therapy services, are established.
ES-3 PEI Early Start-Anti-Stigma Discrimination	Challenges have been the need to increase culturally sensitive educational trainings and presentations on stigma and discrimination in Service Areas, as well as barriers in outreaching to various organizations involved in providing mental health support to consumers, including law enforcement, veterans, and schools. Strategies to mitigate these include increasing collaborative relationships with faith based organizations, grass root organizations providing education to various underrepresented ethnic populations, and community colleges to increase their awareness and understanding of mental health. Developing trainings and presentations to address ethnic specific stigma and discrimination issues also needs to be undertaken.
PEI-1 School Based Services	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. To address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training. Another challenge for our providers implementing groups in schools has been getting school buy-in, space, and appropriate referrals. Success has come when agencies are able to develop strong relationships with schools and clarify roles and expectations prior to beginning a school-based program. The most successful providers spent time with school personnel educating them about the mental health challenges their students may face and the benefits of treatment. Although some mental health providers had to drop CBITS, others found that they were able to work with school personnel to develop a smooth referral process which involved the school staff rather than a “hand-off.” This facilitated getting appropriate referrals, building groups, and getting buy-in. Space continues to be a challenge which the providers have come to accept as part of doing school-based services.
PEI-2 Family Education & Support Services	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. DMH entered directly into training contracts MAP and Triple P in order to train as many staff as possible. To further address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training. DPH experienced a long delay in recruiting and hiring nurses, so the NFP program was not fully staffed during much of FY 2010/11, although the program finally staffed all nursing positions in the following FY.

Plan, Plan ID	Challenges or Barriers and Strategies Used
PEI-3 At-Risk Family Services	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. DMH entered directly into training contracts CPP, FOCUS, MAP, and Triple P in order to train as many staff as possible. To further address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training. Conducting outreach to at-risk families was challenging. This was especially apparent in the recruitment of military and veteran families for the pilot FOCUS program. Lessons learned from the pilot conducted at two DMH clinics will guide future implementation including training additional staff for outreach during after hours including weekends.
PEI-4 Trauma Recovery Services	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. DMH entered directly into training contracts CPP, MAP, SS, and TF-CBT in order to train as many staff as possible. To further address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training. Short-term crisis intervention was implemented countywide at DMH clinics, including PE-PTSD, an intensive program addressing trauma. Barriers consisted of identifying appropriate candidates for these services. Strategies included educating clinical staff regarding the target PEI population as well as guidance regarding other EBPS and promising practices addressing the trauma-exposed population. Technical challenges were also encountered with a number of EBPs which required the audio or visual recording of client sessions for training purposed. Specific recording devices and recording procedures for each practice needed to comply with the DMH HIPAA mandate, which resulted in the delayed certification of therapists in directly operated clinics.

Plan, Plan ID	Challenges or Barriers and Strategies Used
PEI – 5 Primary Care & Behavioral Health	Limited space within DHS has presented challenges for DMH staff that have had to share an office for service delivery. This has been addressed repeatedly and in some instances, DMH has been granted additional space within DHS (FY11-12). As a result of limited space and funding, the mental health teams have had to assume responsibility for many support functions that would normally be handled in more traditional clinics, such as learning how to conduct their own financial screenings and being responsible for their own data entry. Additionally, a centralized system for claiming for services provided in the DMH/DHS Collaboration programs had to be designed. Identification of bilingual staff, particularly Spanish-speaking, with experience in providing mental health services has been a significant challenge. As a result of having programs across the county, supervisors are located centrally but travel to the service sites across the county. Highly responsible staff able to function somewhat independently while being able to adapt to the difference of service delivery in health care settings presented challenges in locating appropriate staff. Participation by the primary care providers in trainings related to the evidence-based practice used by DMH, including the role of primary care providers in this model, has been very challenging. The schedules have generally not permitted such participation though one location has been willing to encourage primary care staff to view the trainings webinars during their staff meeting. Finally, the adoption of a short-term, structured evidenced-based practice has been a challenge for many providers, in particular those who come from more psychodynamic backgrounds. DMH is addressing this through enhanced training in MHIP, by providing in-person initial trainings and ongoing participation via webinar for clinicians to gain a firm grasp of implementing the Problem Solving Treatment which is a component of MHIP.
PEI-6 Early Care & Support for TAY	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. With the exception of SS, the programs for this project required agencies to arrange their own training. To address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training.
PEI-7 Juvenile Justice Services	The implementation of the PEI programs entailed a massive transformation of the DMH mental health system requiring the training of thousands of staff in a variety of EBPs, promising practices (PPs), and Community-defined Evidence (CDEs) practices. Due to the large numbers of staff to be trained, it was often the case that the developers and/or their trained lacked the capacity, and sometimes, the desire, to train the large numbers of staff in a short period of time. This has resulted in a delayed implementation of the programs or fewer than desired staff trained at the onset. With the exception of TF-CBT, the programs for this project required agencies to arrange their own training. To address this challenge, DMH provided contract agencies with training funds, in addition to direct service funds, to contract directly with the trainers as well as stipends for time staff spent in training. Staffing problems have delayed the implementation of the Countywide Juvenile Justice Transition Aftercare Program. With Board approval in May 2011, DMH was able to begin recruiting staff and arranging for their training the various EBPs.
PEI-8 Early Care & Support for Older Adults	DMH attempted to implement a number of the early intervention service EBPs that had been selected for older adults, but challenges and barriers included difficulty with negotiations with developers, unavailability of trainers, and discontinuance and/or lack of interest in replicating the program.
PEI-9 Improving Access for Underserved Populations	Outreach to sectors of underserved populations has proven to be challenging throughout all of the PEI projects.
PEI-10 American Indian Project	This program was not implemented in FY10-11. A major problem was that no training was available in California, requiring all staff to attend out-of-state training workshops that were offered on a very limited, often annual only, basis. DMH entered into negotiations with the developers, and it is anticipated that training will be available in Los Angeles County for American Indian Life Skills when agencies have been identified to implement this program.

SECTION III: Prevention & Early Intervention

C. LIST ANY SIGNIFICANT CHANGES FOR FISCAL YEAR 2012/13

Plan, Plan ID	Changes
ES-1 PEI Early Start-Suicide Prevention	Suicide Prevention Specialist Team (SPST) launched a 2 year project to train all Los Angeles County Department of Children and Family Services staff, providing 4 trainings a month with a focus on increasing suicide awareness, strength based frameworks, intervention and postvention. The Team hopes to develop additional training competencies in other intervention programs and expand the range of services it can provide the community.
ES-2 PEI Early Start – School Mental Health Initiative	No changes are expected for this program for FY 2012-13
ES-3 PEI Early Start-Anti-Stigma Discrimination	No changes are expected for this program for FY 2012-13
PEI-1 School Based Services	In FY 2012-13 DMH plans to implement a number of prevention programs: 1. Families and Schools Together (FAST), a multi-family selective prevention EBP, will teams consisting of community members, youth, school staff, and mental health staff, will be implemented by schools and mental health agencies. 2. Prevention programs, including outreach and education, mentoring, after-school tutoring, and other programs addressing risk factors for children/youth at risk for school failure, will be implemented at schools through a variety of community-based agencies.
PEI-2 Family Education & Support Services	In FY 2012-13 DMH plans to implement a number of prevention programs through community-based agencies: 1. Prevention programs, including outreach and education, parenting groups, youth groups, and other strategies addressing risk factors for children/youth in stressed families. 2. Triple P Levels 2 and 3 includes community outreach and parent education, together with collaboration with existing Triple P mental health providers.
PEI-3 At-Risk Family Services	The Families OverComing Under Stress (FOCUS) program, implemented in FY 2011-12, will be significantly expanded to include civilian as well as military families. Working with UCLA, it is the goal of the expansion to engage in the following: 1) conduct outreach training for peers, some of which will be veterans, to effectively promote the program and address concerns, 2) train teams of school based personnel to conduct groups at selected school sites, and 3) train additional DMH clinical staff. DMH is seeking to significant expand the number of new agencies providing PEI programs, including PCIT, through a partnership with First 5 LA.
PEI-4 Trauma Recovery Services	In FY 2012-13 DMH plans to implement a number of prevention programs implemented by programs serving domestic violence programs in collaboration with the Los Angeles County Department of Public Social Services.
PEI – 5 Primary Care & Behavioral Health	The number of DMH/DHS Collaboration programs will expand. Services will also be provided through contracts offered to health facilities to provide mental health services on site as well as service provision from both directly operated and legal entity providers who have partnered with health service agencies to offer early intervention mental health services using the MHIP model.
PEI-6 Early Care & Support for TAY	DMH will initiate a first-break program for individuals in the prodromal stage of psychosis. This CDE program, the Center for the Assessment and Prevention of Prodromal States (CAPPS), will be implemented in all eight services with contract agencies through a bidding process, as well as with two DMH clinics. DMH will enter into an agreement with the Los Angeles County Department of Public Social Services (DPSS) General Relief Opportunities for Work (GROW) for life skills training for TAY transitioning out of foster care. DMH will also expand its agreement (planned to begin in spring 2012) with the Los Angeles County Department of Public Health (DPH) Substance Abuse Prevention and Control (SAPC) Adolescent Intervention, Treatment and Recovery Programs (AITRP) agencies to provide services to reduce or prevent mental health problems associated individuals at risk of or abusing alcohol and other drugs. Lastly, DMH will implement a number of prevention programs targeting the TAY population through community-based agencies: 1. Outreach and Education Pilot for TAY at risk of substance abuse. 2. Outreach and Education Pilot for Underserved TAY, including GLBTQ youth.

Plan, Plan ID	Changes
PEI-7 Juvenile Justice Services	DMH will expand its program, Gang Violence Reduction Initiative, (planned to begin in spring 2012) with several county departments, including the Public Defend, Chief Executive Office, L.A. County Public Library, and L.A. County Commission on Human Relations, as well as multiple community based agencies. This Initiative will provide a variety of programs addressing the needs of high-risk, high-need youth and young adults. In addition, DMH will implement a number of prevention programs through community-based agencies that target the TAY population at risk of juvenile justice involvement and TAY involved in probation.
PEI-8 Early Care & Support for Older Adults	The Program to Encourage Active Rewarding Lives (PEARLS) program to be implemented in late FY 11/12, with full operation expected in FY 12/13. DMH will also implement Interpersonal Psychotherapy for Depression (IPT) and has planned training in this EBP for May/June 2011. In FY 2012/13 DMH plans to implement a number of prevention programs through community-based agencies that include outreach and education, case management, and home visits to older adults.
PEI-9 Improving Access for Underserved Populations	DMH will bid out programs utilizing the EBP Group Cognitive Behavioral Therapy for the deaf/hard of hearing as well as the blind/visually impaired populations in FY 2012-13. Another program under development for implement I FY 2012.13 involves faith-based organizations and the delivery of mental health prevention services. In FY 2012/13 DMH plans to implement a number of prevention programs through community-based agencies, including outreach and education, parenting groups, youth groups, and other strategies addressing risk factors for underserved populations. Targeted groups are African/African Americans (including Ethiopians), Asian/Pacific Islanders (including Cambodians, Koreans, Samoans, etc.) Latinos, Eastern Europeans (including Armenians), GLBT and veterans.
PEI-10 American Indian Project	An RFI will be issued in FY 12-13 for American Indian Life Skills. Contracted identified agencies will be trained in AILS, thus building suicide prevention skills among American Indian youth in Los Angeles communities.

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SECTION III: Prevention & Early Intervention
D. Evidence Based Practices (EBP)

1. EBPs Implemented FY 2010-11

• Aggression Replacement Training	• Multidimensional Family Therapy
• Brief Strategic Family Therapy	• Multisystemic Therapy
• Caring for Our Families	• Nurse-Family Partnership
• Child Parent Psychotherapy	• Pacific Clinics Latina Youth Program
• Cognitive Behavioral Intervention for Trauma in Schools	• Parent Child Interacting Therapy
• Crisis Oriented Recovery Services	• Prolonged Exposure for Post-Traumatic Stress Disorder
• Depression Treatment Quality Improvement	• Seeking Safety
• Functional Family Therapy	• School Assessment Response Team
• Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services	• Strengthening Families
• Incredible Years	• Trauma-Focused Cognitive Behavioral Therapy
• Interpersonal Psychotherapy for Depression	• Training Community Partners
• Loving Intervention for Family Enrichment	• Triple P Positive Parenting Program
• Managing and Adapting Practice	• Veterans Systems Navigators

2. EBPs Implemented FY 2011-12

• Aggression Replacement Training	• Multidimensional Family Therapy
• Alternatives for Families: A Cognitive Behavioral Therapy	• Multisystemic Therapy
• Brief Strategic Family Therapy	• Nurse-Family Partnership
• Caring for Our Families	• Pacific Clinics Latina Youth Program
• Center for the Assessment and Prevention of Prodromal States	• Parent Child Interacting Therapy
• Child Parent Psychotherapy	• Program to Encourage Active Rewarding Lives for Seniors
• Cognitive Behavioral Intervention for Trauma in Schools	• Prolonged Exposure for Post-Traumatic Stress Disorder
• Crisis Oriented Recovery Services	• Reflective Parenting Program
• Depression Treatment Quality Improvement	• Seeking Safety
• Functional Family Therapy	• School Assessment Response Team
• Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services	• Strengthening Families
• Group CBT for Major Depression	• Trauma-Focused Cognitive Behavioral Therapy
• Incredible Years	• Training Community Partners
• Interpersonal Psychotherapy for Depression	• Triple P Positive Parenting Program
• Loving Intervention for Family Enrichment	• UCLA Ties Transition Model
• Managing and Adapting Practice	• Veterans Systems Navigators
• Mental Health Integrated Program	

3. Trainings in Evidence Based Practices FY 2010-11

Evidence Based Practices	# of Clinics	# of Staff
Child Parent Psychotherapy (CPP	39	188
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	29	130
Managing and Adapting Practice (MAP)	76	342
Prolonged Exposure forPost-Traumatic Stress Disorder (PE-PTSD)	14	30
Seeking Safety (SS)	86	1,425
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	79	1,160
Triple P Positive Parenting Program (Triple P)	40	735

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4. Implementation of Evidence Based Practices by Age Group and Service Area

Adult Clients Served FY 2010-11									
Evidence Based Practice	**Service Area 1**	**Service Area 2**	**Service Area 3**	**Service Area 4**	**Service Area 5**	**Service Area 6**	**Service Area 7**	**Service Area 8**	**TOTAL**
Blank/Multiple EBPs	0	7	0	1	0	1	1	0	10
Crisis Oriented Recovery Services	35	176	60	0	0	1,173	71	370	1,885
Interpersonal Psychotherapy for Depression	0	0	0	0	0	0	0	11	11
No EBP	0	1,753	67	218	3	2,086	604	500	5,231
Prolonged Exposure for Post-Traumatic Stress Disorder	0	0	0	0	0	0	0	16	16
School Assessment Response Team	8	7	71	47	19	30	3	97	282
Seeking Safety	6	0	0	1	0	0	0	60	67
Trauma-Focused Cognitive Behavioral Therapy	0	0	0	0	0	0	0	1	1
Unknown EBP	561	658	306	585	44	194	32	448	2,828
TOTAL	**610**	**2,601**	**504**	**852**	**66**	**3,484**	**711**	**1,503**	**10,331**

Child Clients Served FY 2010-11									
Evidence Based Practice	**Service Area 1**	**Service Area 2**	**Service Area 3**	**Service Area 4**	**Service Area 5**	**Service Area 6**	**Service Area 7**	**Service Area 8**	**TOTAL**
Aggression Replacement Training	83	357	494	58	0	35	38	68	1,133
Blank/Multiple EBPs	0	3	19	9	8	7	5	61	112
Brief Strategic Family Therapy	0	1	100	7	2	2	1	6	119
Caring for Our Families	0	3	0	28	14	11	11	238	305
Child Parent Psychotherapy	51	42	73	225	24	60	38	156	669
Cognitive Behavioral Intervention for Trauma in Schools	2	14	11	21	12	118	20	16	214
Crisis Oriented Recovery Services	24	16	22	14	15	378	1	29	499
Depression Treatment Quality Improvement	4	51	57	14	0	0	0	14	140
Functional Family Therapy	78	44	0	61	0	161	138	307	789
Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services	0	0	0	0	0	0	0	1	1
Incredible Years	37	2	43	413	0	25	0	19	539
Interpersonal Psychotherapy for Depression	52	10	141	94	43	56	59	19	474
Loving Intervention for Family Enrichment	0	0	0	0	1	0	0	84	85
Managing and Adapting Practice	453	691	1,005	562	56	438	202	907	4,314
Multisystemic Therapy	0	19	1	1	1	14	1	35	72
No EBP	1,414	2,707	3,147	2,336	343	2,930	1,354	2,985	17,216
Pacific Clinics Latina Youth Program	0	0	0	0	0	0	62	0	62
Parent Child Interaction Therapy	12	107	93	80	0	0	0	331	623
Prolonged Exposure for Post-Traumatic Stress Disorder	0	0	0	0	0	0	0	1	1
School Assessment Response Team	349	318	975	898	110	402	500	555	4,107
Seeking Safety	149	724	669	256	26	104	102	313	2,343
Strengthening Families	0	85	3	1	0	3	24	2	118
Training Community Partners	0	0	0	0	0	0	0	1	1
Trauma-Focused Cognitive Behavioral Therapy	535	1,331	1,606	1,040	197	931	657	1,372	7,669
Triple P Positive Parenting Program	193	594	443	416	90	707	210	172	2,825
Unknown EBP	97	594	521	477	69	352	78	615	2,803
Grand Total	**3,533**	**7,713**	**9,423**	**7,011**	**1,011**	**6,734**	**3,501**	**8,307**	**47,233**

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Older Adult Clients Served FY 2010-11									
Evidence Based Practice	**Service Area 1**	**Service Area 2**	**Service Area 3**	**Service Area 4**	**Service Area 5**	**Service Area 6**	**Service Area 7**	**Service Area 8**	**TOTAL**
Blank/Multiple EBPs	0	1	0	0	0	0	0	0	1
Crisis Oriented Recovery Services	4	6	11	0	0	103	7	28	159
No EBP	0	193	1	26	0	129	30	37	416
Pacific Clinics Latina Youth Program	0	0	0	0	0	0	1	0	1
School Assessment Response Team	3	0	11	4	3	2	2	14	39
Seeking Safety	0	0	0	0	0	0	0	4	4
Unknown EBP	25	58	8	53	0	14	0	34	192
TOTAL	**32**	**258**	**31**	**83**	**3**	**248**	**40**	**117**	**812**

Transitional Age Youth Clients Served FY 2010-11									
Evidence Based Practice	**Service Area 1**	**Service Area 2**	**Service Area 3**	**Service Area 4**	**Service Area 5**	**Service Area 6**	**Service Area 7**	**Service Area 8**	**TOTAL**
Aggression Replacement Training	27	567	263	80	0	19	7	60	1,023
Blank/Multiple EBPs	0	23	4	4	1	4	2	70	108
Brief Strategic Family Therapy	0	2	14	0	0	0	0	2	18
Caring for Our Families	0	1	0	10	2	2	1	47	63
Cognitive Behavioral Intervention for Trauma in Schools	0	8	1	0	0	9	0	4	22
Crisis Oriented Recovery Services	6	62	18	1	2	245	13	139	486
Depression Treatment Quality Improvement	1	20	32	0	0	0	0	13	66
Functional Family Therapy	13	24	0	17	0	71	54	190	369
Gay/Lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services	0	0	0	0	0	2	0	0	2
Interpersonal Psychotherapy for Depression	16	9	199	70	19	26	30	11	380
Loving Intervention for Family Enrichment	0	0	0	0	0	0	0	20	20
Managing and Adapting Practice	70	281	206	129	20	69	24	179	978
Multidimensional Family Therap	0	0	12	0	0	1	0	0	13
Multisystemic Therapy	0	28	0	0	1	9	0	28	66
No EBP	323	1,367	1,215	539	71	1,039	604	845	6,003
Pacific Clinics Latina Youth Program	0	0	0	0	0	0	70	0	70
Prolonged Exposure for Post-Traumatic Stress Disorder	0	0	0	0	0	0	0	2	2
School Assessment Response Team	176	212	497	629	67	125	226	280	2,212
Seeking Safety	217	1,152	827	305	18	93	159	273	3,044
Strengthening Families	0	188	0	0	0	0	0	0	188
Trauma-Focused Cognitive Behavioral Therapy	113	219	431	181	35	210	143	265	1,597
Triple P Positive Parenting Program	10	31	32	23	6	60	5	13	180
Unknown EBP	239	275	300	200	18	97	25	264	1,418
Grand Total	**1,211**	**4,469**	**4,051**	**2,188**	**260**	**2,081**	**1,363**	**2,705**	**18,328**

SECTION IV: Innovation

A. Program History

Innovation: 4 models to test out different approaches to the integration of mental health, primary care and substance abuse services for clients with serious mental illness and one or more co-occurring disorders. Services to continue through the end of FY 2013-14. The evaluation of Innovation is estimated to begin at the end of FY 2011-12. The programs will be evaluated by model and program according to:

- Health status of clients served
- Mental health status of clients served
- Substance use patterns of clients served
- Degree of integrated service attained
- Client satisfaction
- Community satisfaction
- Cost effectiveness
- Degree to which programs in certain models enhance client quality of life through the reduced use of psychiatric and medical emergency departments, reduced psychiatric hospitalizations, increases in employment and education and reductions in homelessness and increases in clients living independently.

B. Program Description and Status

Program No., Program	Program Description	Program Status
1. Community-Designed Integrated Services Management Model (ISM)	The Community-Designed Integrated Service Management Model (ISM) envisions a holistic model of care whose components are defined by specific ethnic communities and also promotes collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support the recovery of consumers. The five ethnic communities targeted are African Immigrant / African American, American Indian / Alaska Native, Asian Pacific Islander, Eastern European / Middle Eastern and Latino. The ISM model consists of discrete teams of specially-trained and culturally competent "service integrators" that help clients use the resources of both formal "(i.e., mental health, health, substance abuse, child welfare, and other formal service providers) and nontraditional" (i.e., community defined healers) networks of providers, who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations.	Board approval for contracts occurred on March 6, 2012, with services beginning after that.
2. Integrated Clinic Model	The Integrated Clinic Model (ICM) is designed to improve access to quality culturally competent services for individuals with physical health, mental health and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites. ICM's are staffed with multidisciplinary professional teams and specially trained peer counselors and paraprofessionals. ICMs provide: Recovery Oriented Assessments, Mental Health Treatment Services, Co-occurring Substance Use Services, Peer Counseling and Self Help, Primary Care Services, Homeless/Housing Services, Care Management, Wellness Activities and Outreach.	Board approval occurred on February 14, 2012, with services beginning after that.

Program No., Program	Program Description	Program Status
3. Integrated Mobile Health Team Model (IMHT)	The Integrated Mobile Health Team (IMHT) service model is designed to improve and better coordinate the quality of care for individuals with a mental illness and their families, if appropriate, who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities. Vulnerabilities include but are not limited to age, years homeless, co-occurring substance abuse disorders and/or physical health conditions. Improving the quality of care will be accomplished by having multidisciplinary staff that provide mental health, physical health and substance abuse services work as one team, under one point of supervision, operate under one set of administrative and operational policies and procedures and use an integrated medical record/chart. The program is designed to provide the level of services necessary to support clients to successfully transition from homelessness into PSH and to improve their mental health and co-occurring disorders.	Board approval occurred on February 7, 2012, with services beginning after that
4. Integrated Peer-Run Model	The Innovative Integrated Peer Run Model: Peer-Run Integrated Services Management (PRISM) and Peer-Run Respite Care Homes (PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. PRISM offers linkage to health, mental health, substance abuse, and housing services as part of a program designed to empower individuals to sustain their own recovery. PRRCH offers guests a short-stay voluntary opportunity to grow through distress in a warm, safe, and healing environment while engaging in recovery focused supportive services as desired.	Services will be bid out, with the bidders' conference scheduled for April 17, 2012. Services projected to begin in the fall of 2012.

Section V. WET Regional Partnership

A. PROJECT STATUS

This program fosters partnerships with academic institutions for purposes of enhancing the skills of the workforce.

Project No.	Project	Project Description	Funding Amount
1.	Translational Research Fellowship Program	Four fellowships are offered through UCLA and USC for purposes of conducting applied research to enhance service delivery.	FY 2011-12: $66,666 FY 2012-13: $200,000 FY 2013-14: $133,333
2.	Milestones of Recovery Scale (MORS)	Development and validation of older adult MORS	FY 2011-12: $99,000
3.	Child System and Treatment Enhancement Projects (STEPS)	Goal to design, train and support best practices in child and adolescent community mental health. The current focus is Cognitive Behavioral Therapy (CBT) and parenting techniques.	FY 2011-12: $216,000 FY 2012-13: $177,000
4.	California Social Work Education Center (CalSWEC) Aging Initiative Project	• Creation of a statewide coalition to develop a social work workforce with expertise on aging • Development of core competencies in geriatric social work • The development of workforce development strategies • Creating capacity building and sustainability for the workforce with older adult expertise	FY 2011-12: $20,000 FY 2012-13: $20,000
5.	Olive View Psychiatric Residency Program	Fund salaries of 6 psychiatry residents to help with the decompression of the Psychiatric Emergency Services.	FY 2012-13: $500,000 FY 2013-14: $500,000 FY 2014-15: $500,000

Section VI. PEI Statewide Training, Technical Assistance, and Capacity Building (TTACB)

A. PROJECT STATUS

Project No.	Project Description	Project Status
1.	Expand, enhance and develop the resources and online tools in the Youth Suicide Prevention Project website in partnership with Dr. Laurel Bear. We propose to develop and enhance Alhambra Unified School District's "Gateway to Success" program by: Integrating "Gateway To Success" into our in partnership with Dr. Laurel Bear to support development of suicide prevention programs for other school districts; developing video and multimedia tools to enhance already existing "Gateway To Success" materials and resources for school personnel and district communities; & focus on inclusion of communities/families to engage in efforts to promote mental health, well-being, early identification of needs, accessing Mental Health resources/services, etc. - Development and dissemination of materials - Effective approaches regarding working with diverse audiences, underserved and/or UREP populations	Dr. Southard signed the amendment on March 12, 2012. LACOE/CDOL staff have completed videotaping of a "Gateways to Success" staff training workshop conducted by Laurel Baer as well as individual interview sessions with her. Relevant content and highlights are being edited for final production of segments to be uploaded to the Youth Suicide Prevention Project (YSPP) website and for subsequent dissemination of corresponding resource information/materials.
2.	This proposal focuses on families of children ages 0-5 who have developmental disabilities and behavioral issues that do or can lead to mental health services needs. People with disabilities are identified as a target population in the County's PEI Plan submitted to the State in August 2009 (cited 13 times). We propose to develop and implement a coaching curriculum to coach parents of very young children who are at risk of or have a dual developmental and mental health diagnosis, to empower them to navigate both systems in a DD-MH cross-walk. The curriculum would be available to other DD/MH collaboratives statewide. - Interactive and Practicum sessions - Peer Support - Development and dissemination of materials	A vendor was identified: Family Resource Library and Assistive Technology Center and trainings are scheduled to begin in June 2012.
3.	Extended training for FOCUS (Families Over Coming Under Stress) Service Extenders - ES 3 - Interactive and practicum sessions, development and dissemination of materials and related consulting services to enhance the sharing of information and resources for veterans and their families in need of services to overcome and reduce stress of deployment	No funding this fiscal year from PEI Technical Assistance. Funding to begin in FY 2012-13. Amendment request has been submitted to Budget on March 1, 2012. It is pending Budget approval.
4.	Wellness Outreach Workers (WOW) -various PEI components- Interactive and practicum sessions transforming recovering clients into credentialed DMH volunteers and peer advocate candidates	During the current FY 2011-12, two WOW trainings were provided (12/8-9/2011 and 2/22-23/2012) for a total of 100 consumer and family member volunteers. A third training is scheduled for 4/24-25/2012 that will add another 50 potential WOW volunteers. WOW trainings have been provided in both English and Spanish. Currently there are 80 individuals providing client supportive services in our Adult programs and receiving a WOW stipend. The Adult System of Care (ASOC) is working closely with the directly operated clinics to encourage more of their consumers to become WOW. We are also providing bimonthly meetings to all WOW training graduates to assist them in further honing their skills to support the recovery of their peers. Due to the additional WOW trainees and the support of ASOC, we are on target to maximize our allocation for FY 2011-12. In FY 2012-13, ASOC will offer at least two WOW trainings that will add another 100 volunteers to the pool of potential WOW. We anticipate that the full allocation for FY 12/13 will be utilized and there may be a need for some additional funds.

Project No.	Project Description	Project Status
5.	Community Health Workers Training - Collaboration between the Department of Health Service, Mental Health, and the Worker Education and Resource Center to create a pilot curriculum for community health outreach workers on the development, implementation and evaluation of prevention.	FY 2011-12 funding of $180,550 supported with PEI ONE TIME budget line using SR 63696, encumbrance 12HS0014 planned to be moved under PEI TTACB. FY 2012-13 PEI TTACB funding is approved, pending extension of DS0. The curriculum has been completed and training began for 30 Peer Staff in the WERC model for Community Health Care Workers on January 26, 2012. This 160 hour course covers health care education topics including: Communications Leadership Mental Health Substance Abuse Domestic Violence Sexual Education Nutrition Cancer Health Education FY 2011-12 classes will complete by June 30, 2012.
6.	Regional data workgroup. Multi-county regional collaborative funded through CalMHSA to strengthen the capactiy and skill sets in evaluation and data-informed decision-making, with the goal of increasing quality data and service quality.	The board letter will be heard by the Board of Supervisors on 5/29/12.
7.	P-ABC B - 5 Materials	Materials have been ordered.
8.	Translation -Provide translation services department-wide	Project has been deferred till Fiscal Year 2012-13.
9.	Hope and Recovery; Empowering our lives Conference	Conferences were held in July, September and October, 2011.
10.	REGENTS of CA- UCLA AFFILIATION AGREEMENT	On-going services are being delivered.
11.	Human Resources Bureau - Various Department wide computer trainings	Trainings have been identified and the special requests to implement them have been generated.
12.	Human Resources Bureau - Various professional training for HRB staff	Trainings began 2/16/12.
13.	Hire a consultant to outreach, training and provide technical assistance services for the purpose of increasing the use of the arts and media for community development within and between mental health agencies, to increase social support for people with mental illness, and to break through the barriers of internal and external stigma.	The bidding was closed on April 10, 2012.
14.	Augustus F. Hawkins- Faith-Based PEI Outreach & Engagement Training	On April 4, 2012, Bid was awarded to Lidia Gamulin, LCSW. Ms. Gamulin provided her first training on Saturday, April 28, 2012. She is continuing her trainings and Technical Assistance activities.
15.	West Central Family- Early Care and Support for Lesbian, Gay, Bisexual and Transgender (LGBT) TAY and Adults	On April 5, 2012, bid was awarded to Lisa Powell, Esq. Ms. Powell is in the implementation process and has scheduled her first training for May 16, 2012. She will continue her trainings and Technical Assistance activities.
16.	This project focuses on LGBTQ Latino TAY who could benefit from MH services but are unwilling or unable to because of fear/stigma related to being LGBTQ. Many of these youth/young adults are experience depression, trauma, bullying, and referrals to service providers who lack the cultural awareness and/or sensitivity to engage these high-risk TAY. We are proposing to identify 1-2 agencies that currently specialize in serving LGBTQ TAY (especially UREP primarily Latino) that will provide training and technical assistance to MH and Non-Branded Providers on successful O&E strategies for this population; including establishing "welcoming" and safe places for clinical engagement, etc. The agency(s) will prepare training materials and disseminate information via presentations, etc. They will work to establish a network of train-the-trainers that will continuously identify and build upon effective strategies for this population.	Bid closed week of 4/16. One agency in SA-2 and one agency in SA-7. On April 25, 2012, a PO was issued to The Village Family Services for SA 2 and on April 25, 2012, a PO was issued to Whittier Rio Hondo AIDS Project for SA 7. Both programs are currently in the implementation process and will begin trainings and Technical Assistance activities immediately.

Project No.	Project Description	Project Status
17.	The focus of this prevention and early intervention project is to provide peer support, advocacy through education, and engagement to TAY. Young adults who have been trained as mental health workers and/or peer advocates will provide psycho educational and O&E to high risk youth/young adults in non-MH branded settings. The primary goal of this peer-driven project is to educate MH and reduce self-stigma and other self-imposed barriers that prevent TAY from seeking needed MH and COD services. Non-MH branded CB's and FBO's that serve TAY and families, and TAY navigators will be targeted as collaborative partners.	On April 16, 2012, the Amendment was signed and approved for Pacific Clinics to start providing services. As of April 16, 2012, Pacific Clinics immediately began implementing the project. One (1) bid closed week of 4/16 to serve SA-5. On April 25, 2012, a PO was issued to Step Up on Second Street. This program is in the implementation process and will begin trainings and TA activities immediately.
18.	TAY Mobile Library Project- PEI Early Start Anti-Stigma and Discrimination program seeks to increase awareness, understanding, and access to mental health services and supports	This project expands existing TAY library project by creating additional mobile display units. Appropriate items are being ordered and some of these items have been received through the Special Requests (SR) process.
19.	JJ MH Competency-Judge Nash Project	The end of March 2012, a Department Services Order was sent to the Department of Probation for the Los Angeles County Juvenile Dependency and Delinquency Court System Project provided by Probation Department to DMH for FY 2011-2012.
20.	Peer-to-Peer project for an existing provider with a Drop-In Center in SA-6	On April 16, 2012, the Amendment was signed and approved for Tessie Cleveland to start providing services. As of April 16, 2012, Tessie Cleveland immediately began implementing the project
21.	This project focuses on the monolingual Spanish speaking population. The Shots Fired Series of training videos on targeted school violence is being translated into Spanish.	Awaiting the approval of the sole source by the Los Angeles County Internal Services Department
22.	This proposal will hire a consultant to develop a curriculum and provide training on focusing on mental health, mental illness, suicide prevention and accessing mental health services that are tailored for people of Ethiopian descent.	This project has been deferred until Fiscal Year 2012-13.

Section VII. Capital Facilities and Technological Needs

A. PROJECT STATUS

Project	Project Description	Project Status
Technological Needs		
Integrated Behavioral Health Information System (IBHIS)	The purpose of this project is to purchase a commercial-off-the-shelf Electronic Health Record System and implement the system at all DMH directly operated clinic locations.	During Fiscal Year 2011-12 the following was accomplished: • Vendor (Netsmart) selected • Vendor contract negotiated and approved by County Board of Supervisors • Vendor's project management team (12 staff) onsite at DMH • Project planning and implementation activities initiated • Phased implementations will be scheduled over the next two fiscal years
Contract Provider Technological Needs Projects	The purpose of the project is to provide MHSA IT funds ($22,906,000) for Information Technology Projects to over 120 Legal Entity Contract Providers (LECP) that provide direct mental health services to DMH clients. The principal purpose of the funding is to partially offset the costs our LECP(s) will incur to implement Electronic Health Record Systems in preparation for submitting Electronic Data Interchange (EDI) transactions to DMH upon full implementation of the IBHIS. Other IT projects consistent with the State MHSA IT Guidelines may be funded as well, if LECP(s) have already met EDI requirements.	From project initiation through January 2012, MHSA IT funds have been allocated to 40 LECP(s) through executed Technological Needs Funding Agreements. Forty-three contractor IT projects have been initiated and 3 have been completed. DMH anticipates executing approximately 30 new Technological Needs Funding Agreements in FY 2012-13.
Consumer/Family Access to Computer Resources	The purpose of this project is to provide access to computer resources, computer training, and technical assistance to DMH consumers and family members and ensure that they can effectively use computer resources made available to them. Through this project LAC-DMH is setting-up one or more consumer/family dedicated computer workstations in various clinic and other settings.	Implementation underway: • 32 computers successfully set up at five DMH clinics. • 51 more computers at sixteen more sites are planned to be set up prior to June 30, 2012. There are five additional sites targeted to be reevaluated in Fiscal Year 2012-13. Collectively, they need a total of 21 computers.
Data Warehouse Re-design	Implementation of the IBHIS necessitates re-designing the current LAC-DMH data warehouse. Along with IBHIS, recently implemented MHSA programs (Prevention and Early Intervention, Workforce Education and Training, and Innovation) have and will continue to bring new clinical, administrative, and financial data that must be stored in the data warehouse. This project will prepare LAC-DMH for warehousing these data from disparate data sources as well as establish appropriate resources for warehousing legacy data.	This project is closely tied to the IBHIS Project and has been held until DMH is well underway with IBHIS planning and implementation activities. However, DMH anticipates initiation of this project during FY 2012-13.
Personal Health Record (PHR) Awareness and Education Project	Through the stakeholder process, LAC-DMH received considerable feedback suggesting that many mental health consumers have limited awareness of PHR(s) and how a PHR may be used as a recovery and wellness tool. DMH obtained MHSA Information Technology funds to support the development of written and online PHR awareness and education materials to increase consumer and service provider awareness of PHR(s) and there potential benefits.	Like Data Warehouse Re-design, this project is closely tied to the IBHIS Project. No project activities have been initiated and no activities are expected to occur prior to FY 2012-13. The IBHIS product, Netsmart Avatar, offers a consumer portal that offers some customary PHR functionality. In FY 2012-13 DMH will evaluate the Avatar consumer portal and determine the best course for moving forward with the PHR Awareness and Education Project. If major changes to the project scope and approach are needed, stakeholder input will be sought, including active involvement of the Systems Leadership Team.
Telepsychiatry Implementation Project	The purpose of this project is to expand an existing limited telepsychiatry program by implementing a networked solution with a central administrative unit and a minimum of 8 remote endpoints. The goal of this project is to increase the availability of mental health services, as well as clinical training and supervision, especially to rural and underserved areas, and to reduce the high cost of in-person services delivery.	Fiscal Year 2011-12 Status: A Countywide networked infrastructure has been deployed. Eight telepsychiatry endpoints have been deployed and are in use. An administrative and service delivery hub is operational in a temporary location; a permanent location is being identified. Fiscal Year 2012-13 planned activities: Additional telepsychiatry endpoints will be purchased and deployed to geographically dispersed clinics where services are most needed. Policies, procedures and trainings will be developed, formalized and delivered.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH **EXHIBIT C-VII**
MHSA ANNUAL PLAN UPDATE FISCAL YEAR 2012-13

Project	Project Status
Capital Facilities	
Downtown Mental Health Center	In progress. Options are being reviewed to purchase current building and renovate or to find a separate building to purchase, etc.
Arcadia Mental Health Center	In progress. Pending Board approval of scope of work on May 1, 2012.
San Antonio Mental Health Center	Not initiated yet.
West Valley Mental Health Center	
Long Beach Mental Health Center	
Training/Conference Center	
Renovate/Construct New Facilities to Support MHSA Programs and Administrative Services	
Renovate/Expand County Owned Facilities to Support MHSA Programs and Administrative Services	
Purchase of Land and Building to Support MHSA Programs and Administrative Services	

SECTION I: NUMBER OF INDIVIDUALS SERVED

The Los Angeles County Department of Mental Health (DMH), the largest county mental health department in the country, directly operates more than 80 programs and contracts with more than 700 providers, including non-governmental agencies and individual practitioners who provide a spectrum of mental health services to people of all ages to support hope, wellness and recovery.

A. Community Services and Supports (CSS)

1. Unique number of clients served by programs during FY 10/11, as applicable.

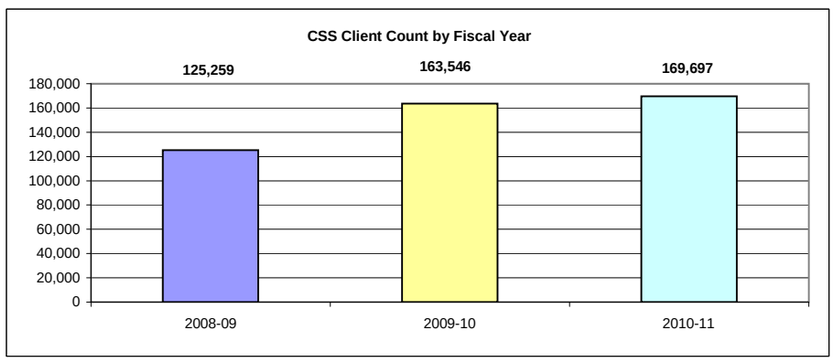
	Full Service Partnership				Field Capable Clinical Services				Family Support Services	TAY Drop-In Centers	TAY Housing Services	TAY Probation Camps	Wellness/ Client Run	IMD Step Down Facilities	Adult Housing	Jail Transition & Linkage	OA Service Extenders	Alternative Crisis Services	Systems Navigator	Planning Outreach & Engagement
Age Group (Plan ID #)	Child (C-01)	TAY (T-01)	Adult (A-01)	Older Adult (OA-01)	Child (C-06)	TAY (T-06)	Adult (A-06)	Older Adult (OA-03)	Child (C-02)	TAY (T-02)	TAY (T-03)	TAY (T-04)	Adult (A-02)	Adult (A-03)	Adult (A-04)	Adult (A-05)	Older Adult (OA-4)	Adult (ACS-01)	All (SN-01)	All (POE-01)
Client Count																				
Clients Served	3,180	1,620	4,672	406	10,065	2,091	10,382	3,026	407	834	704	2,229	47,470	498	507	3,952	21	42,156	16,064	19,413
Ethnicity																				
African American	694	446	1,687	105	1,753	408	2,335	456	-----	-----	-----	-----	14,179	-----	-----	-----	-----	-----	-----	-----
Asian	105	69	290	37	254	94	1,363	259	-----	-----	-----	-----	3,047	-----	-----	-----	-----	-----	-----	-----
Hispanic	2,006	788	1,045	55	6,934	1,224	3,233	974	-----	-----	-----	-----	15,203	-----	-----	-----	-----	-----	-----	-----
Native American	13	11	59	2	24	8	172	13	-----	-----	-----	-----	204	-----	-----	-----	-----	-----	-----	-----
Other	42	25	64	2	158	46	181	54	-----	-----	-----	-----	870	-----	-----	-----	-----	-----	-----	-----
Pacific Islander	4	2	11	1	15	3	16	2	-----	-----	-----	-----	81	-----	-----	-----	-----	-----	-----	-----
Unknown*	21	13	53	6	156	24	214	88	407	834	704	2,229	1,186	498	507	3,952	21	42,156	16,064	19,413
White	295	266	1,463	198	771	284	2,868	1,180	-----	-----	-----	-----	12,700							
TOTAL:	3,180	1,620	4,672	406	10,065	2,091	10,382	3,026	407	834	704	2,229	47,470	498	507	3,952	21	42,156	16,064	19,413
Primary Language																				
American Sign	0	0	0	0	2	0	4	0	-----	-----	-----	-----	13	-----	-----	-----	-----	-----	-----	-----
Arabic	0	1	1	1	4		10	6	-----	-----	-----	-----	76	-----	-----	-----	-----	-----	-----	-----
Armenian	21	10	22	0	24	9	53	20	-----	-----	-----	-----	625	-----	-----	-----	-----	-----	-----	-----
Cambodian	4	0	18	2	2	0	158	10	-----	-----	-----	-----	760	-----	-----	-----	-----	-----	-----	-----
Cantonese	4	0	12	3	28	7	131	42	-----	-----	-----	-----	170	-----	-----	-----	-----	-----	-----	-----
Chinese	2	0	10	2	5	2	25	4	-----	-----	-----	-----	84	-----	-----	-----	-----	-----	-----	-----
English	2230	1332	3959	334	6757	1619	7655	1975	-----	-----	-----	-----	35613	-----	-----	-----	-----	-----	-----	-----
Farsi	1	0	9	2	5	2	47	45	-----	-----	-----	-----	139	-----	-----	-----	-----	-----	-----	-----
Hmong	0	0	0	0	0	0	0	0	-----	-----	-----	-----	0	-----	-----	-----	-----	-----	-----	-----
Korean	14	8	37	2	25	5	291	44	-----	-----	-----	-----	308	-----	-----	-----	-----	-----	-----	-----
Mandarin	6	1	14	9	21	5	69	53	-----	-----	-----	-----	145	-----	-----	-----	-----	-----	-----	-----
Other	3	3	24	8	21	6	178	7	-----	-----	-----	-----	473	-----	-----	-----	-----	-----	-----	-----
Russian	1	1	18	1	2	3	13	16	-----	-----	-----	-----	156	-----	-----	-----	-----	-----	-----	-----
Spanish	848	211	363	28	3080	396	1297	734	-----	-----	-----	-----	7402	-----	-----	-----	-----	-----	-----	-----
Tagalog	1	4	15	4	2	1	59	10	-----	-----	-----	-----	206	-----	-----	-----	-----	-----	-----	-----
Unknown*	33	48	143	8	55	24	187	35	407	834	704	2,229	893	498	507	3,952	21	42,156	16,064	19,413
Vietnamese	12	1	27	2	32	12	205	25	-----	-----	-----	-----	407	-----	-----	-----	-----	-----	-----	-----
TOTAL:	3,180	1,620	4,672	406	10,065	2,091	10,382	3,026	407	834	704	2,229	47,470	498	507	3,952	21	42,156	16,064	19,413

2. Total Number of Individuals served through CSS Programs: **169,697**

3. Estimated number of individuals to be served by the programs during FY 12/13, as applicable.

	Full Service Partnership				Field Capable Clinical Services				Family Support Services	TAY Drop-In Centers	TAY Housing Services	TAY Probation Camps	Wellness/ Client Run	IMD Step Down Facilities	Adult Housing	Jail Transition & Linkage	OA Service Extenders	Alternative Crisis Services	Systems Navigator	Planning Outreach & Engagement
Age Group (Plan ID #)	Child (C-01)	TAY (T-01)	Adult (A-01)	Older Adult (OA-01)	Child (C-06)	TAY (T-06)	Adult (A-06)	Older Adult (OA-03)	Child (C-02)	TAY (T-02)	TAY (T-03)	TAY (T-04)	Adult (A-02)	Adult (A-03)	Adult (A-04)	Adult (A-05)	Older Adult (OA-4)	Adult (ACS-01)	All (SN-01)	All (POE-01)
Client Estimate	1,849	1,224	4,068	383	17,150	1,660	5,094	2,767	400	1,082	864	1,000	31,255	450	1680	4,560	40	49,400	15,600	18,000

4. Client count comparison by Fiscal Year



B. Prevention and Early Intervention (PEI): Unique number of clients served by PEI program during FY 10/11, as applicable.

Unique Client Count						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
Clients Served	26,621	9,667	10,156	495	292	**47,231**

Ethnicity						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
African American	4,948	2,278	3,565	280	25	11,096
Asian	414	232	397	22	9	1,074
Hispanic	17,957	5,761	3,268	104	232	27,322
Native American	104	28	75	0	1	208
Other	419	127	193	6	4	749
Pacific Islander	44	15	13	1	0	73
Unknown*	404	137	148	8	5	702
White	2,331	1,089	2,497	74	16	6,007
TOTAL:	**26,621**	**9,667**	**10,156**	**495**	**292**	**47,231**

Primary Language						
Age Group	Child	TAY	Adult	Older Adult	Cross Cutting	**Total**
American Sign	21	12	2	0	0	35
Arabic	14	2	13	0	1	30
Armenian	31	17	144	7	2	201
Cambodian	18	9	58	4	0	89
Cantonese	31	5	12	0	0	48
Chinese	6	8	15	0	0	29
English	18,523	7,453	7,821	379	164	34,340
Farsi	9	6	106	2	0	123
Korean	26	14	32	3	1	76
Mandarin	29	14	16	0	0	59
Other	40	20	93	5	0	158
Russian	3	1	48	1	0	53
Spanish	7,681	1,964	1,579	77	116	11,417
Tagalog	9	2	35	5	0	51
Unknown*	161	129	164	6	8	468
Vietnamese	19	11	18	6	0	54
TOTAL:	**26,621**	**9,667**	**10,156**	**495**	**292**	**47,231**

COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH
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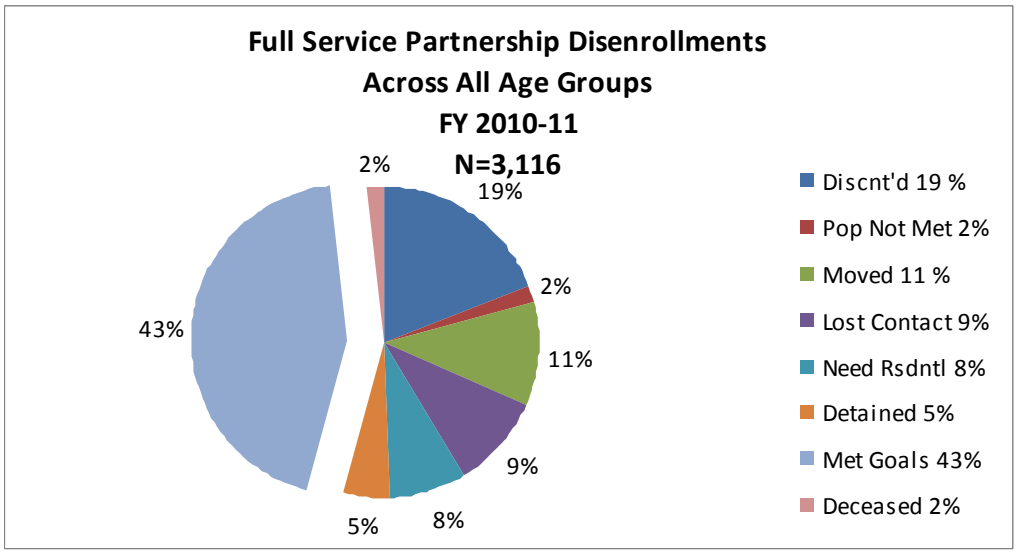
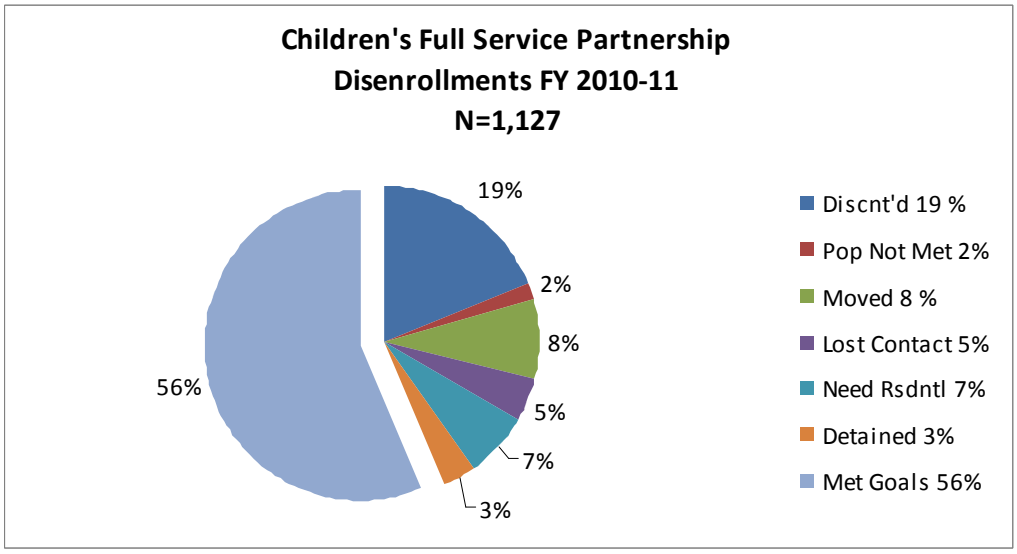
Section II: Full Service Partnership (FSP) Disenrollments for Fiscal Year 2010/11

A. Disenrollment Data

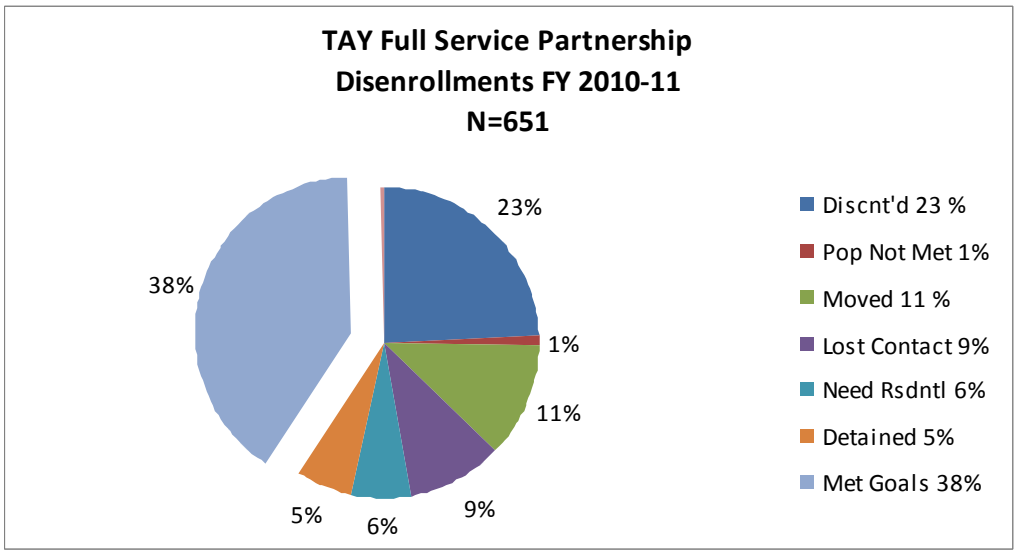
- Of the 3,116 clients that disenrolled from the FSP program, 43% met their goals



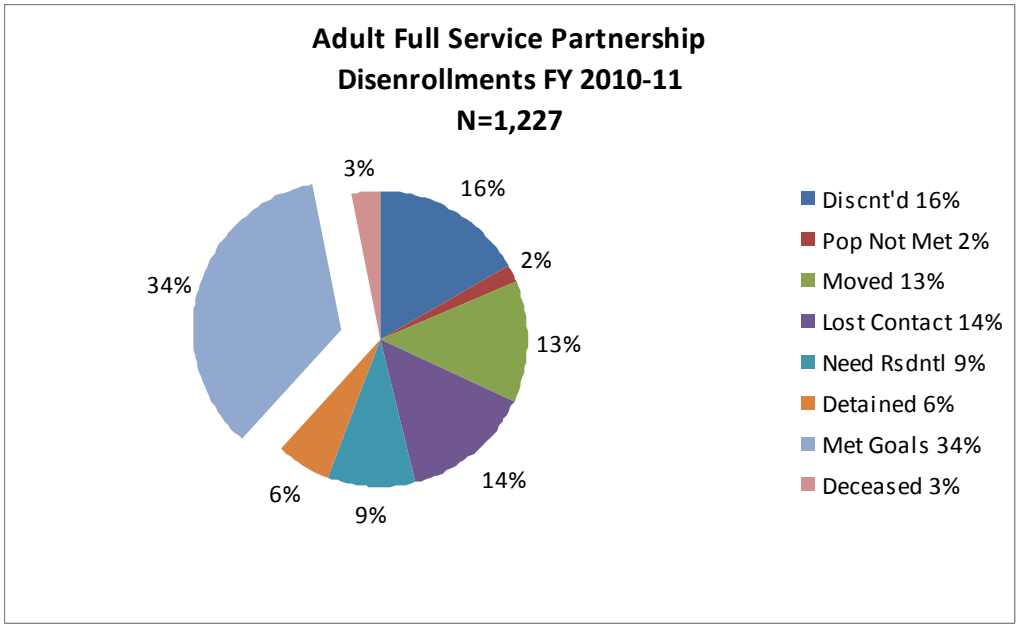
- Of the 1,127 clients that disenrolled from the Children's FSP program, 56% met their goals



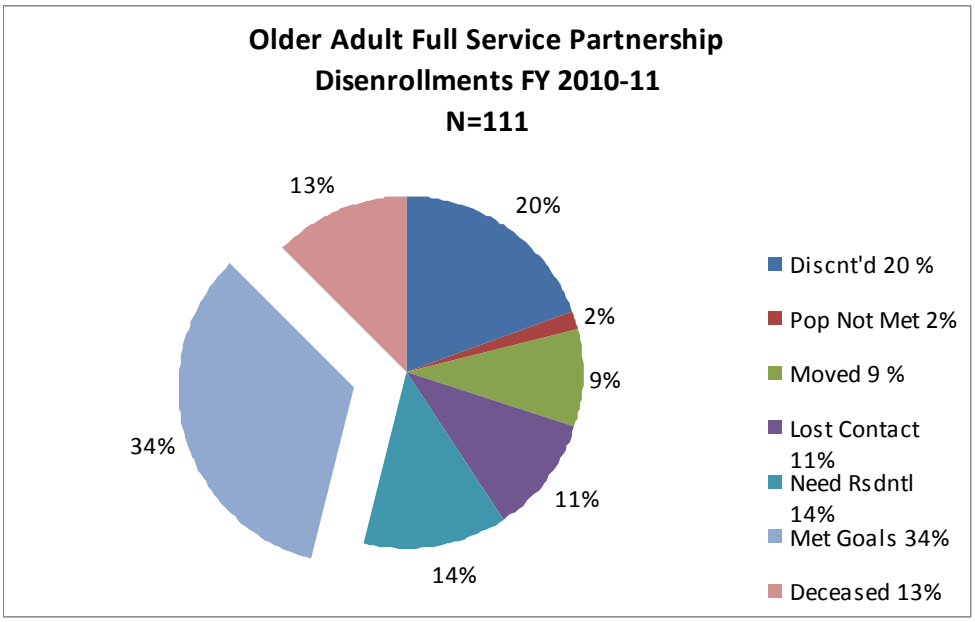
- Of the 651 clients that disenrolled from the Transitional Age Youth (TAY) FSP program, 38% met their goals



- Of the 1,227 clients that disenrolled from the Adult FSP program, 34% met their goals



- Of the 111 clients that disenrolled from the Older Adult FSP program, 34% met their goals



B. Child FSP

Children's Countywide MHSA Administration (CW) analyzed Child Full Service Partnership (FSP) disenrollment data for FY 2010-11 for all child FSP programs. CW decided to visit agencies that had a 35% or lower successful disenrollment rate in order to provide supportive technical assistance. An analysis of disenrollment data indicated that the countywide average disenrollment for goals met is 56%. Based on this criterion, five provider sites were identified. The successful disenrollment rates for these identified sites ranged from 0% to 33%. Disenrollment data gathered indicated the following challenges and barriers:

- Limited or no case manager
- No parent partner involvement
- Inconsistencies in documentation
- Lack of permanent housing
- Confusion when a client has both private and Medi-cal coverage
- Slot availability for uninsured and indigent clients
-

Each year CW conducts a telephonic survey of children and families who are currently enrolled in FSP or have been in the past. A comparative analysis of

2009 and 2010 survey data indicates an increase of all categories surveyed in 2010 over the previous year. The increased satisfaction in key FSP performance criteria combined with an 88% overall satisfaction demonstrates a commitment to the FSP model.

Resolution:

- Provided documentation training, "Strengthening Families and Resiliency," to assist providers with using a resiliency perspective in documentation to meet medical necessity, to improve quality assurance and to decrease claiming denials.
- Conduct a focus group with parents of enrolled FSP children to determine what is working and what needs adjustment.
- Offer training to increase the capacity of parent partners and their skills.
- Modify the FSP Exclusionary Guidelines II.C. to NOT exclude clients with Other Health Coverage and Medi-Cal.

EXHIBIT D-III

COUNTY OF LOS ANGELES –DEPARTMENT OF MENTAL HEALTH
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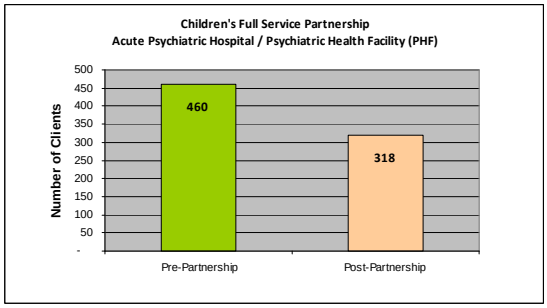
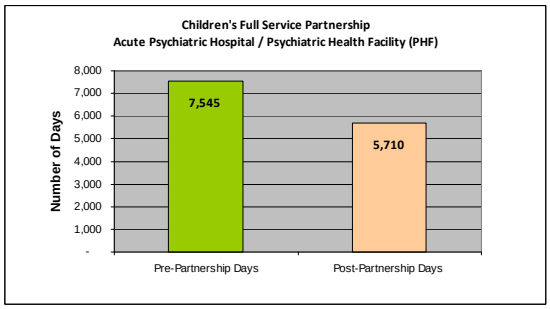
Section III: Full Service Partnership (FSP) Annualized Living Arrangement Data FY 2010-11

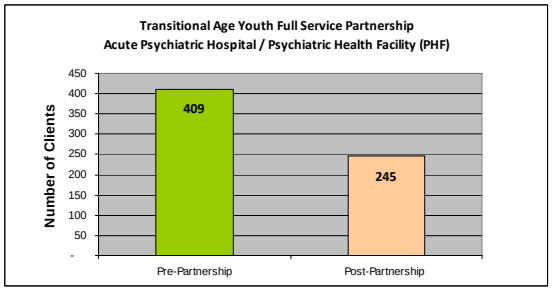
FSP Program	Number of Clients Included
Child	4,075
Transitional Age Youth	1,876
Adult	5,377
Older Adult	519

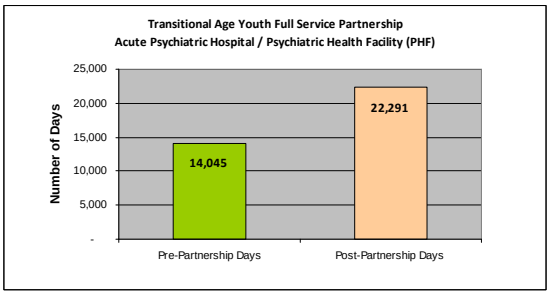
- Acute Psychiatric Hospital / Psychiatric Health Facility (PHF)
  - Children
    - 31% decrease in the number of clients that were hospitalized
    - 24% decrease in the number of days clients were hospitalized



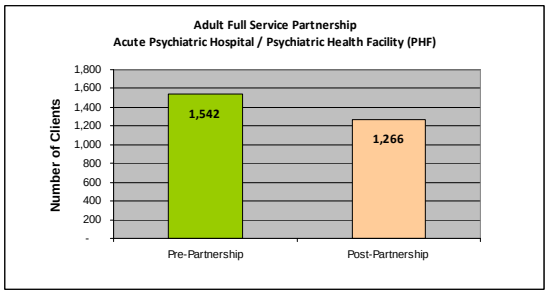


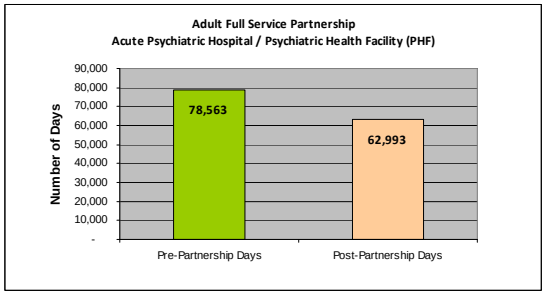
  - Transitional Age Youth
    - 40% decrease in the number of clients that were hospitalized
    - 59% increase in the number of days clients were hospitalized



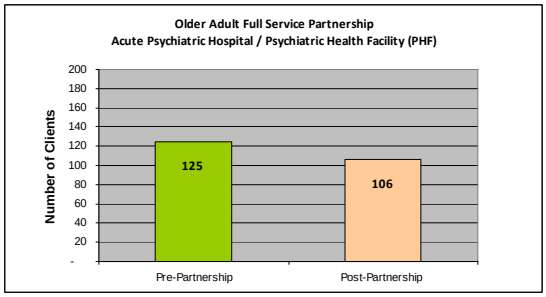


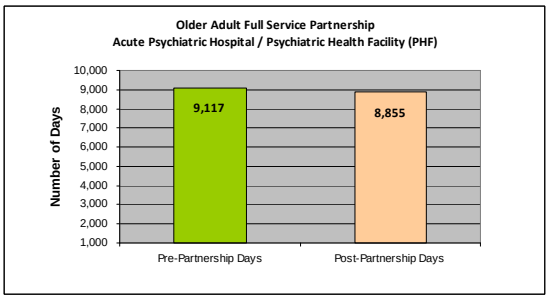
- Adult
  - 18% decrease in the number of clients that were hospitalized
  - 20% decrease in the number of days clients were hospitalized



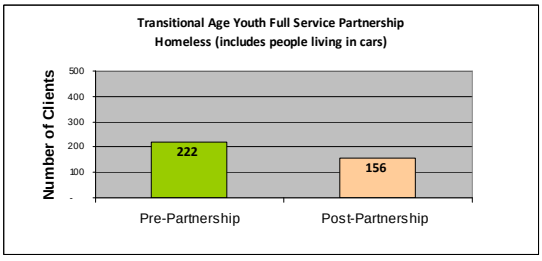


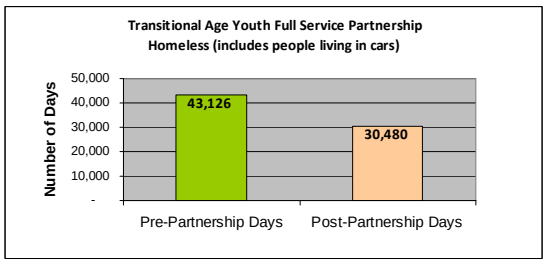
- Older Adult
  - 15% decrease in the number of clients that were hospitalized
  - 3% decrease in the number of days clients were hospitalized



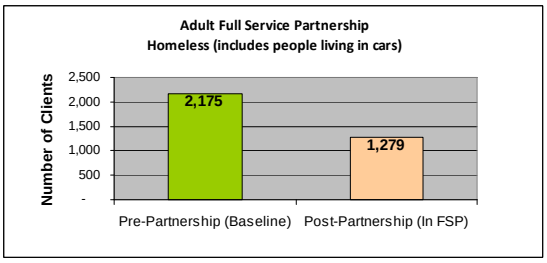


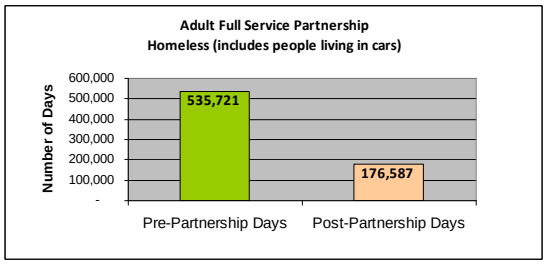
- Homeless
  - Transitional Age Youth
    - 30% decrease in the number of clients that were homeless
    - 29% decrease in the number of days clients were homeless



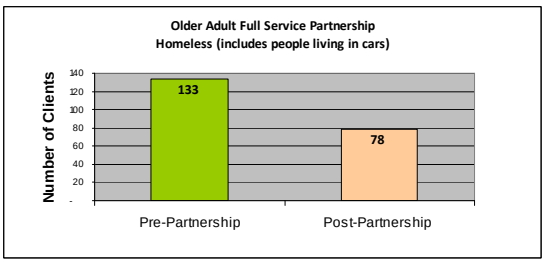


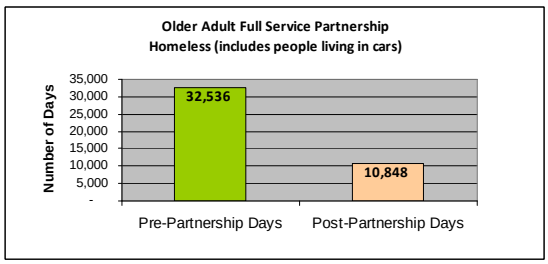
- Adult
  - 41% decrease in the number of clients that were homeless
  - 67% decrease in the number of days clients were homeless



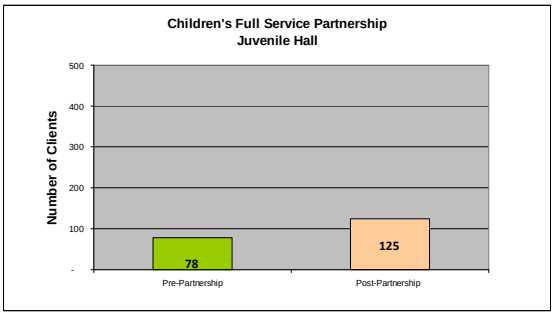


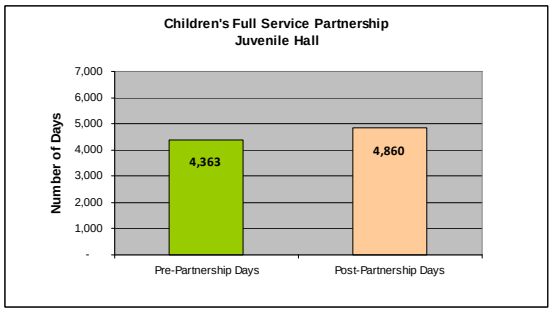
- Older Adult
  - 41% decrease in the number of clients that were homeless
  - 67% decrease in the number of days clients were homeless



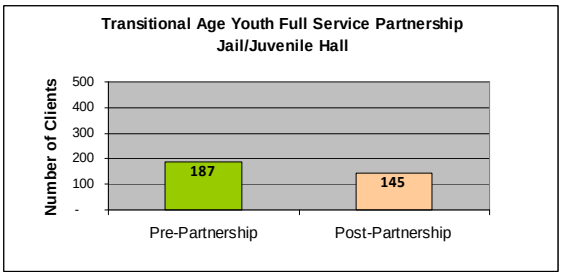


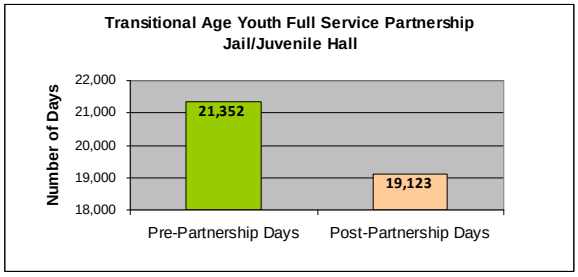
- Incarcerations (includes Jail and Hall)
  - Children
    - 60% increase in the number of clients that were in juvenile hall
    - 11% increase in the number of client days of incarceration in juvenile hall



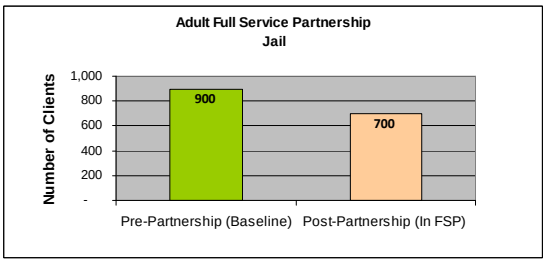


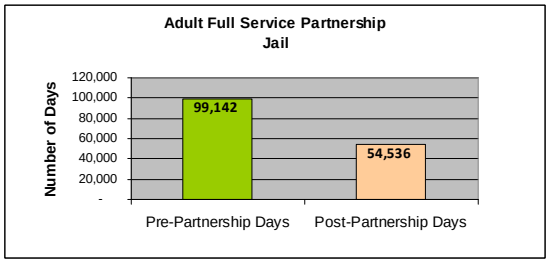
- Transitional Age Youth
  - 22% decrease in the number of clients that were incarcerated
  - 10% decrease in the number of days clients were incarcerated



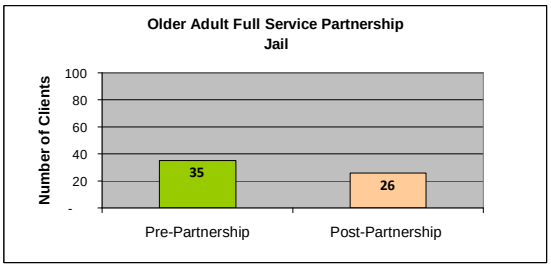


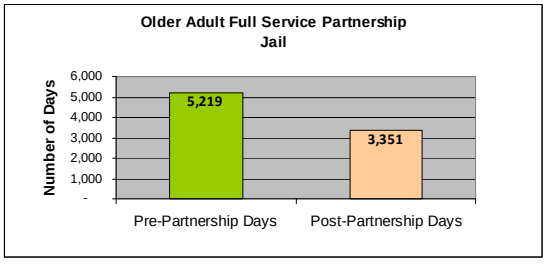
- Adult
  - 22% decrease in the number of clients that were incarcerated
  - 45% decrease in the number of days clients were incarcerated



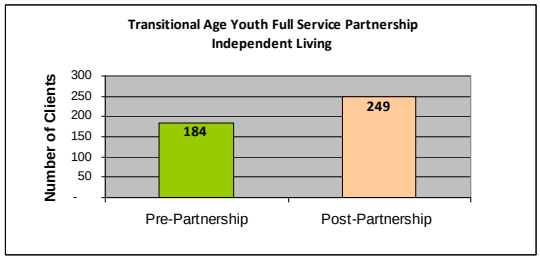


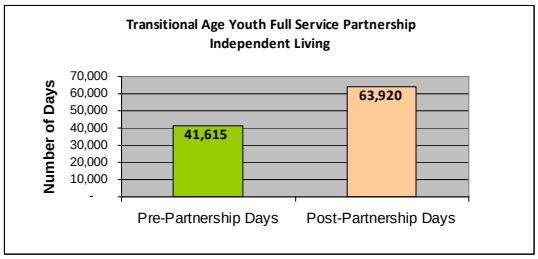
- Older Adult
  - 26% decrease in the number of clients that were incarcerated
  - 36% decrease in the number of days clients were incarcerated



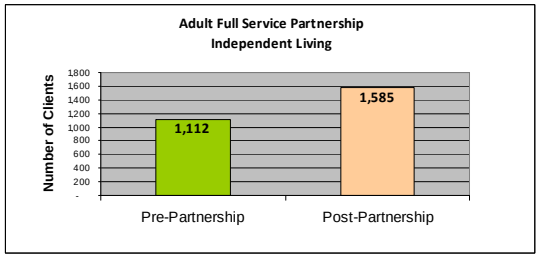


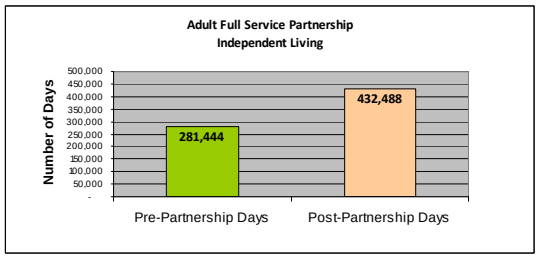
- Independent Living
    - Transitional Age Youth
        - 35% increase in the number of clients that lived independently
        - 54% increase in the number of days that clients lived independently



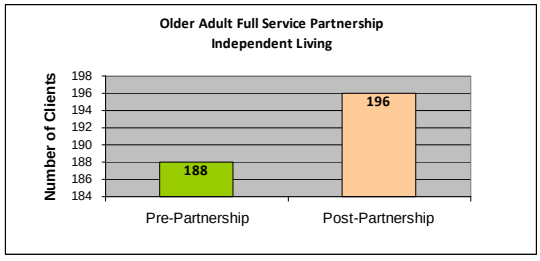


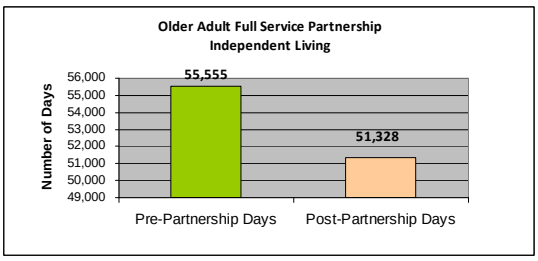
    - Adult
        - 43% increase in the number of clients that lived independently
        - 54% increase in the number of days that clients lived independently





    - Older Adult
        - 4% increase in the number of clients that lived independently
        - 8% decrease in the number of days that clients lived independently





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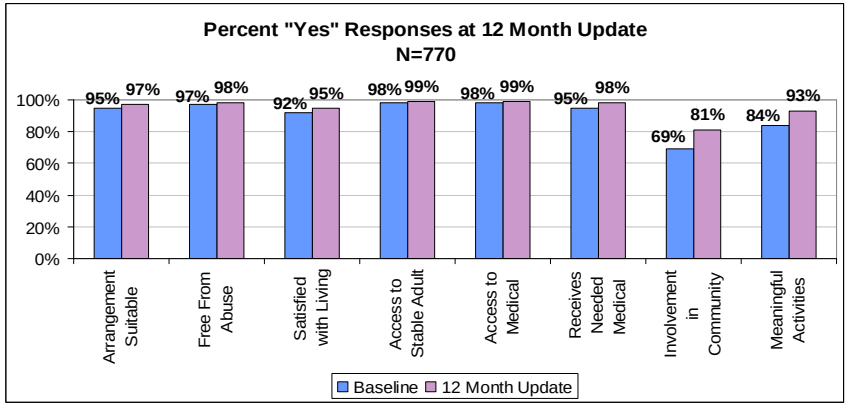
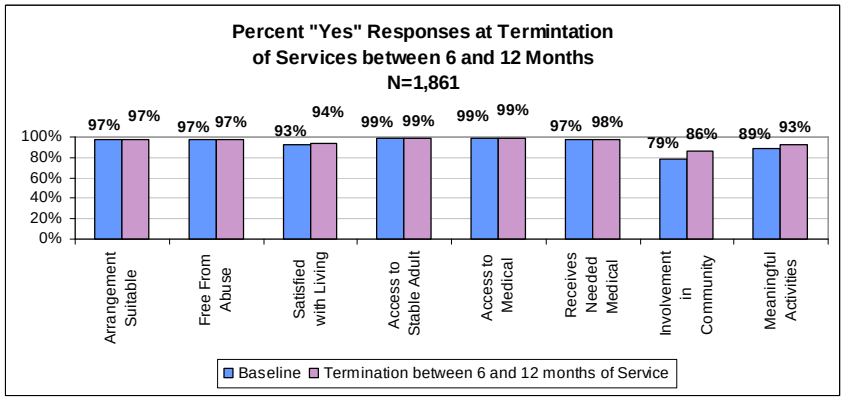
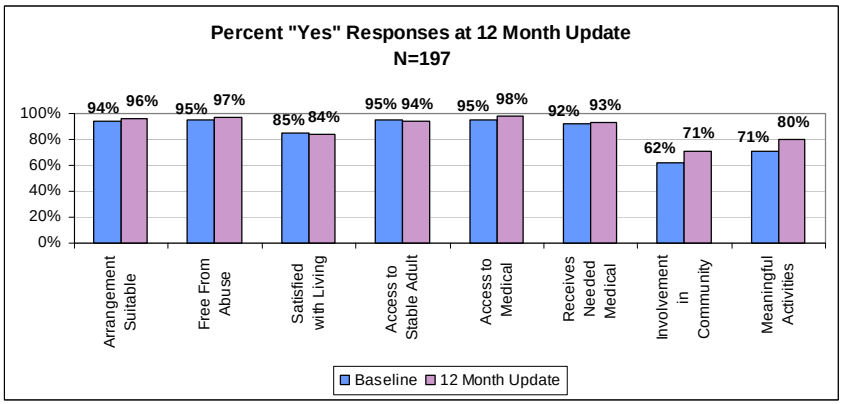
Section IV: Field Capable Clinical Services (FCCS) for FY 2011-12 (data as of March 14, 2012)

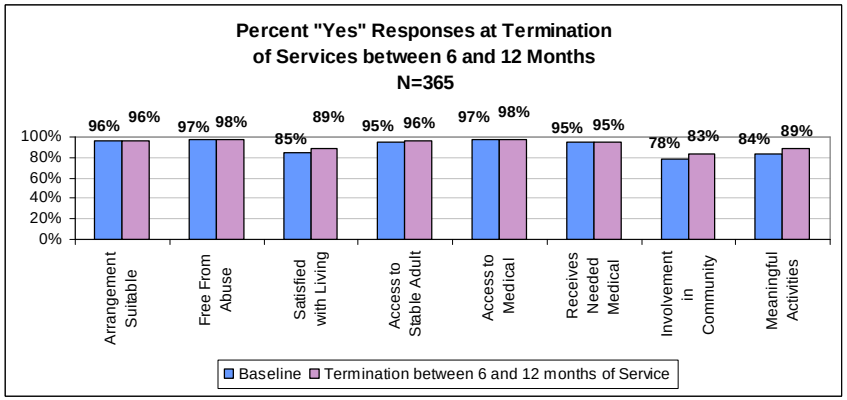
- Child
  - Of the 770 FCCS clients, 93% reported participation in meaningful activities after 12 months of treatment.
  - Of the 1,861clients that terminated FCCS services between 6 and 12 months, 93% reported participation in meaningful activities.



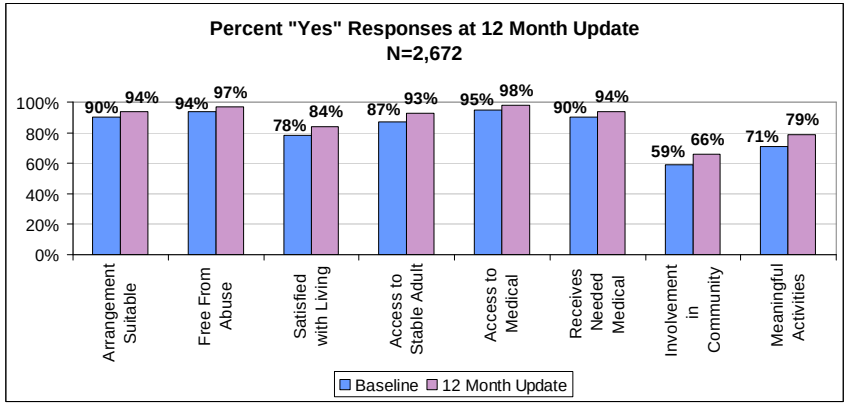


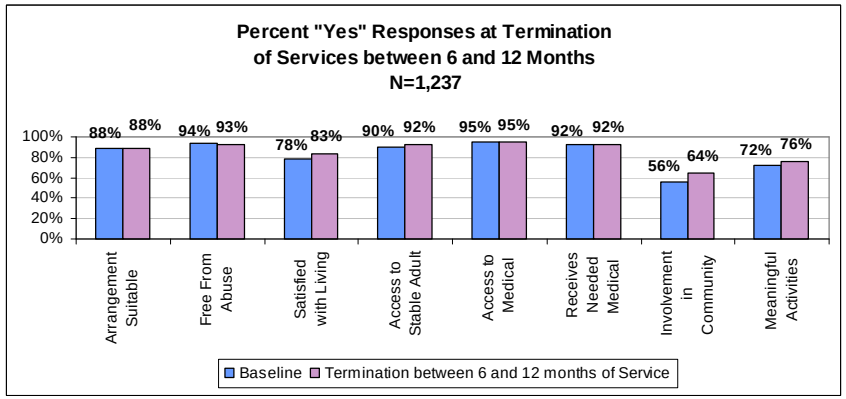
- Transitional Age Youth
  - Of the 197 FCCS clients, 80% reported participation in meaningful activities after 12 months of treatment.
  - Of the 365 clients that terminated FCCS services between 6 and 12 months, 89% reported participation in meaningful activities.



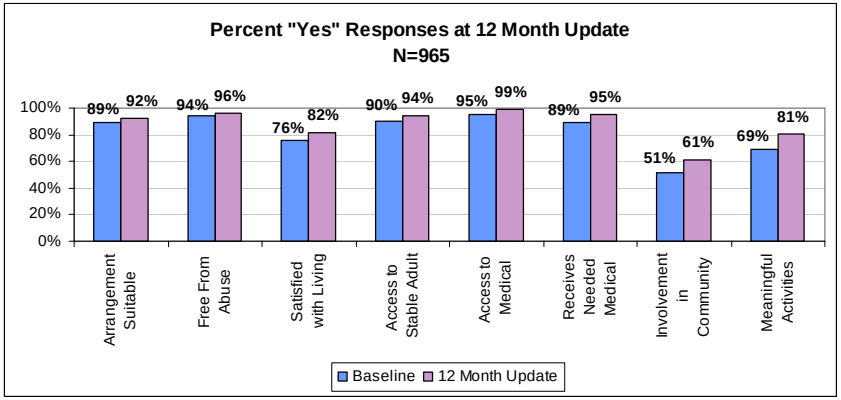


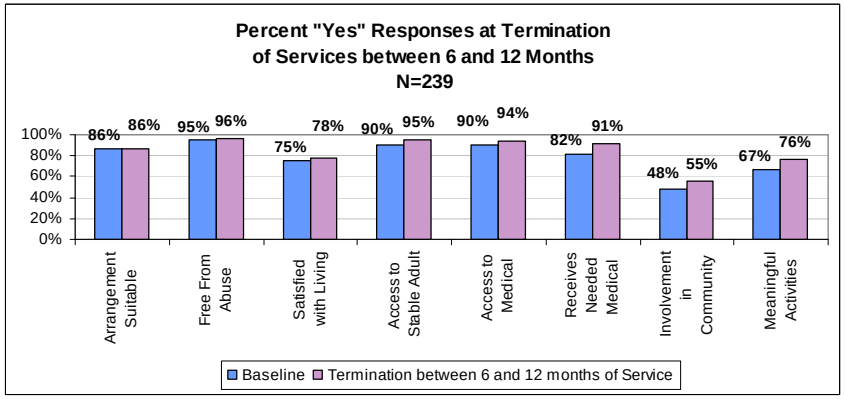
- Adult
  - Of the 2,672 FCCS clients, 79% reported participation in meaningful activities after 12 months of treatment.
  - Of the 1,237 clients that terminated FCCS services between 6 and 12 months, 76% reported participation in meaningful activities.





- Older Adult
  - Of the 965 FCCS clients, 81% reported participation in meaningful activities after 12 months of treatment.
  - Of the 239 clients that terminated FCCS services between 6 and 12 months, 76% reported participation in meaningful activities.





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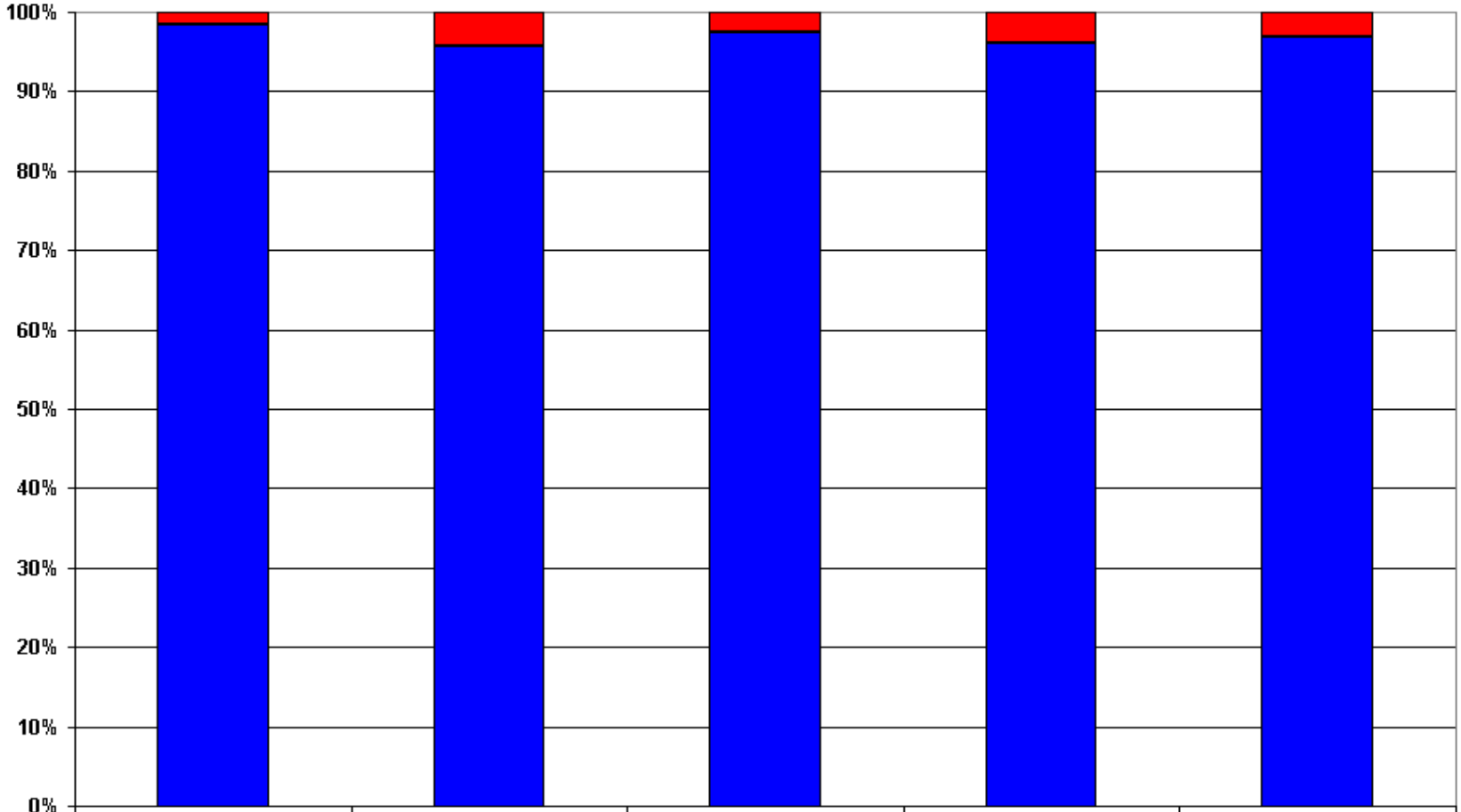
Section V: Urgent Care Center (UCC) Data

New Admissions to Urgent Care Centers (UCC) with
Psychiatric Emergency Hospitalization within 30 Days of Receiving Services
Fiscal Year 2010-2011



	MHUCC - Long Beach		Olive View UCSP		Westside UCC		Eastside UCC		All Sites	
Yes	52	(1.5%)	69	(4.3%)	173	(2.6%)	465	(3.9%)	759	(3.2%)
No	3,482	(98.5%)	1,542	(95.7%)	6,561	(97.4%)	11,514	(96.1%)	23,099	(96.8%)

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Section VII: Workforce Education and Training (WET) Outcomes – Fiscal Year 2010/11

Plan: Transformation Academy without Walls

- Public Mental Health Workforce Immersion into MHSA
  During FY 2010-2011 the contactor trained a total of 136 individual staff members of the public mental health workforce (while only contractually obligated to train 100 individuals).
- Licensure Preparation Program (LPP)
  During FY 11-12 and 12-13, combined, the total number of staff to benefit from these offerings is:

Unlicensed:	Part I	Part II	Total
MSW	53	82	135
MFT	73	73	146
Psychologist	22	60	82
Total			363

Plan: Interpreter Training Program

TITLE OF TRAINING	TOTAL
Monolingual Clinicians - Use of Interpreter Services in Mental Health Settings	22
Introduction to Interpreting in Mental Health Settings	78
Advanced Interpreting in Mental Health Settings	31
TOTAL	131

Plan: Intensive Mental Health Recovery Specialist Training Program

Through two contractors, this training was completed by 137 individuals interested in employment in the public mental health system.

Plan: Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System (Immersion of Faculty-MFT, MSW, etc)

During FY 2010-11, a total of 932 faculty and students attended the MHSA presentations or MHSA mini-immersion.

Plan: Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians

- During FY 2010-2011 this program was available to 20 MFT, 18 MSW, and 2 Nurse Practitioners students. All MFT and MSW stipends were awarded.

- In addition to the stipends, 6 post-doctoral fellows are funded to receive additional educational opportunities that support evidence-based model and the under- and un- served communities.

EXHIBIT D-VI

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

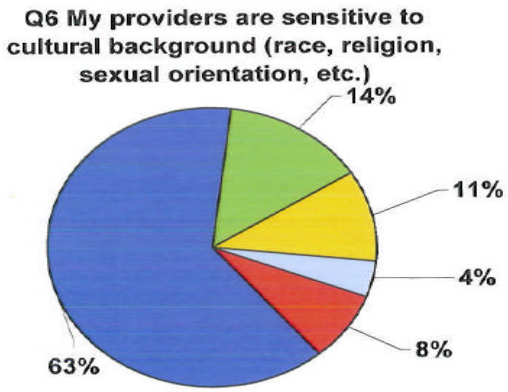
- During FY 2010-11 twenty-nine mental health consumers interested in becoming part of the public mental health workforce as mental health peer advocates completed the Core Peer Advocate Training.

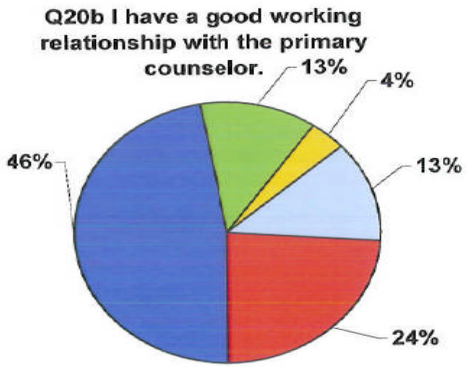
- Twenty individuals who are currently employed in the mental health system in a peer advocate capacity completed the Advance Peer Support training program.

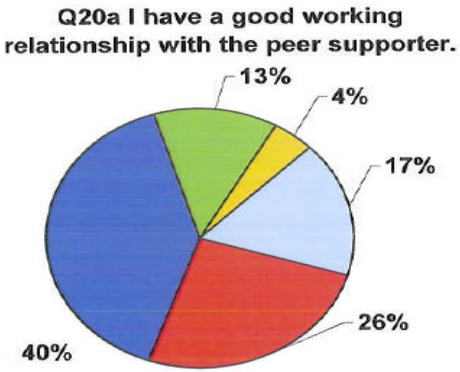
- Eleven individuals who are currently employed in the mental health system in a peer advocate capacity completed the Train-the-Trainer training program.

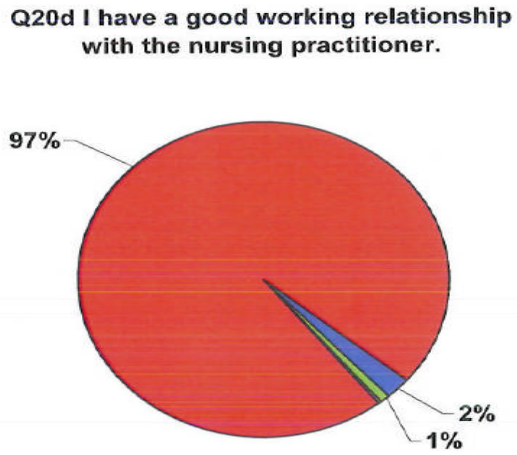
Wellness Center
Countywide Consumer Feedback Form
January- June 2011
N=1,599

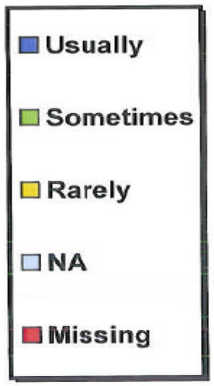
Alliance:

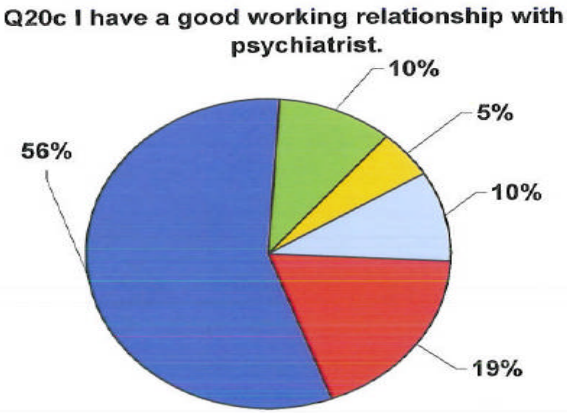






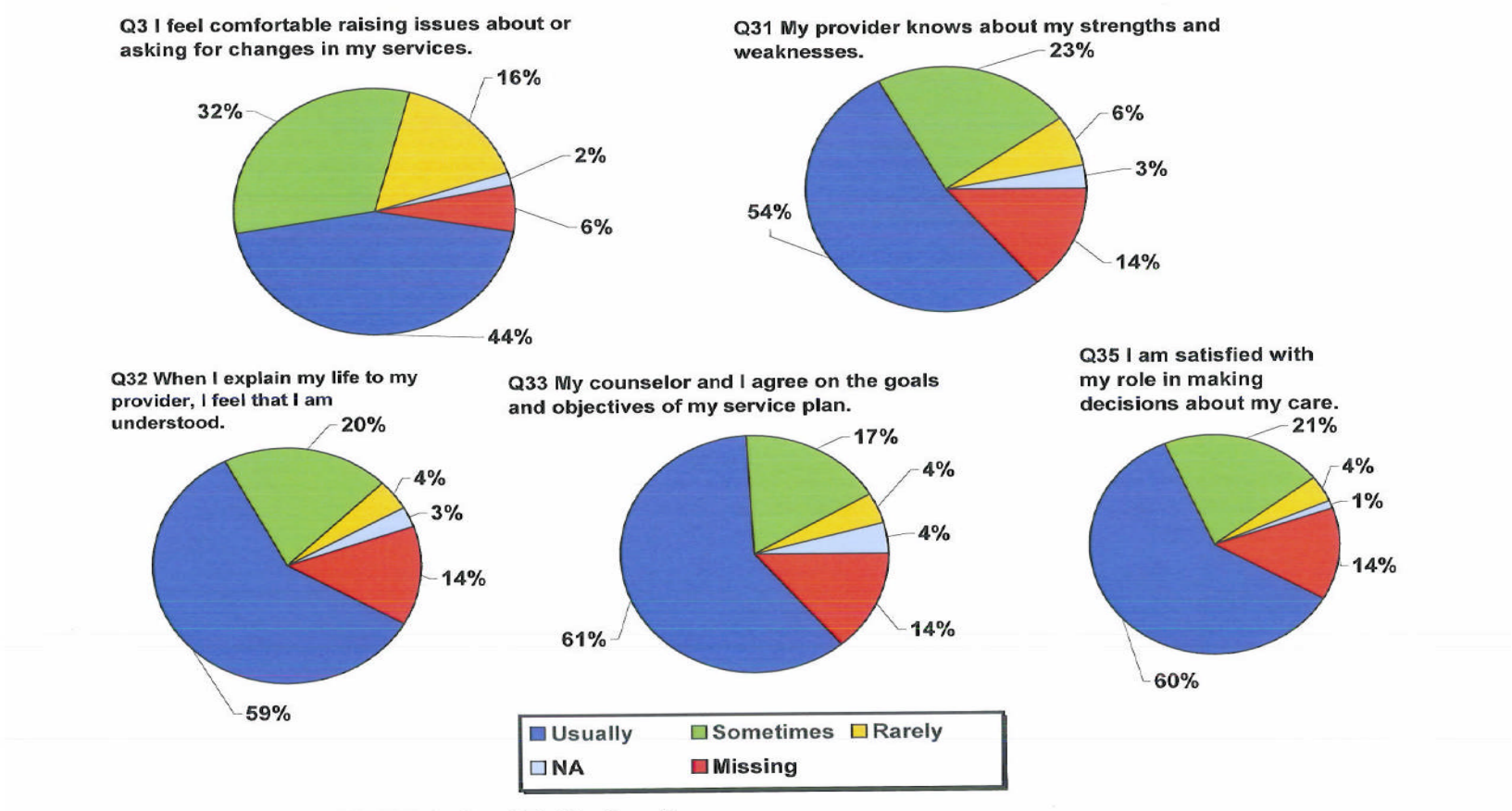






Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Consumer Engagement:



Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Feelings about Taking Medications:

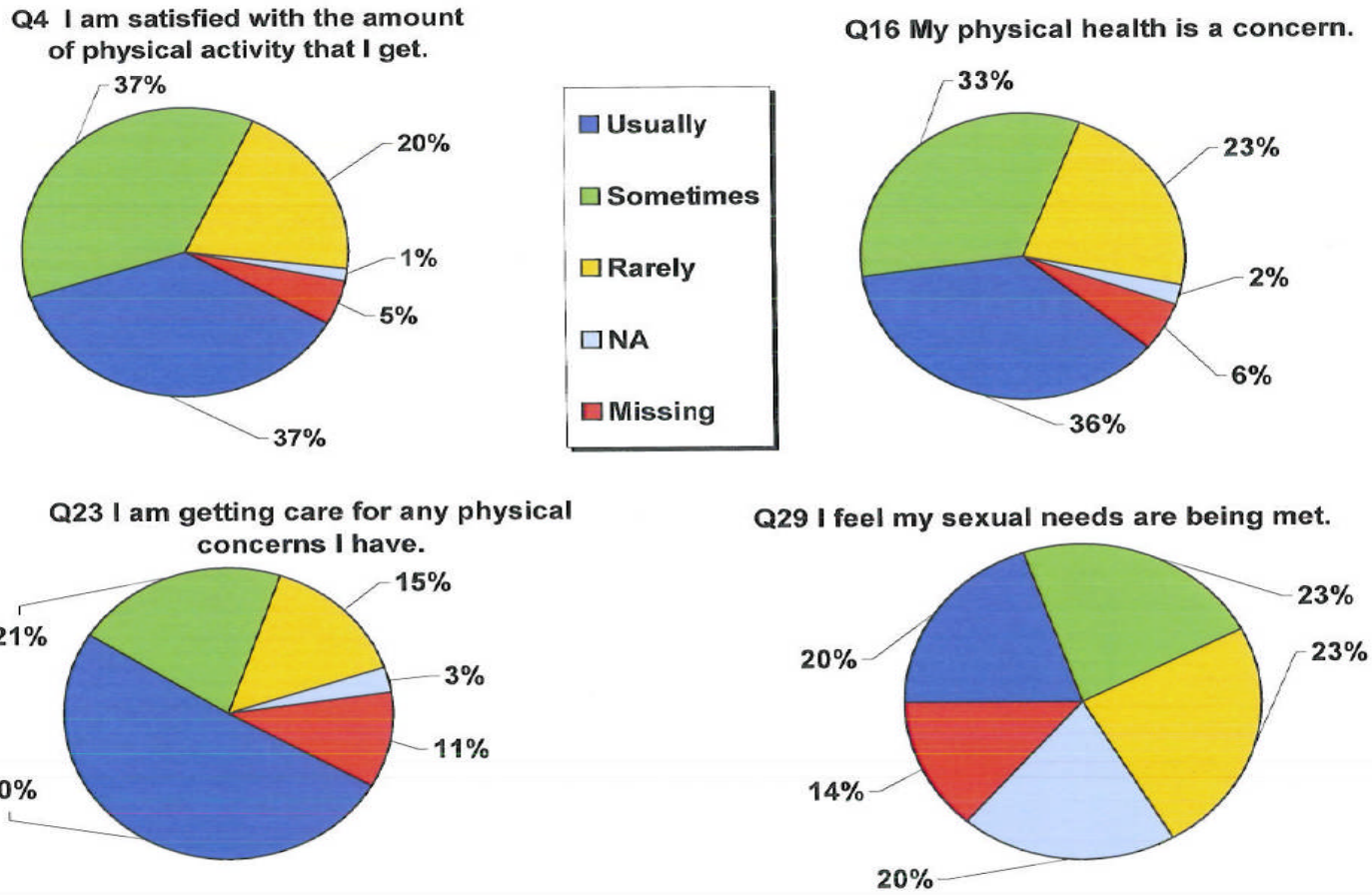
FEELINGS ABOUT TAKING MEDICATIONS

Q38 Please check all the statements below which describe how you may feel about your medications.

Survey Responses	% Responses
Does not apply.	4%
Cannot afford.	3%
No longer need.	2%
Use vitamins.	14%
Would like to change.	6%
Working fine.	36%
Aren't working.	6%
Interfere with sexuality.	6%
Make me anxious.	3%
Make me gain weight.	12%
Make me too tired.	7%

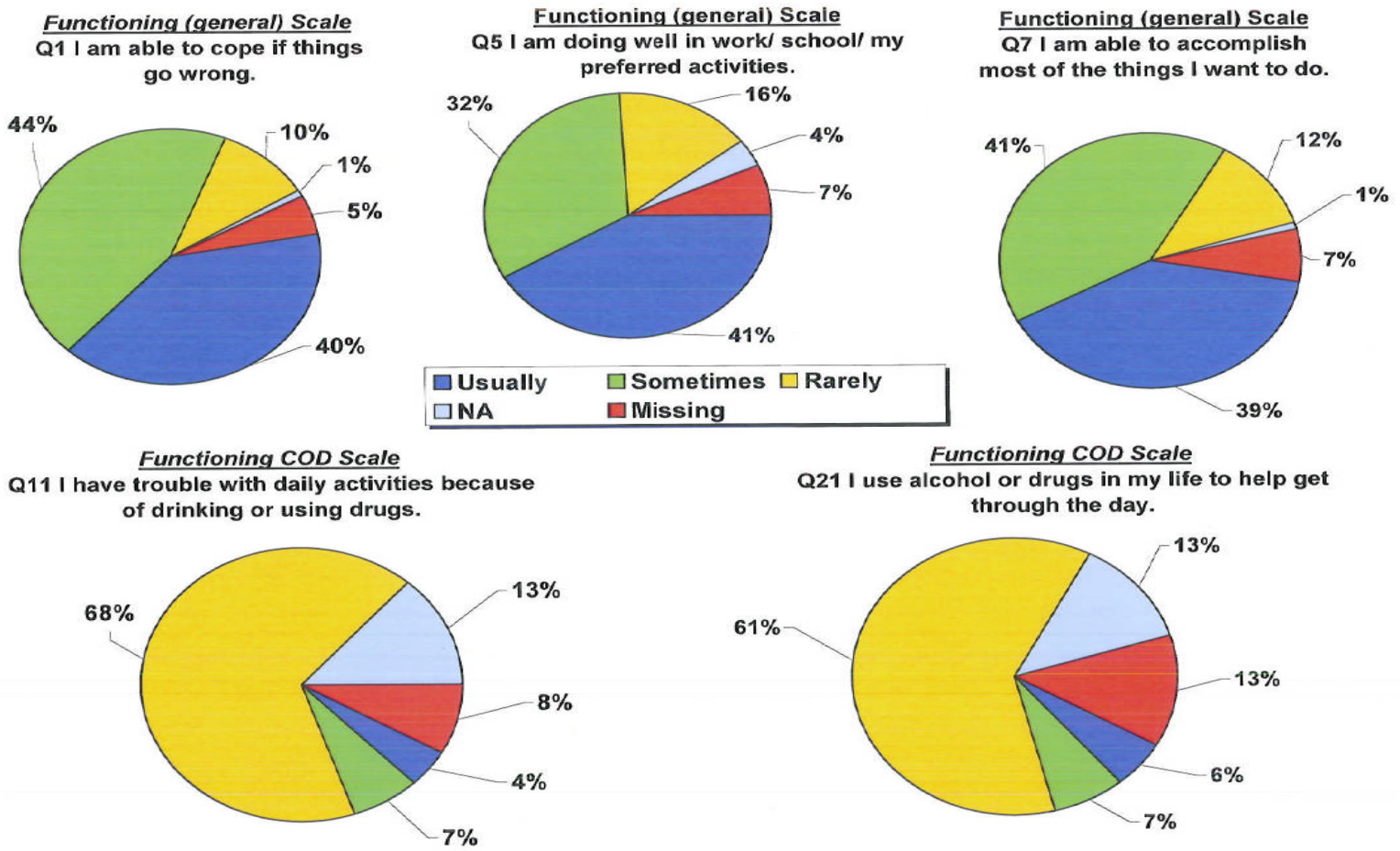
Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Functioning Physical Health Scale:



Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Functioning (general) Scale/ Functioning COD Scale:



Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Employment/Living Situation:

EMPLOYMENT

Q36 In the past month, have you been (check all that apply):

Survey Responses	% Responses
Employed Full time.	8%
Employed Part time.	11%
Enrolled in job training.	2%
Enrolled in school.	13%
Involved in other meaningful activities.	19%
Involved in unpaid or volunteer work.	13%
None of the above.	34%

LIVING SITUATION

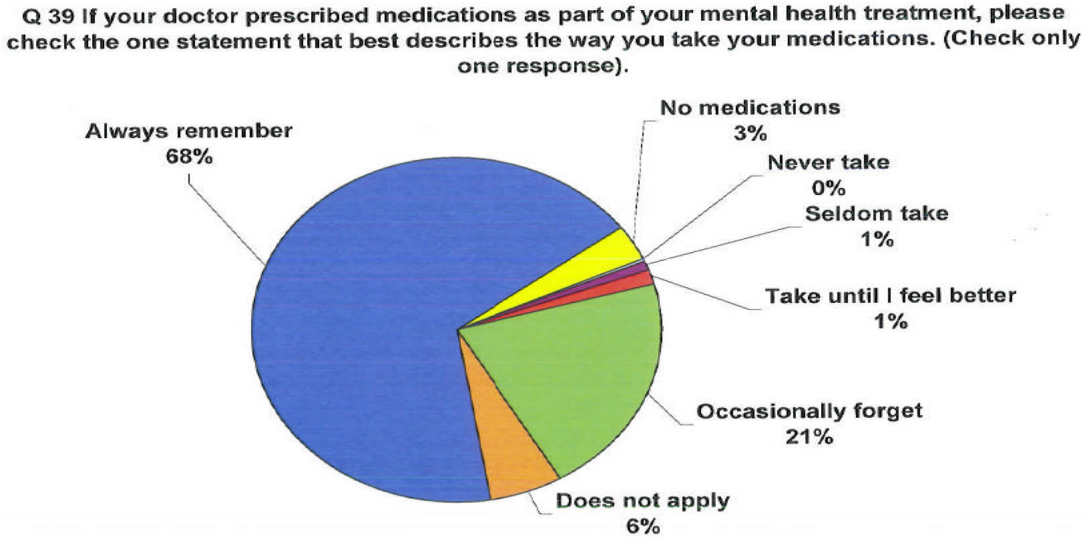
Q37 Please check all of the places where you have lived in the past month:

Survey Responses	% Responses
I lived in a hospital.	0%
I lived in my own place (house, apartment, etc.)	31%
I lived at someone else's place.	8%
*I lived in a residential treatment center.	3%
I lived in lots of places.	2%
I lived with my family.	35%
I lived with roommates.	7%
I was homeless.	4%
I was in jail.	2%
Other: _____	7%

*A residential treatment center includes a board and care facility, nursing home, detox, group home, sober living homes, etc.

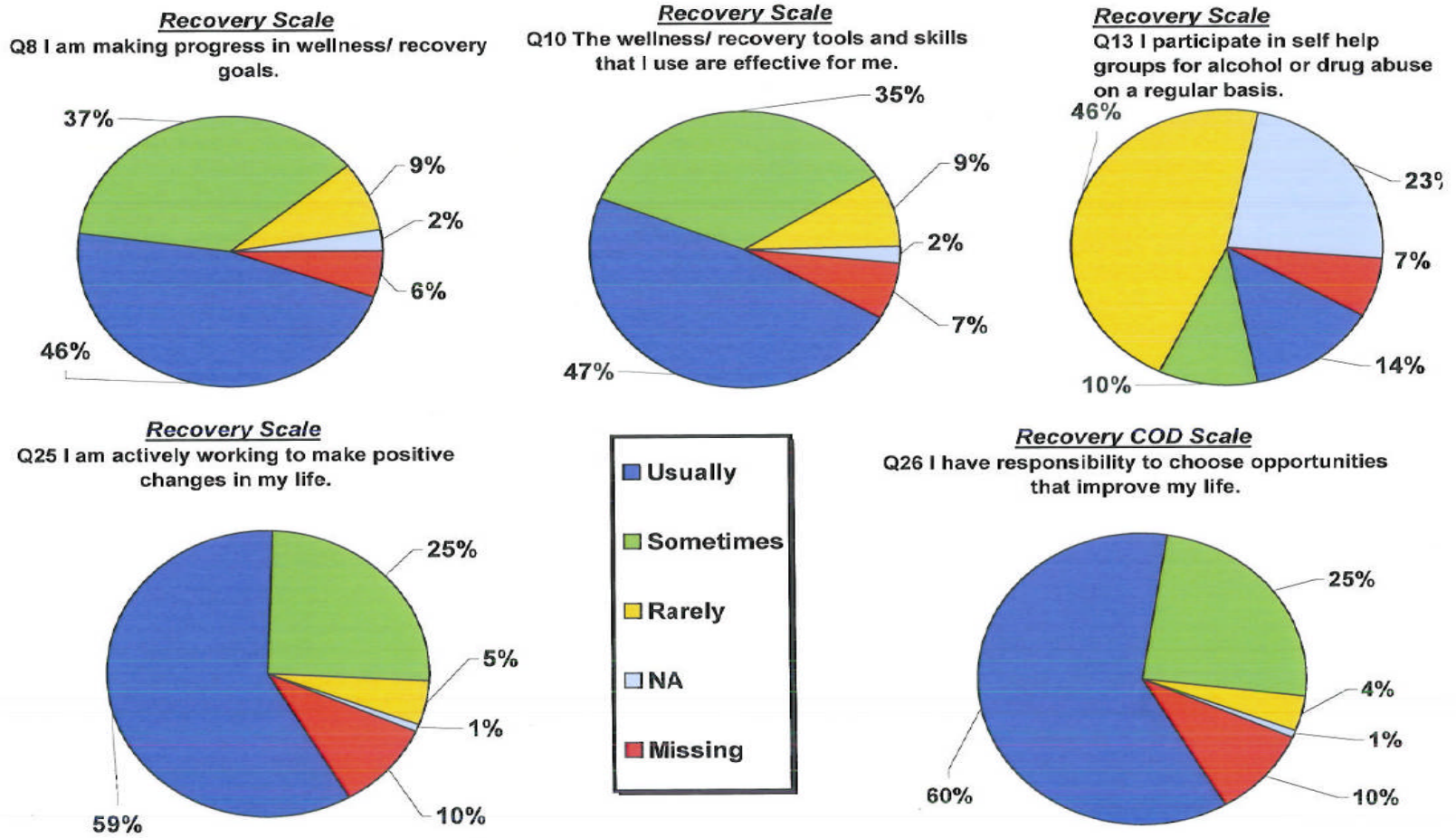
Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Prescribed Medications:



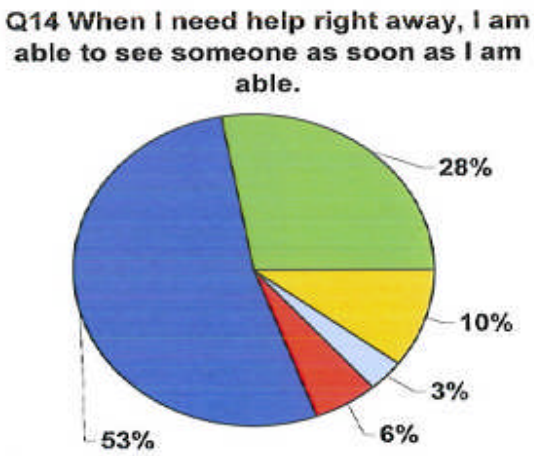
Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

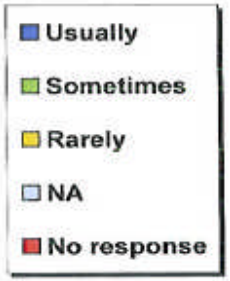
Recovery Scale/ Recovery COD Scale:

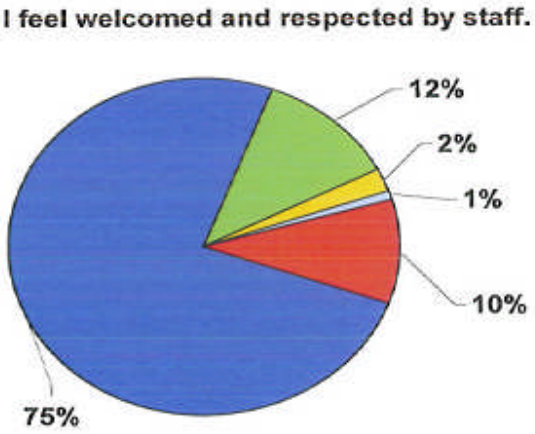


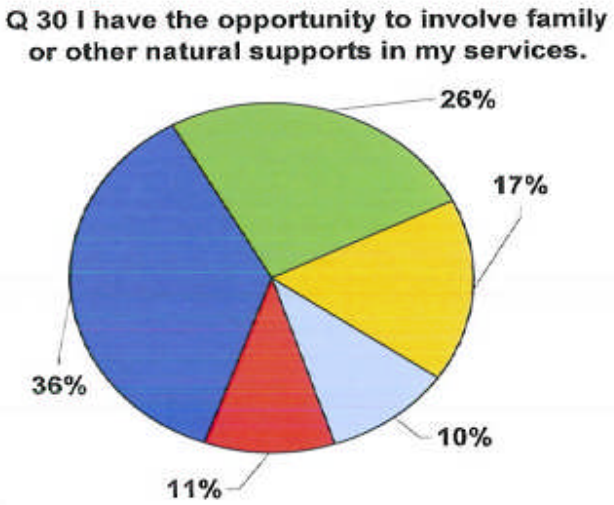
Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

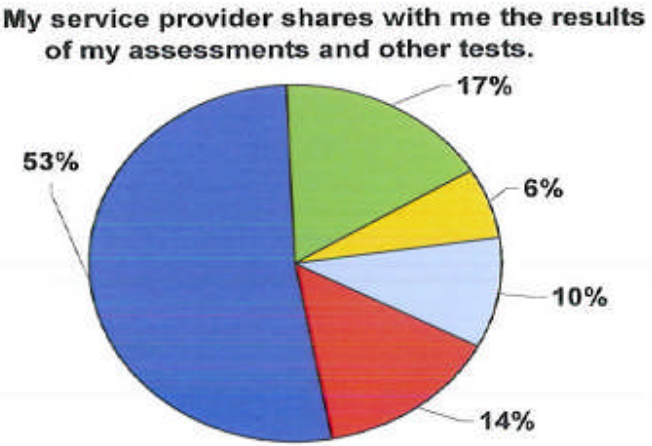
Service Access/Appropriateness/Quality:





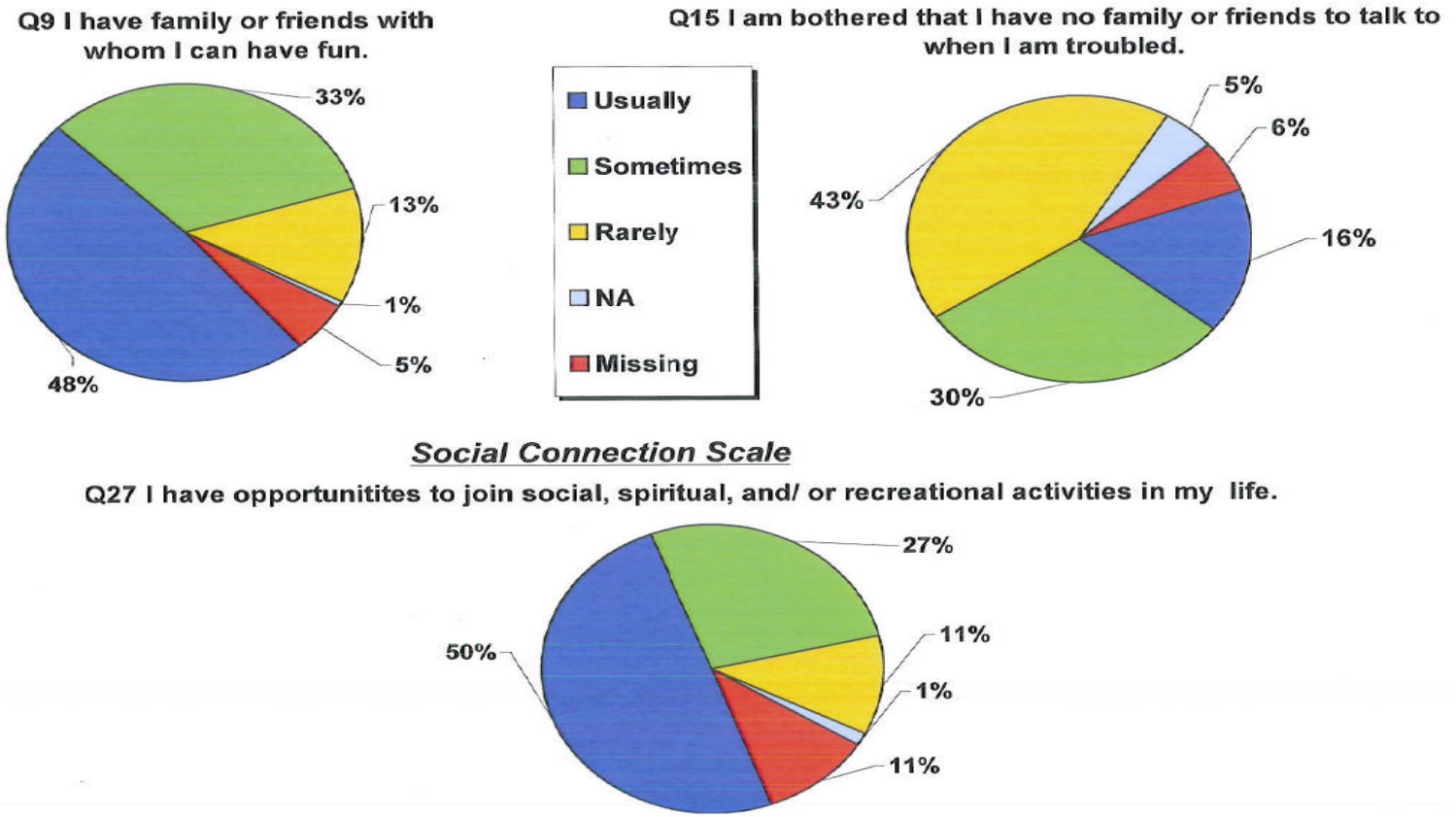






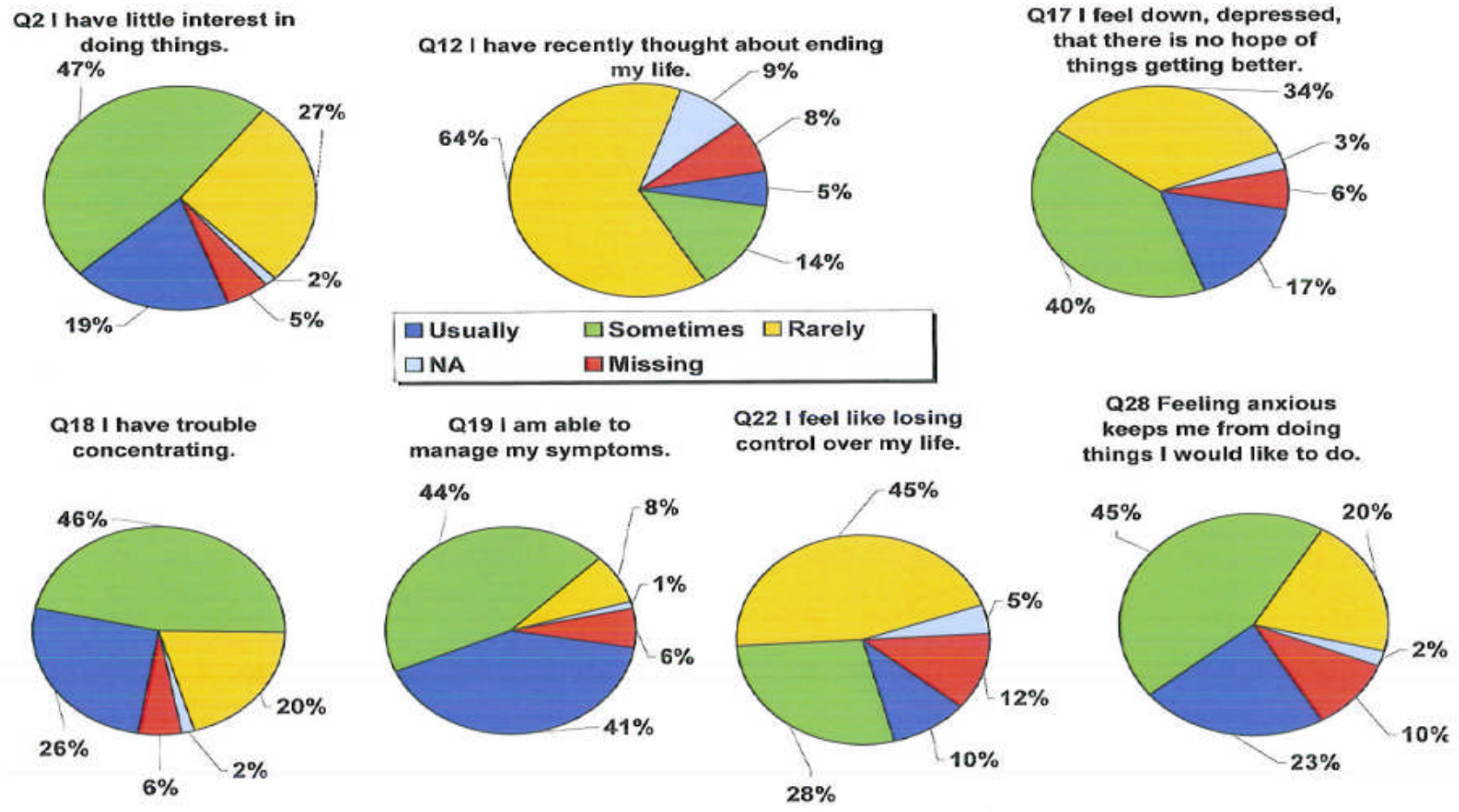
Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Social Connection:



Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Symptom Scale:



Data as of 10/6/2011, taken from Consumer Feedback Form: Wellness Survey/Alliance January-June 2011

Managing and Adapting Practice

LA PEI Aggregate Program Performance Dashboard Report v2
July/August 2011 Data Submission

Prepared by the California Institute for Mental Health (CiMH)

This program performance dashboard report describes children served through the Managing and Adapting Practice (MAP) treatment model in agencies receiving Prevention and Early Intervention (PEI) funding in Los Angeles County. Data were submitted in July and August of 2011, reflecting clients served through the end of June 2011.

Sixty-seven LA PEI-funded private-provider agencies and three LAC DMH directly-operated clinics submitted data to CIMH in July and August of 2011, reflecting children served in their MAP programs through June of 2011. This report presents data from:

- **Alma Family Services**
- **Almansor Center**
- **Amanacer**
- **Aviva**
- **Bienvenidos Children's Center, Inc.**
- **Catholic Healthcare West**
- **Child & Family Center**
- **Child and Family Guidance Center**
- **ChildNet**
- **Children's Bureau**
- **Children's Hospital, L.A.**
- **Children's Institute, Inc.**
- **CIFHS – The Family Center**
- **Community Family Guidance Center**
- **Counseling4Kids**
- **David and Margaret**
- **Didi Hirsch**
- **D'Veal Family and Youth Services**
- **Dubnoff Center for Child Development**
- **Eisner Pediatric & Family Medical Center**
- **El Centro del Pueblo**
- **EMQ/FF Hollygrove**
- **ENKI Health and Research Systems**
- **Exceptional Children's Foundation**
- **Five Acres**
- **Foothill Family Services**
- **For the Child, Inc.**
- **Gateways Hospital & Mental Health Center**
- **Hathaway-Sycamores Child & Family Services**
- **Helpline Youth Counseling**
- **Hillsides**
- **Hillview Mental Health Center**
- **Institute for Multicultural Counseling & Educational Services**
- **Koreatown Youth & Community Center**
- **Long Beach Child and Adolescent Program**
- **Los Angeles Child Guidance Clinic**
- **Masada Homes**
- **McKinley Children's Center**
- **Optimist Youth Homes & Family Services**
- **Pacific Clinics**
- **Pasadena Unified School District**
- **Penny Lane**
- **Prototypes**
- **Providence Community Services**
- **Rosemary Children's Services**
- **San Antonio Mental Health Center**
- **San Fernando Mental Health**
- **San Fernando Valley Mental Health Center**
- **San Gabriel Children's Center**
- **Shields for Families**
- **South Bay Children's Center**
- **South Central Health & Rehabilitation Center**
- **Special Service for Groups**
- **St. Anne's**
- **St. John's**
- **Star View Community Services**
- **Stirling Behavioral Health**
- **Tarzana Treatment Services**
- **Tessie Cleveland**
- **The Children's Center Antelope Valley**
- **The Guidance Center**
- **The Help Group**
- **The Village Family Services**
- **The Whole Child**
- **Tobinworld**
- **Trinity Youth Services**
- **UCLA Ties for Families**
- **United American Indian Involvement**
- **VIP Community Mental Health Center**
- **Vista del Mar**

This dashboard report reflects a total of **2,675** clients referred to MAP programs offered by these 67 private-provider agencies and three directly-operated DMH clinics.

Table 1. LA PEI MAP Status – Entry and Dropout Rates of Referred Clients (N=2,675)		
	Entry Rate	**Dropout Rate**
Overall MAP	95.5% n=2,554	12.9% n=330
Anxiety	*not available*	12.0% n=60
Depression	*not available*	15.6% n=132
Disruptive Behavior	*not available*	14.8% n=180
Trauma	*not available*	20.5% n=25

Note1: Overall Entry Rate is defined as clients who were referred to MAP and have a first session documented in one of the four LA PEI MAP treatment foci (anxiety, depression, disruptive behavior, or trauma).
Note2: Dropout Rate is defined as clients who entered LA PEI MAP but did not complete the full intervention as determined by the therapist.

Table 2. Treatment Focus Distribution – All Clients who Entered LA PEI MAP				
	Focus #1 100% (n=2,554)	**Focus #2 4.9% (n=124)**	**Focus #3 0.2% (n=4)**	**Focus #4 0.1% (n=3)**
Anxiety	18.2% n=466	27.4% n=34	-	33.3% n=1
Depression	31.4% n=802	33.1% n=41	50.0% n=2	-
Disruptive Behavior	46.1% n=1,177	30.6% n=38	50.0% n=2	-
Trauma	4.3% n=109	8.9% n=11	-	66.7% n=2

Table 3. Demographics – Clients who Entered LA PEI MAP								
	Age	Gender		Ethnicity				
	(average age, in years)	Female	Male	African-American	Asian/ Pacific Islander	Caucasian	Hispanic/ Latino	Other
Overall MAP N=2,554	11.4 n=2,509	41.2% n=1,051	58.8% n=1,502	20.7% n=529	1.1% n=29	7.9% n=203	66.5% n=1,698	3.5% n=89
Anxiety N=501	10.9 n=493	51.9% n=260	48.1% n=241	12.0% n=60	1.6% n=8	10.0% n=50	72.1% n=361	4.2% n=21
Depression N=844	12.9 n=824	53.9% n=453	46.2% n=390	16.5% n=139	1.4% n=12	6.3% n=53	72.4% n=611	3.2% n=27
Disruptive Behavior N=1,216	10.6 n=1,198	29.4% n=358	70.6% n=858	26.8% n=326	0.9% n=11	8.1% n=99	60.6% n=737	3.3% n=40
Trauma N=122	11.5 n=118	48.4% n=59	51.6% n=63	30.3% n=37	0.8% n=1	7.4% n=9	55.7% n=68	4.9% n=6

Note1: Percentages may not total100 due to missing data.
Note2: Age calculated as the difference between the date of the first session and the client's date of birth.

Table 4. DSM-IV Primary Axis I Diagnosis – Clients who Entered LA PEI MAP								
	Anxiety Disorders	Depressive Disorders	Disruptive Behavior Disorders	Post-Traumatic Stress Disorder	Attention Deficit/ Hyper-activity Disorders	Psychotic Disorders	Other	Missing
Overall MAP N=2,554	13.4% n=342	34.5% n=881	26.9% n=686	3.4% n=87	15.4% n=393	3.1% n=78	2.6% n=65	0.9% n=22
Anxiety N=501	59.9% n=300	16.0% n=80	5.8% n=29	3.8% n=19	6.8% n=34	2.8% n=14	3.6% n=18	1.4% n=7
Depression N=844	3.3% n=28	81.3% n=686	4.6% n=39	2.3% n=19	3.2% n=27	3.2% n=27	1.1% n=9	1.1% n=9
Disruptive Behavior N=1,216	2.4% n=29	11.6% n=140	51.2% n=622	1.1% n=13	27.5% n=333	3.1% n=37	2.8% n=34	0.7% n=8
Trauma N=122	6.7% n=8	23.3% n=28	14.2% n=17	38.5% n=47	5.0% n=6	7.5% n=9	5.0% n=6	0.8% n=1

Table 5. Process Data by Treatment Focus – Clients who Entered LA PEI MAP		
	Clients With At Least One* Required Target-Specific Outcome Measure Completed Prior to Treatment	**Clients With At Least One* Required Outcome Measure of General Mental Health Functioning (YOQ or YOQ-SR) Prior to Treatment**
Overall MAP N=2,554	35.6% n=908	70.9% n=1,810
Anxiety N=501	47.9% n=240	66.3% n=332
Depression N=844	33.5% n=283	69.9% n=590
Disruptive Behavior N=1,216	19.9% n=242	72.9% n=886
Trauma N=122	53.3% n=65	78.7% n=96

*Including parent/caregiver report and/or child/youth self-report.
±Please see Appendix A. for a description of the four target-specific outcome measures and the measure of general mental health functioning.

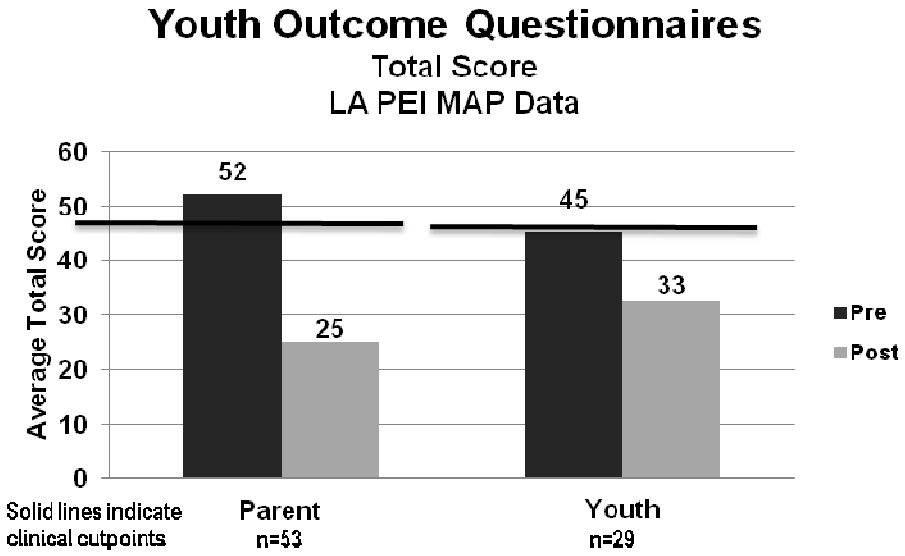
Table 6. Service Delivery Data by Treatment Focus – Clients who Completed One or More Foci			
	Number of Clients who Completed	**Average Length of Treatment**	**Average Number of Sessions**
Overall MAP N=2,554	n=250	22.6 weeks (±14.1) Range: 1 - 94 weeks n=236	19.4 (±13.1) Range: 1 - 73 sessions n=240
Anxiety N=501	n=75	20.1 weeks (±13.0) Range: 3 - 54 weeks n=70	16.2 (±13.2) Range: 1 - 73 sessions n=66
Depression N=844	n=98	20.1 weeks (±11.7) Range: 1 - 62 weeks n=93	16.9 (±10.8) Range: 1 - 64 sessions n=94
Disruptive Behavior N=1,216	n=113	22.7 weeks (±13.7) Range: 2 - 52 weeks n=105	21.1 (±13.0) Range: 3 - 59 sessions n=107
Trauma N=122	n=18	17.8 weeks (±7.2) Range: 2 - 28 weeks n=15	17.8 (±7.8) Range: 7 - 30 sessions n=18

Note1: Completion is defined as having a "yes" documented for completion status.
Note2: Length of treatment is calculated as the difference between the date of the last session and the date of the first session, summed across treatment foci.
Note3: ± indicates the standard deviation

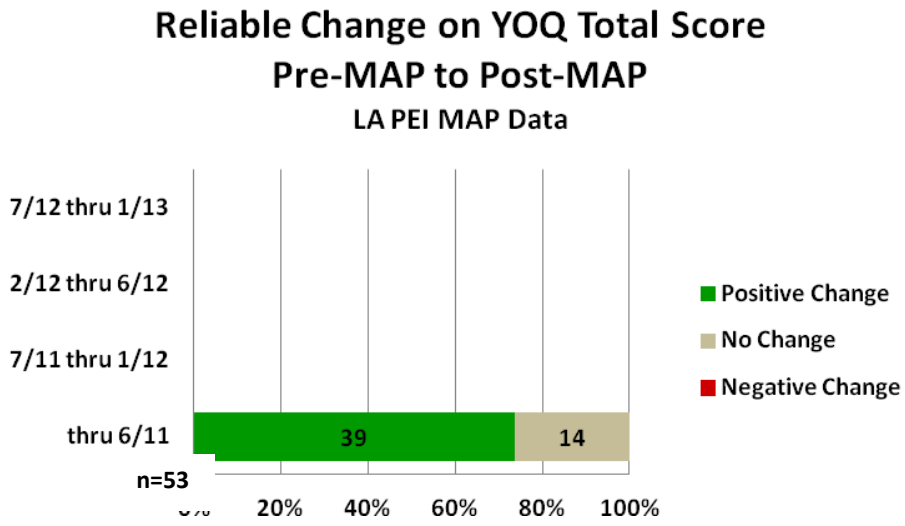
Table 7. Overall LA PEI MAP Outcome Data± – Clients who Completed MAP (n=250)					
	Youth Outcome Questionnaire (YOQ and YOQ-SR) Total Score				
	Percent Improvement± from the Average Pre-MAP Score to the Average Post-MAP Score	Effect Size Estimate± (Cohen's *d*)	Percent of Clients Showing Reliable Change± from Pre-MAP to Post-MAP		
			Positive Change	No Change	Negative Change
Parent/Caregiver	52.6%* n=53 [pre=52.0]	1.28	73.6% n=39	26.4% n=14	0% n=0
Child/Youth	27.8% n=29 [pre=45.2]	.44	37.9% n=11	41.4% n=12	20.7% n=6

±Please see Appendix A. for a description of the MAP outcome measures and the outcome indicators (percent improvement in average scores; effect size estimate; and, percent of clients showing reliable change).
Note1: Possible YOQ and YOQ-SR Total Scores range from -16 – 240, with a clinical cutpoint of 47 for parent/caregiver report and 46 for youth self-report.
Note2: Follow-up analyses of aggregate data revealed no significant differences in entry rate, dropout rate, duration of therapy, number of sessions, or change in outcomes by gender or ethnicity.
*Paired t-test indicates a statistically significant difference, $p \leq .01$.

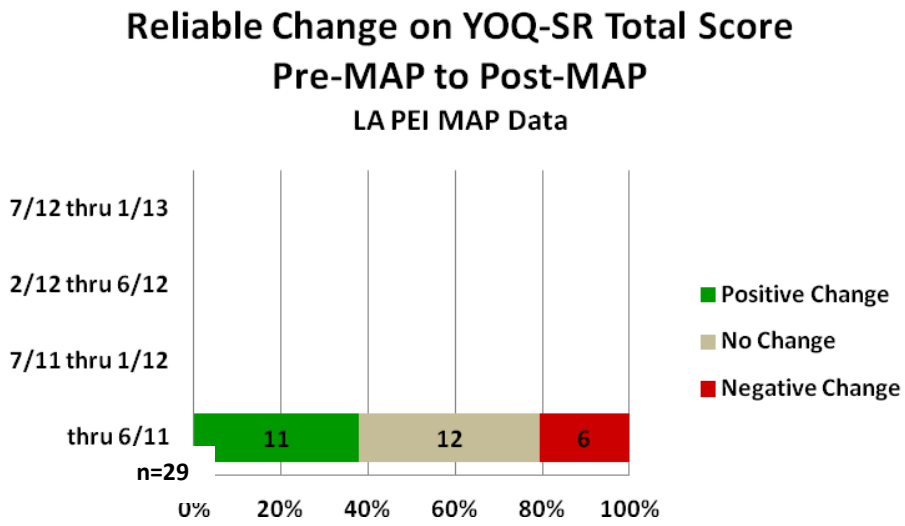
Graph 1. Overall LA PEI MAP Outcomes: Average YOQ and YOQ-SR Total Scores – Clients who Completed MAP (n=250)



Graph 2. Overall LA PEI MAP Outcomes: Percent of Clients Showing Reliable Change on YOQ Total Score within Each Data Submission Interval



Graph 3. Overall LA PEI MAP Outcomes: Percent of Clients Showing Reliable Change on YOQ-SR Total Score within Each Data Submission Interval



There are not yet sufficient data to report on outcomes specific to each of the four LA PEI MAP treatment targets. The second MAP data submission (January, 2012) should yield sufficient data for reporting on outcomes specifically related to anxiety, depression, disruptive behavior, and trauma treatment within the context of the MAP model.

Appendix A. Description of MAP Outcome Measures and Outcome Indicators

MAP Overall/General Mental Health Measure: Youth Outcome Questionnaires (YOQ / YOQ-SR)

The *Youth Outcome Questionnaires (YOQ and YOQ-SR)* are general outcome measures of overall child and youth mental health functioning and are for use with all MAP clients. These 64-item standardized questionnaires assess children's global mental health functioning within the prior week according to both youth self-reports (ages 12-18) and reports of their parents/caregivers (for children ages 4-17).

Possible Total YOQ and YOQ-SR scores range from -16-240. Scores of 47 or higher for parent/caregiver report and 46 or higher for youth self-report are most similar to clinical populations.

MAP Anxiety Measure: Revised Child Anxiety and Depression Scales (RCADS / RCADS-P)

The *Revised Child Anxiety and Depression Scales* (RCADS and RCADS-P) are target-specific measures for clients participating in treatment focused on anxiety. These 47-item measures assess the frequency/severity of symptomotology associated with specific anxiety diagnoses and depression according to children ages 6-18 and their parents/caregivers.

Possible Total Anxiety and Depression Scores on the RCADS/RCADS-P range from 0-141.

MAP Depression Measure: Patient Health Questionnaire-9 (PHQ-9)

The *Patient Health Questionnaire-9* (PHQ-9) is a target-specific outcome measure for clients participating in treatment focused on depression. This 9-item self-report measure for clients ages 12 and older assesses the overall frequency/severity of depressive symptoms experienced during the prior two weeks.

Possible Total PHQ-9 scores range from 0-27, with scores of 15 or higher indicating moderately severe to severe depression.

MAP Disruptive Behavior Measure: Eyberg Child Behavior Inventory (ECBI)

The *Eyberg Child Behavior Inventory* (ECBI) is target-specific outcome measure for clients participating in treatment focused on disruptive behaviors. This 36-item measure has two components: one that assesses the frequency, or intensity, of current child behavior problems displayed by children between the ages of 2-16; and one that assesses the extent to which these behaviors are currently perceived as problematic to the child's parent/caregiver.

The *Sutter-Eyberg Student Behavior Inventory* (SESBI) is a companion measure to the ECBI and can be completed by child care workers or teachers. It is a 38-item measure that also assesses the intensity and problematic level of disruptive behaviors currently displayed by children ages 2-16.

Possible ECBI Intensity Raw Scores range from 36-252, with a clinical cutpoint of 131; and possible ECBI Problem Raw Scores range from 0-36, with a clinical cutpoint of 15. Possible SESBI Intensity Raw Scores range from 38-266, with a clinical cutpoint of 151; and possible SESBI Problem Raw Scores range from 0-38, with a clinical cutpoint of 19.

Appendix A. Description of MAP Outcome Measures and Outcome Indicators (cont'd)

MAP Trauma Measure: Post-Traumatic Stress Disorder Reaction Index (PTSD-RI)
The *UCLA Post-Traumatic Stress Disorder Reaction Index* (PTSD-RI) is a target-specific outcome measure for clients participating in treatment focused on trauma. The evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports (ages 6-20) and reports of their parents/caregivers (for children ages 3-18).

Possible Total PTSD Severity Scores range from 0-68; and scores of 38 or higher have the greatest sensitivity and specificity for detecting PTSD.

Outcome Indicator: Percent Improvement in Average Pre- and Post- Scores
The percent improvement in the average scores from pre-MAP treatment to post-MAP treatment is reported for each outcome measure, when available. A paired t test analysis is conducted with each set of scores; and, when the difference observed is not likely to be due to chance ($p<01$), this is indicated with a footnote.

In addition to reporting the percent of change in average scores in Table 7, Graph 1 presents the average pre-score and the average post-score, with solid lines indicating the clinical cutpoints.

Outcome Indicator: Effect Size Estimate, Cohen's *d*
Cohen's *d* is a standardized effect size measure that estimates the magnitude, or strength, of a relationship. In this dashboard report it estimates the strength of the relationship between the average pre score and the average post score, expressed in terms of standard deviations. An effect size of .5 indicates that the average pre score is .5 standard deviations greater than the average post score. While there is no absolute agreement about what magnitude of an effect size is necessary to establish practical or clinical significance, conventional interpretations of Cohen's *d* are that effect sizes of .2 to .3 represent a "small" effect; effect sizes around .5 reflect a "medium" effect; and, effect sizes of .8 or greater represent a "large" effect. However, an alternate schema has been proposed for the social sciences, where the recommended minimum effect size representing a "practically" significant effect is .41, with 1.15 representing a moderate effect and 2.70 a strong effect [see Ferguson, C.J. (2009). An Effect Size Primer: A Guide for Clinicians and Researchers. *Professional Psychology: Research and Practice, 40 (5),* 532-538].

Outcome Indicator: Percent of Clients Showing Reliable Change
The percent of clients showing reliable change reflects those with an amount of change on an outcome measure from pre-MAP to post-MAP that meets or exceeds the value of the Reliable Change Index (RCI). RCI, as calculated using the Jacobson-Truax (1991) method, is the amount of change that can be considered reliable based on the difference from pre- to post-, taking the variability of the pre-treatment group and measurement error into consideration. It reflects an amount of change that is not likely to be due to measurement error ($p<.05$) [see Wise, E.A. (2004). Methods for Analyzing Psychotherapy Outcomes: A Review of Clinical Significance, Reliable Change, and Recommendations for Future Directions. *Journal of Personality Assessment, 82(1),* 50-59].
The percent of clients with positive change, no change, and negative change are reported in Table 7; and, Graphs 2 and 3 present reliable change within each data submission interval.

EXHIBIT D-IX

Trauma Focused Cognitive Behavioral Therapy
CIMH Community Development Teams

Aggregate Program Performance Dashboard Report
March/April 2011 Data Submission v3

This aggregate program performance dashboard report describes children for whom data were submitted in March and April of 2011 that participated in Trauma Focused Cognitive Behavioral Therapy (TF-CBT) through the CIMH-sponsored TF-CBT Community Development Teams, reflecting children served through the end of January 2011. Each dashboard report reflects only those sites that submitted data at the specified data submission date, and is intended to reflect a historical record of their TF-CBT implementation.

Nine counties and 59 private-provider agencies submitted data to CIMH in March and April of 2011, reflecting children served in their TF-CBT programs through January of 2011. This report presents data from:

- **Aldea, Inc.**
- **Alma Family Services**
- **Almansor Center**
- **Amanacer**
- **Aviva**
- **Catholic Healthcare West**
- **Child and Family Guidance Center**
- **ChildNet**
- **Children's Hospital, L.A.**
- **Children's Institute, Inc.**
- **CIFHS – The Family Center**
- **Community Family Guidance Center**
- **Contra Costa County**
- **Counseling4Kids**
- **David and Margaret**
- **Didi Hirsch**
- **D'Veal Family and Youth Services**
- **El Centro de Amistad**
- **El Centro del Pueblo**
- **EMQ/FF Hollygrove**
- **ENKI Health and Research Systems**
- **Exceptional Children's Foundation**
- **Five Acres**
- **Foothill Family Services**
- **Gateways Hospital**
- **Harbor View CSC**
- **Hathaway-Sycamores**
- **Humboldt County**
- **Imperial County**
- **Kedren Mental Health**
- **Los Angeles County**
- **Los Angeles Child Guidance Clinic**
- **Martin's Achievement Place**
- **Maryvale**
- **Masada Homes**
- **Napa County**
- **Nevada County**
- **Olive Crest**
- **Optimist Mental Health**
- **Pacific Clinics**
- **Pasadena Unified School District**
- **Penny Lane**
- **Prototypes**
- **Providence**
- **River Oak**
- **Riverside County**
- **Rosemary Children's Services**
- **Sacramento Children's Home**
- **San Fernando Valley Mental Health Center**
- **San Gabriel Children's Center**
- **San Joaquin County**
- **San Luis Obispo County**
- **Stanford Home for Children**
- **Shields for Families**
- **South Bay Children's Center**
- **Special Service for Groups**
- **St. Anne's**
- **St. John's**
- **Star View**
- **Stirling Behavioral Health**
- **Tessie Cleveland**
- **The Help Group**
- **The Village Family Services**
- **United American Indian Involvement**
- **Verdugo Mental Health**
- **VIP**
- **Vista del Mar**

Counties and agencies should be commended for their dedication to this aspect of the Community Development Teams, as we often find program performance and outcome evaluation activities to be critical but challenging to initiate and maintain over time.

This dashboard report reflects a total of **4,450** children referred to the TF-CBT programs in these nine counties and 59 private-provider agencies.

Table 1. TF-CBT Status (N=4,450)

Entry Rate	Dropout Rate
98.3% n=4,374	16.3% n=714

Note1: Entry Rate is defined as children who were referred to TF-CBT and have a first session documented.
Note2: Dropout Rate is defined as children who stopped participating prior to successfully completing TF-CBT.

Table 2. Client Demographics – Children Who Entered TF-CBT (n=4,374)

	Gender		Ethnicity					Primary Axis I Diagnosis		
Age (in years)	Female	Male	African-American	Asian/ Pacific Islander	Caucasian	Hispanic/ Latino	Other	PTSD	Other Anxiety/ Mood/ Adjustment	Other
11.2 n=4290	56.4% n=2467	43.5% n=1902	16.1% n=705	1.3% n=58	11.6% n=507	67.4% n=2947	3.3% n=145	26.8% n=1172	52.1% n=2277	20.6% n=903

Note1: Percentages may not total 100 due to missing data.
Note2: Age calculated as the difference between the date of the first session and child's date of birth.

Table 3. Process Data – Children Who Entered TF-CBT (n=4,374)

Clients With At Least One* Completed UCLA Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) Prior to TF-CBT	Clients With At Least One* Completed Youth Outcome Questionnaire (YOQ or YOQ-SR) Prior to TF-CBT
82.0% (n=3587)	73.5% (n=3213)

*Including parent/caregiver report and/or child/youth self-report.
±Please see Appendix A. for a description of the UCLA Post-Traumatic Stress Disorder Reaction Index and the Youth Outcome Questionnaires.

Table 4. Service Delivery Data – Children Who Completed TF-CBT (n=956)	
Average Length of Therapy	**Average Number of Sessions**
25.6 weeks (±13.1) Range 2 – 141 weeks n=916	19.4 (±11.6) Range 1 – 254 sessions n=906

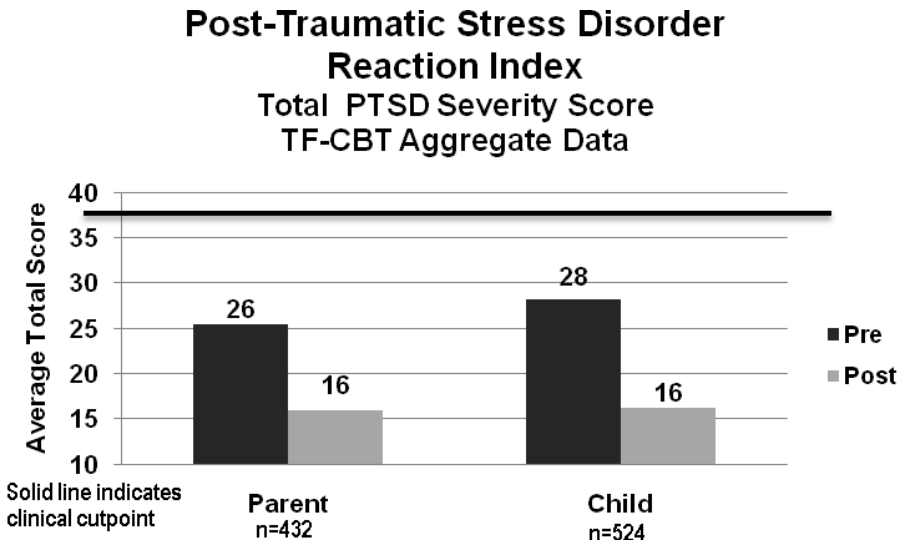
Note1: Completion of TF-CBT is defined as having a "yes" documented for completion status.
Note2: Duration is calculated as the difference between the date of the last session and the date of the first session.

Table 5. Outcome Data± – Children Who Completed TF-CBT (n=956)		
	Percent Improvement From Pre TF-CBT to Post TF-CBT	
	Post-Traumatic Stress Disorder Reaction Index (PTSD-RI) Total PTSD Severity Score	**Youth Outcome Questionnaire (YOQ and YOQ-SR) Total Score**
Parent/Caregiver	37.5%* n=432 [pre=25.5]	43.9%* n=395 [pre=56.5]
Child/Youth	42.6%* n=524 [pre=28.2]	40.5%* n=330 [pre=57.5]

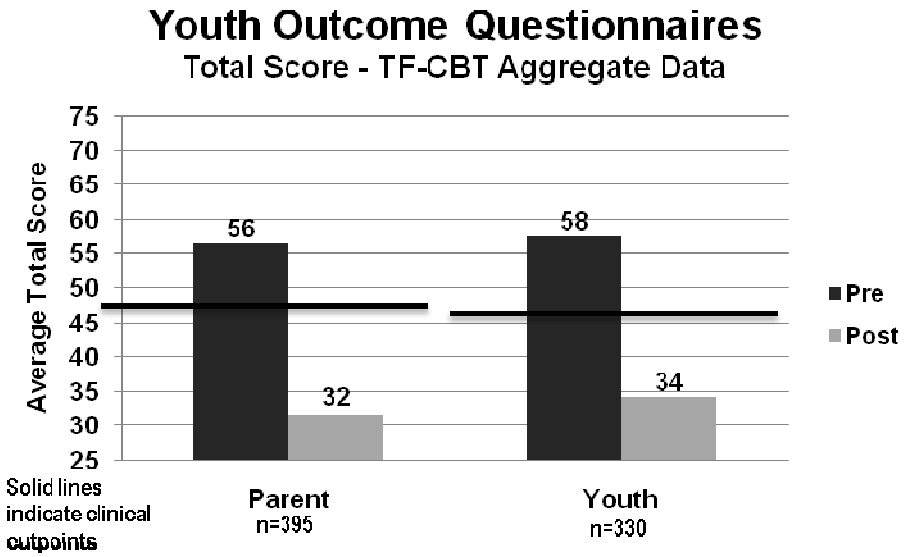
±Please see Appendix A. for a description of the TF-CBT outcome measures.
Note1: Possible PTSD-RI Total Severity Scores range from 0-68, with a clinical cutpoint of 38.
Note2: Possible YOQ and YOQ-SR Total Scores range from -16-240, with a clinical cutpoint of 47 for parent/caregiver report and 46 for youth self-report.
Note3: Follow-up analyses revealed no significant differences in entry rate, dropout rate, or change in outcomes by gender or ethnicity.
*A statistically significant difference, $p \leq .01$.

EXHIBIT D-IX

Graph 1. TF-CBT Outcomes: PTSD-RI Total Severity Score – Children who Completed TF-CBT (n=956)



Graph 2. TF-CBT Outcomes: YOQ and YOQ-SR Total Scores – Children who Completed TF-CBT (n=956)



Appendix A. Description of TF-CBT Outcome Measures

Post-Traumatic Stress Disorder Reaction Index (PTSD-RI)

The *UCLA Post-Traumatic Stress Disorder Reaction Index* (PTSD-RI) is an outcome measure completed before and after participation in TF-CBT. The evaluation component of this measure has 20 items that assess the frequency of occurrence of post-traumatic stress disorder symptoms during the prior month according to both child/youth self-reports and reports of their parents/caregivers (for children ages 3-18).

Possible Total PTSD Severity Scores range from 0-68; and scores of 38 or higher have the greatest sensitivity and specificity for detecting PTSD.

The percent improvement in Total PTSD Severity Scores from pre-TF-CBT to post-TF-CBT is reported when available.

Youth Outcome Questionnaires (YOQ and YOQ-SR)

The *Youth Outcome Questionnaires (YOQ and YOQ-SR)* are outcome measures completed before and after participation in TF-CBT. These 64-item standardized questionnaires assess children's global mental health functioning within the prior week according to both youth self-reports (ages 12-18) and reports of their parents/caregivers (for children ages 4-17).

Possible Total YOQ and YOQ-SR scores range from -16-240. Scores of 47 or higher for parent/caregiver report and 46 or higher for youth self-report are most similar to clinical populations.

The percent improvement in Total YOQ and YOQ-SR Scores from pre-TF-CBT to post-TF-CBT is reported when available.

EXHIBIT D-X

Triple P Parenting

LA PEI Aggregate Program Performance Dashboard Report
June 2011 Data Submission

Prepared by the California Institute for Mental Health (CIMH)

This aggregate program performance dashboard report describes children for whom data were submitted in June of 2011 that participated in LA PEI-funded Triple P Parenting programs in Los Angeles County, reflecting clients served through the end of May 2011.

Thirty-two private-provider agencies submitted data to CIMH in June and July of 2011, reflecting clients served in their Triple P Parenting programs through May of 2011. This report presents data from:

- **AADAP, Inc.**
- **Child and Family Center**
- **Child & Family Guidance Center**
- **Counseling4Kids**
- **Didi Hirsch**
- **D'Veal Family & Youth Services**
- **El Centro de Amistad**
- **Eisner Pediatric & Family Medical Center**
- **ENKI Health and Research Systems**
- **Five Acres**
- **Foothill Family Services**
- **Gateways Hospital**
- **Harbor View CSC**
- **Hathaway-Sycamores**
- **Hillsides**
- **Kedren Mental Health**
- **Koreatown Youth & Community Center**
- **Los Angeles Child Guidance Clinic**
- **Maryvale**
- **Masada Homes**
- **Optimist Youth Homes and Family Services**
- **Pacific Clinics**
- **Penny Lane**
- **Rosemary Children's Services**
- **San Fernando Valley Community Mental Health Centers**
- **St. Francis Medical Center**
- **The Guidance Center of Long Beach**
- **The Help Group**
- **The Village**
- **The Whole Child**
- **VIP**
- **Vista del Mar**

This dashboard report reflects a total of **845** clients referred to Triple P programs offered by these 32 private-provider agencies.

Table 1. Triple P Level 4/5 Status (N=845)	
Entry Rate	**Dropout Rate**
97.5% n=824	20.9% n=172

Note1: Entry Rate is defined as children who were referred to Triple P Level 4/5 and have a first session documented.
Note2: Dropout Rate is defined as children who stopped participating prior to successfully completing Triple P.

Table 2. Client Demographics – Children Who Entered Triple P Level 4/5 (n=824)										
Age	**Gender**		**Ethnicity**					**Primary Language**		
(in years)	**Female**	**Male**	**African American**	**Asian/Pacific Islander**	**Caucasian**	**Hispanic/ Latino**	**Other**	**English**	**Spanish**	**Other**
9.0 n=811	35.7% n=294	64.3% n=530	8.3% n=68	1.3% n=11	9.5% n=78	77.7% n=640	3.3% n=27	53.2% n=438	45.1% n=372	1.7% n=14

Note: Age calculated as the difference between the date of the first contact and the child client's date of birth.

Table 3. DSM-IV Diagnosis – Children Who Entered Triple P Level 4/5 (n=824)					
Primary DSM-IV Axis I Diagnosis					
Disruptive Behavior Disorders	**Attention Deficit/ Hyperactivity Disorders**	**Mood/ Anxiety/ Adjustment Disorders**	**Post-Traumatic Stress Disorder**	**Other**	**Missing/ Not Reported**
28.2% n=232	27.5% n=227	32.9% n=271	4.0% n=33	7.0% n=58	0.4% n=3

Table 4. Level and Type of Triple P Parenting – Children Who Entered Triple P Level 4/5 (n=824)						
Level 4 Standard Child	**Level 4 Standard Teen**	**Level 4 Group Child**	**Level 4 Group Teen**	**Level 5 Enhanced**	**Level 5 Pathways**	**Missing/ Not Reported**
71.5% n=589	18.4% n=152	0.7% n=6	0.2% n=2	0.2% n=2	0.2% n=2	8.6% n=71

Table 5. Process Data – Children Who Entered Triple P Level 4/5 (n=824)	
Clients with an Eyberg Child Behavior Inventory Completed Prior to Triple P (Pre-ECBI)	**Clients With At Least One* Youth Outcome Questionnaire Completed Prior to Triple P (Pre-YOQ or Pre-YOQ-SR)**
35.7% n=294	65.8% n=542

*Including parent/caregiver report and/or youth self-report.
±Please see Appendix A. for a description of the Eyberg Child Behavior Inventory and the Youth Outcome Questionnaires.

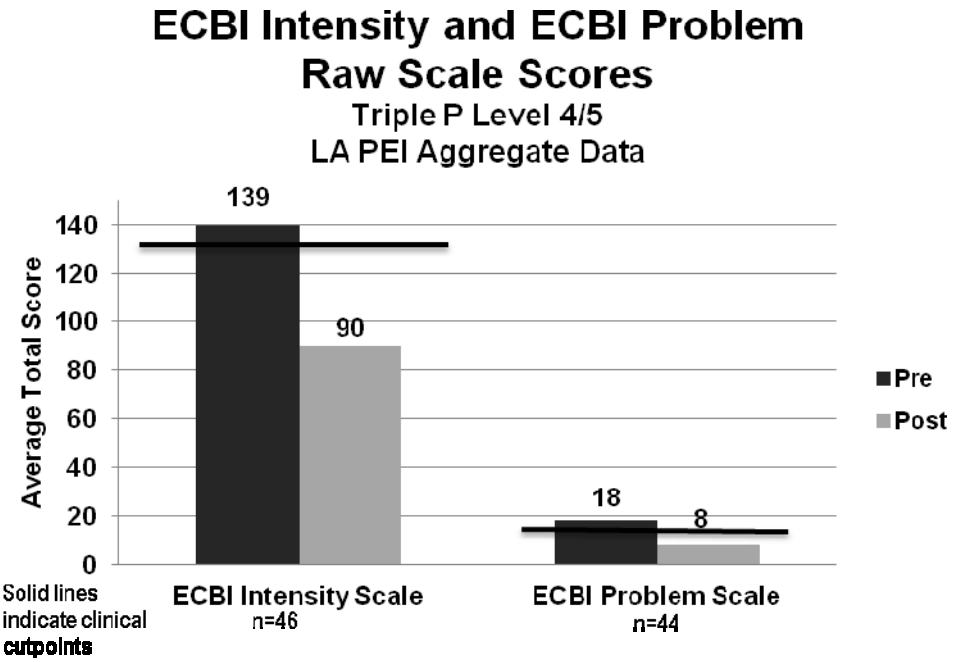
Table 6. Service Delivery Data – Children Who Completed Triple P Level 4/5 (n=194)	
Average Length of Triple P	**Average Number of Sessions**
20.0 weeks (±9.8) Range 1 – 65 weeks n=189	14.9 sessions (±5.4) Range 1 – 30 sessions n=163

Note1: Completion of Triple P is defined as having a "yes" documented for completion status.
Note2: Duration is calculated as the difference between the date of the last session and the date of the first session.

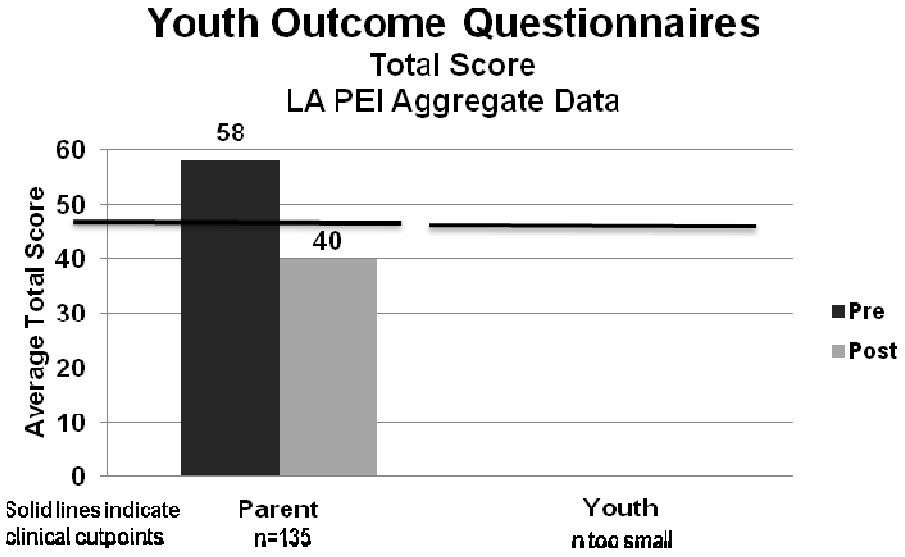
Table 7. Outcome Data± – Children Who Completed Triple P Level 4/5 (n=194)			
	Percent Improvement From Pre Triple P to Post Triple P		
	Eyberg Child Behavior Inventory (ECBI)		**Youth Outcome Questionnaire (YOQ and YOQ-SR)**
	Intensity Raw Score	**Problem Raw Score**	**Total Score**
Parent/Caregiver Report	35.3%* n=46 [pre=139.4]	59.8%* n=44 [pre=18.2]	30.2%* n=78 [pre=57.6]
Youth Self-Report			n too small

±Please see Appendix A. for a description of the Triple P Level 4/5 outcome measures.
Note1: Possible ECBI Intensity Raw Scores range from 36-252, with a clinical cutpoint of 131; and, possible ECBI Problem Raw Scores range from 0-36, with a clinical cutpoint of 15.
Note2: Possible YOQ and YOQ-SR Total Scores range from -16-240, with a clinical cutpoint of 47 for parent/caregiver report and 46 for youth self-report.
Note3: Aggregate outcomes based on fewer than 20 clients are not reported.
Note4: Follow-up analyses of aggregate data revealed no significant differences in entry rate, dropout rate, duration of therapy, number of sessions, or change in outcomes by gender or ethnicity.
*A statistically significant improvement, $p \leq .01$.

Graph 1. LA PEI Triple P Outcomes: ECBI Scores for Clients Who Completed Level 4/5 (n=194)



Graph 2. LA PEI Triple P Outcomes: YOQ and YOQ-SR Total Scores for Clients Who Completed Level 4/5 (n=194)



Appendix A. Description of Triple P Outcome Measures

Eyberg Child Behavior Inventory (ECBI)

The *Eyberg Child Behavior Inventory* (ECBI) is an outcome measure completed before and after participation in Triple P Level 4/5. This 36-item parent-report measure has two components: one that assesses the frequency, or intensity, of current child behavior problems displayed by children between the ages of 2-16; and one that assesses the extent to which these behaviors are currently perceived as problematic to the child's parent/caregiver.

Possible ECBI Intensity Raw Scores range from 36-252, with a clinical cutpoint of 131; and possible ECBI Problem Raw Scores range from 0-36, with a clinical cutpoint of 15.

The percent improvement in both the ECBI Intensity and Problem Raw Scores from pre-Triple P Level 4/5 to post-Triple P Level 4/5 is reported when available.

Youth Outcome Questionnaires (YOQ and YOQ-SR)

The *Youth Outcome Questionnaires (YOQ and YOQ-SR)* are outcome measures completed before and after participation in Triple P Level 4/5. These 64-item standardized questionnaires assess children's global mental health functioning within the prior week according to both youth self-reports (ages 12-18) and reports of their parents/caregivers (for children ages 4-17).

Possible Total YOQ and YOQ-SR scores range from -16-240. Scores of 47 or higher for parent/caregiver report and 46 or higher for youth self-report are most similar to clinical populations.

The percent improvement in Total YOQ and YOQ-SR Scores from pre-Triple P Level 4/5 to post-Triple P Level 4/5is reported when available.

Exhibit D-XI

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-13

Section XI: Prevention Early Intervention (PEI) Outcomes Update

Data Collection Strategy

For most practices implemented under L.A. County's PEI plan, data will be collected using a general outcome measure and a second outcome measure that targets the focus of treatment for the practice. Data is collected at the start and end of the practice. If a client remains in a practice longer than 6 months, an update is collected every 6 months the client is in the program. Measures are selected based on input from practice developers, mental health providers, PEI administration, Age group leads, and Evidence Based Practice (EBP) leads in the Department. Reliability, validity, available norms, language, cost, brevity, and ease of administration and scoring are all considered when selecting a measure.

Since April of 2011, LA County DMH has offered eight different trainings on groups of outcome measures. Training on three additional measures is in development and will be available as new practices are implemented. Training is offered multiple times a month and over 1,900 staff has been trained on how to administer, score, and interpret PEI outcome measures. Once data is collected and scored by the mental health treatment teams, data is reported to DMH in a variety of ways.

Reporting Outcomes

LA County DMH developed a custom build web-based application to collect data for most PEI practices. The PEI Outcome Measures Application (PEIOMA) was ready for data entry starting in June of 2011. Approximately 300 staff have been trained on how to enter data into PEIOMA as the mechanism for reporting their outcomes to L.A. County DMH. To date, data has been entered for 21 different PEI practices by 57 different legal entities, reporting on approximately 3,800 PEI EBP treatment cycles. PEIOMA data entry progress is monitored weekly. Staff from the MHSA Implementation and Outcomes Division maintains close contact with mental health providers to encourage them to collect and enter data accurately. Initial reports of PEIOMA data are being finalized. The initial reports will focus on client demographics, summary and detail reports related to compliance, and percent of data that was not able to be captured and why. Development of additional reports will focus on a client's change in scores over time based on data reported at the start and end of treatment.

LACDMH has also contracted with California Institute of Mental Health (CiMH) to collect outcome data as a part of the services CiMH provides to support three PEI EBPs. Data for Managing and Adapting Practice (MAP), Triple P, and Trauma Focused Cognitive Behavior Therapy (TF-CBT) is collected twice a year by CiMH, reports are generated approximately 60 days after the data collection period ends and disseminated to LACDMH and providers.

Exhibit D-XI

Exploring Clinical Utility of Outcomes

While training on the administration and scoring of the outcome measures, there is an effort to inform trainees on how to incorporate the data collection practices into their clinical sessions and how to utilize the data yielded from the questionnaires to provide additional information or gauge how treatment is progressing. Another vehicle for exploring the clinical utility of outcome measures collected is incorporating data reports into PEI learning network discussions. Learning networks for PEI practices will be initiated over the next few months. Initial meetings have been set up for Aggression Replacement Training (ART), Child Parent Psychotherapy (CPP), Group CBT for Major Depression, Incredible Years (IY), and Seeking Safety. The focus of the learning networks is to bring providers together that are implementing the same practice to share successful strategies, resolve challenges, and utilize data available to facilitate this process. The learning networks will meet quarterly unless the network decides more frequent meeting is useful. Providers will drive the agenda and discussion with the MHSA Implementation and Outcomes Division providing the reports and administrative support for the networks.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ANNUAL UPDATE FY 2012-13

EXHIBIT E-I

MHSA BUDGET SUMMARY

Date: **May 30, 2012**

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2012/13 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$30,754,604	$48,493,036	$104,594,858	$121,660,300	$48,094,100	
2. Estimated New FY 2012/13 Funding	$253,036,294			$65,684,084	$16,771,614	
3. Transfer in FY 2012/13[a/]						$0
4. Access Local Pruduent Reserve in FY 2012/13						$0
5. Estimated Available Funding for FY 2012/13	$283,790,898	$48,493,036	$104,594,858	$187,344,384	$64,865,714	
B. Estimated FY 2012/13 Expenditures	$283,790,898	$13,102,677	$33,892,165	$138,206,014	$32,541,483	
C. Estimated FY 2012/13 Contingency Funding	$0	$35,390,359	$70,702,693	$49,138,370	$32,324,231	

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

D. Estimated Local Prudent Reserve Balance	**CSS Plan**	**PEI Plan**	**Total**
1. Total Deposit Amount	$127,577,750	$ 33,147,652	$ 160,725,402
2. Distributions from Local Prudent Reserve in FY 11-12	$7,675,547	$0	$7,675,547
3. Contributions to the Local Prudent Reserve in FY 11-12	$0	$12,324,453	$12,324,453
4. Distributions from Local Prudent Reserve in FY12-13	-$15,000,000		-$15,000,000
5. Distributions from Local Prudent Reserve in FY13-14	-$15,000,000		-$15,000,000
6. Estimated Local Prudent Reserve Balance on June 30, 2013	$105,253,297	$45,472,105	$150,725,402

Section D estimated amounts are based on the projected amount per each Plan and may be subject to change.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ANNUAL UPDATE FY 2012-13

EXHIBIT E-II

FY 2012-13 Projected Funding Increase by PEI Practice and Project

LA County estimates an increase of $ 11 million in PEI funding for FY 2012-13. The funding will be used to extend one-time funding given to providers implementing the following PEI practices for children, families and transition age youth:

			PEI PROJECTS						
Evidence Based Description	Adj. %	PEI Increase for FY 2012-13	School-Based Services PEI-1	Family Education & Support Services PEI-2	At-Risk Family Services PEI-3	Trauma Recovery Services PEI-4	Early Care & Support for TAY PEI-6	Juvenile Justice Services PEI-7	Total
Aggression Replacement Training	3.60%	396,130	132,043				132,043	132,043	396,130
Alternatives for Families/Abuse Focused CBT	0.66%	72,408			72,408				72,408
Brief Strategic Family Therapy	0.18%	19,791			19,791				19,791
Caring for Our Families	1.92%	211,091		105,545	105,545				211,091
Child-Parent Psychotherapy	3.57%	392,391			196,195	196,195			392,391
Cognitive Behavioral Intervention for Trauma in Schools	0.09%	10,214	5,107					5,107	10,214
Crisis Oriented Recovery Services	1.64%	180,899				180,899			180,899
Depression Treatment Quality Improvement Intervention	0.49%	54,442					27,221	27,221	54,442
Functional Family Therapy	3.12%	343,442						343,442	343,442
GLBT Champs	0.02%	2,578					2,578		2,578
Group CBT for Major Depression	0.00%	454			113	113	113	113	454
Incredible Years	1.89%	207,609		103,805	103,805				207,609
Interpersonal Psychotherapy for Depression	1.66%	182,163					182,163		182,163
Loving Intervention for Family Enrichment Program	0.27%	29,656						29,656	29,656
Managing and Adapting Practice	29.19%	3,210,614	802,653	802,653	802,653	802,653			3,210,614
Multidimensional Family Therapy	0.39%	42,869	10,717				21,434	10,717	42,869
Multisystemic Therapy	0.57%	$ 62,400						$ 62,400	$ 62,400
Parent-Child Interaction Therapy	1.61%	176,980			88,490	88,490			176,980
Promoting Alternative Thinking Strategies	0.85%	93,751	93,751						93,751
Reflective Parenting	0.01%	555			555				555
Seeking Safety	17.33%	1,906,156				953,078	953,078		1,906,156
Strengthening Families	0.44%	48,507	48,507						48,507
Trauma Focused CBT	24.65%	2,711,206			677,802	677,802	677,802	677,802	2,711,206
Triple P Positive Parenting Program	5.77%	634,251		317,125	317,125				634,251
UCLA Ties Transition Model	0.09%	9,443			9,443				9,443
Grand Total	100.00%		$ 1,092,779	$ 1,329,129	$ 2,393,926	$ 2,899,231	$ 1,996,433	$ 1,288,502	$ 11,000,000
FY 12-13 Increase		$ 11,000,000	9.9%	12.1%	21.8%	26.4%	18.1%	11.7%	100.0%

EXHIBIT F

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-13

Section I: Prudent Reserve

Utilization of the Prudent Reserve (PR) will make up for the Community Services and Supports (CSS) shortfall for Fiscal Year 2011-12. Funding will address urgent needs associated with CSS elements and initial commitments with 30 million dollars to be used over fiscal years 2012-13 and 2013-14. This will be the last year for several fiscal years counties will be able to withdraw funds from the PR. Funds will be taken out of the PR according to how they were put in, relative to age group allocation.

Section II: Use of the Prudent Reserve

Age Group	Program	Expansion Dollar Amount	Expansion Plan, including approximate additional clients to be served
Child	Field Capable Clinical Services (FCCS)	$2,039,954	627 new clients will be served
	N/A	$109,880	This money will support the infrastructure for Children's System of Care (social worker and clerical staff)
Transitional Age Youth (TAY)	FSP	$800,000	30 more FSP slots will be added and designated as directly operated probation camp slots; an additional 8 slots for contractor Step-Up on Second in Service Area 5
	Emergency Shelter Bed	$300,000	An additional 3,529 shelter bed nights per fiscal year
	Drop-In Center	$250,000	Funding will support an additional TAY Drop-In Center and will provide access to 250 TAY, year-round (including weekends and after hours)
	FCCS	$250,000	The dollars will be used primarily for probation camp youth returning to Service Area 6, 60 unique clients will be served.
	N/A	$410,000	This money will support the infrastructure for TAY System of Care
	TAY Navigator	$100,000	The funds will support a Department of Children & Family Service – Probation Navigator

EXHIBIT F

Age Group	Program	Expansion Dollar Amount	Expansion Plan
Adult	FCCS	$189,000	94 new clients will be served
	Wellness Center	$1,861,000	1,255 new clients will be served
Older Adult	FSP	$587,000	Approximately 66 slots will be added
	FCCS	$549,075	Approximately 100 new clients will be served
	Wellness Center		Approximately 300 existing older adult clients being currently served in Wellness Centers will receive specialized assessment (MMSE), WRAP for older adults, psychosocial groups focused on older adult issues and case management to access specialized housing options, healthcare and Medicare benefits.
Cross Cutting	Alternative Crisis Services (Urgent Care Centers, IMD Step Down Services)	$6,000,000	Approximately 11,000 additional clients would be served in Urgent Care Centers and an additional 126 additional clients served in IMD Step-down programs per year.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA ANNUAL UPDATE FISCAL YEAR 2012-2013

Exhibit G: Outcomes User Support Strategies

The following documents are examples of user support created for providers working with the Full Service Partnership, Field Capable Clinical Services and PEI Outcomes.

Outcomes Measurement Application Newsletter

The Outcome Measures Application (OMA) newsletter is generated on bi-monthly basis. It is a communication strategy between the Department and its provider network to provide OMA information and user support. Features of the newsletter include highlights of upcoming development and changes to outcome data collection, introduction to new reports, data quality tips, and bits of data to share with the readers. During the months of non-distribution of the newsletter, the MHSA Implementation and Outcomes Division host an OMA user group meeting where users have the option to attend in person or participate via webinar. Topics for the user group meeting are similar to those in the OMA newsletter, however, the OMA user group meeting allows the MHSA Implementation and Outcomes Division to have direct contact with the users of OMA and PEI OMA and they are able to ask questions in an open forum.

Prevention Early Intervention Quick Guides and Worksheets

For the implementation of Prevention Early Intervention (PEI) outcomes data collection, the MHSA Implementation and Outcomes Division designed two additional tools to assist providers. The PEI quick guides are one page fact sheets designed to provide the most pertinent information about questionnaires being used to collect data for PEI. Each questionnaire quick guides lists what the questionnaire is measuring, the practices it is being used for, the scales, some basic information about norms and clinical cutoffs, critical items, and where additional information can be found about the questionnaires. The PEI Worksheets were designed to assist with data entry into PEI OMA. On the worksheets, all information necessary for data collection for each PEI practice is listed. The worksheets provide a nice tool that ensures clinicians will be able to provide all the information data entry staff needs to enter the PEI data into PEI OMA. Both the PEI quick guides and PEI worksheets are available on our OMA project website allowing users to access them anytime.

OMA

Outcome Measures Application

Newsletter

The DIG

On behalf of the MHSA Implementation and Outcomes Unit, I want to take a moment to reflect back on the last year.

Adapting to change has been a theme over the last several years. In 2011, I am proud of the strides made to implement evidence-based and promising practices, including attending training, participating in ongoing support to enhance service quality, and collecting and entering outcome data. Our first PEI outcome reports have been produced by California Institute for Mental Health (CiMH) for the practices of Trauma Focused Cognitive Behavioral Therapy and Triple P Parenting and demonstrate that these practices are making a big difference in the lives of the clients being served!

While we have seen a steady increase in the number of providers entering their outcome data into the PEI OMA, there are still many providers who have yet to do that. In order to better understand the impact of PEI practices and provide feedback to clinicians, the Department is mandating that all PEI providers delivering PEI OMA practices, start entering their outcome data into the PEI OMA by February 1, 2012. If your agency is delivering a practice that reports outcomes to CiMH for PEI, please ensure data is being collected and reported on time. We are providing additional training on outcome measures and on use of the PEI OMA to accommodate any provider who has not yet had training. I cannot stress enough the importance of collecting, entering and using the outcome data to ensure quality of service.

Both the Department and providers are learning quite a bit about how to implement such large-scale changes. In 2012, we will continue that learning through provider collaboratives that focus on data and program-informed learning and application, with the ultimate goal of increasing service quality.

I wish each of you the happiest of holidays.

Debbie Innes-Gomberg, Ph.D
District Chief, MHSA Implementation & Outcomes Unit, Program Support Bureau, County of Los Angeles Department of Mental Health

OUTCOME MEASURES APPLICATION

Kara's Corner

As the year is coming to an end, I want to update you on a few things we have been working on. We have been working very hard on completing the FSP Employment Reports. We hope to release about 5 different reports related to employment in the coming weeks. So far, we have noticed there aren't many changes that get reported in OMA related to employment, and many clients are often unemployed. Take the time to review your employment data you have entered for clients. Make sure you have entered a years worth of history of employment on the baseline. Report all employment changes, remembering to indicate the client's complete employment status and the effective date of any employment change. Also make sure you are not reporting that the client is unemployed and employed at the same time. These few steps will go a long way in improving data quality and ensuring data for most of your clients are included in the employment reports.

The MHSA Implementation & Outcomes Unit, in conjunction with CIOB, has made additional progress related to PEI Outcomes. On November 29, we released the first revisions for Phase II of PEI OMA. We added in the Revised Behavior Problem Checklist (RBPC), enabling data to be collected for Brief Strategic Family Therapy (BSFT), Multidimensional Family Therapy (MDFT) and the Strengthening Families Program (SFP). More changes are being planned including adding some features that enable users to make additional edits to information and delete records in the PEI OMA. PEI reporting is well underway. We showed drafts of our first PEI Outcome reports a couple weeks ago and are working to make the final revisions for release.

On behalf of our whole team, we want to wish you a wonderful holiday season and look forward to working with all of you in 2012.

Staff Feature - Robin Ramirez

What is your role in the Implementation Unit? I dabble in a little of everything within the unit. I provide OMA technical assistance and I am the Older Adult liaison when it comes to OMA issues. I work with the age group leads on developing OMA reports and other data requests. I'm currently involved in the distribution of Prevention and Early Intervention outcomes. I collect the data for the Service Area Navigators and coordinate the responses for the Mental Health Services Act annual update.

What is your favorite thing about working with OMA? My favorite thing about working with OMA is to see the data come to life in reports, especially when the reports show that the data is moving in the right direction.

Tell us a little about your family. I'm married with two girls (14 and 9).

What are some of your hobbies? I enjoy doing anything that makes me laugh. I enjoy making party favors such as invitations, banners, cupcake toppers, etc. I go to the movies a lot with my husband and like to play the drums on Rock Band with the kids. I love to eat Italian food. I love to watch the TV show "The Office" and my new favorite show is "The New Girl". I also enjoy boating and relaxing at the lake.

What are five things you can't live without? My family, my best friend, a DVR, an iPhone, and laughter.

Tell us three random things about yourself.

- I grew up in the Boyle Heights neighborhood of Los Angeles.
- I graduated with a B.A. in Sociology from UCLA and a Masters in Public Administration from Cal State Northridge.
- I've worked for the County of Los Angeles for 12 years.

OUTCOME MEASURES APPLICATION

Internet Reports in OMA

Are you wondering what reports are available to OMA users? If so, take this time to familiarize yourself with the internet reports available via OMA. There are a number of reports available for the Full Service Partnership (FSP) and Field Capable Clinical Services (FCCS) programs. The reports include a detailed look at a given provider including provider to program comparisons.

Access to the reports is available through the Internet Reports application. Users will be able to access this application by logging on to the OMA and clicking the Reports button in the upper right hand corner of the screen.

There are currently twelve living arrangement reports for the FSP program:

- Annualized Living Arrangement Graph - Clients by Program and Residential Type
- Annualized Living Arrangement Graph - Clients by Provider and Program
- Annualized Living Arrangement Graph - Clients by Provider and Program Comparison
- Annualized Living Arrangement Graph - Days by Program and Residential Type
- Annualized Living Arrangement Graph - Days by Provider and Program Comparison
- Annualized Living Arrangement Statistics
- Annualized Living Arrangement Summary
- Current Living Arrangement
- High Outlier Residential Status
- Living Arrangement
- Living Arrangement Exceptions

The reports range from graphic representations of annualized pre-post living arrangements for an FSP age group by days and by clients, to your client's current living arrangement status. These reports not only illustrate the improvement in your client's living arrangement but also can help you with monitoring their progress. The living arrangement exceptions report helps you identify those clients that have been excluded from the living arrangement reports due to errors in the data entered in the Baselines and Key Event Changes. The High Outlier Residential Status report allows you to identify those clients that have an excessive number of days being homeless, in a hospital setting and/or jail.

For the FCCS program, there are eight reports available:

- FCCS Percent Yes Responses at Update

You can access the reports from the page illustrated above. It is accessed by clicking on Internet Reports at the top right corner of the screen after you log into OMA.

- FCCS Percent Yes Responses at Update Report at Program Level
- FCCS Residential Status at Baseline
- FCCS Residential Status at Update Report
- FCCS Residential Status at Update Report at Program Level
- FCCS Response at Baseline Active Baseline
- FCCS Response at Baseline All Baseline
- FCCS Response Exception

The FCCS reports the percentage of "yes" responses at baseline, the client's residential status at baseline and compares the percent of yes responses for each question on the baseline to responses for the same clients on a specified update. If a single assessment doesn't meet criteria for a client, all related assessments are excluded and they are included in the FCCS Response Exception report.

The MHSA Implementation & Outcomes Unit is available to support your reporting needs. Please contact Robin Ramirez if you have any report questions, rramirez@dmh.lacounty.gov or (213) 251-6832.

For step-by-step instructions on accessing reports, log on to the DMH OMA wiki website: http://dmhoma.pbworks.com. Click on the link: How do I use OMA Reports?

For information on how to fix the reports, log on to the DMH OMA wiki website: http://dmhoma.pbworks.com. Click on the link: How do I fix problems with Reports?

OUTCOME MEASURES APPLICATION

A New Venture for the MHSA Implementation & Outcomes Team

The MHSA Implementation & Outcomes Team is making plans for a new addition to the FSP and FCCS training schedule, and we need your help. A course for advanced FSP/FCCS training is being developed. We are looking for two groups of providers to assist us in making the course practical, relevant and on the mark.

We are looking for a few providers who are using the OMA for FSP or FCCS and do not feel they understand the utility of the data being collected or how to use the reports that are available to their agency. We are also looking for a few providers that feel very comfortable with the OMA who are familiar with Internet Reports, and use reports regularly (even if you created them) or use data that can be mined out of the system to make clinical decisions.

From these two groups we plan on generating a training approach targeting users who are familiar with the data elements of OMA but still have questions. We will also use this group for input on developing a manual that can guide providers on how to maximize information that can be gleaned out of the OMA.

If you would like to be in on the ground floor as this training is developed please call either Richard Hoskins: (213) 251-6865 or Robin Ramirez: (213) 251-6832. We welcome your input and participation and look forward to working with you on this project.

Triple Check Those Dates!

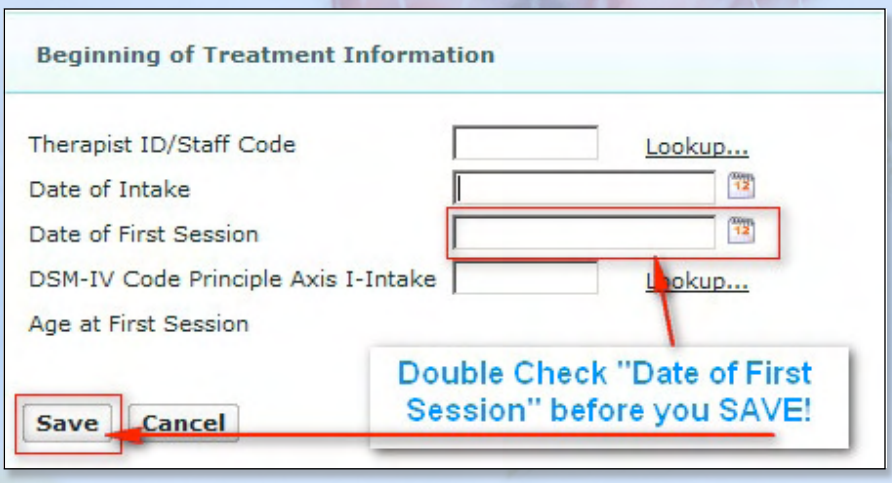
Phase II of PEI OMA is going to include the ability to edit and/or delete mistakes, but for now there is one very easy thing that you can do to avoid errors.

Double-check the "Date of First Session" when you are entering the "Beginning of Treatment Information" on your client! If you put in the wrong date in this screen and SAVE it, you may be stuck! That "Date of First Session" determines which assessments are done and it also determines the due date for each of those assessments. We've seen a couple of users who put the wrong date in and saved it, and now they are unable to enter Outcomes for that client until we roll out the new version of PEI OMA.

This also holds true for entering the "Date of Last Session": double and even triple check the "Date of Last Session" before you hit SAVE!

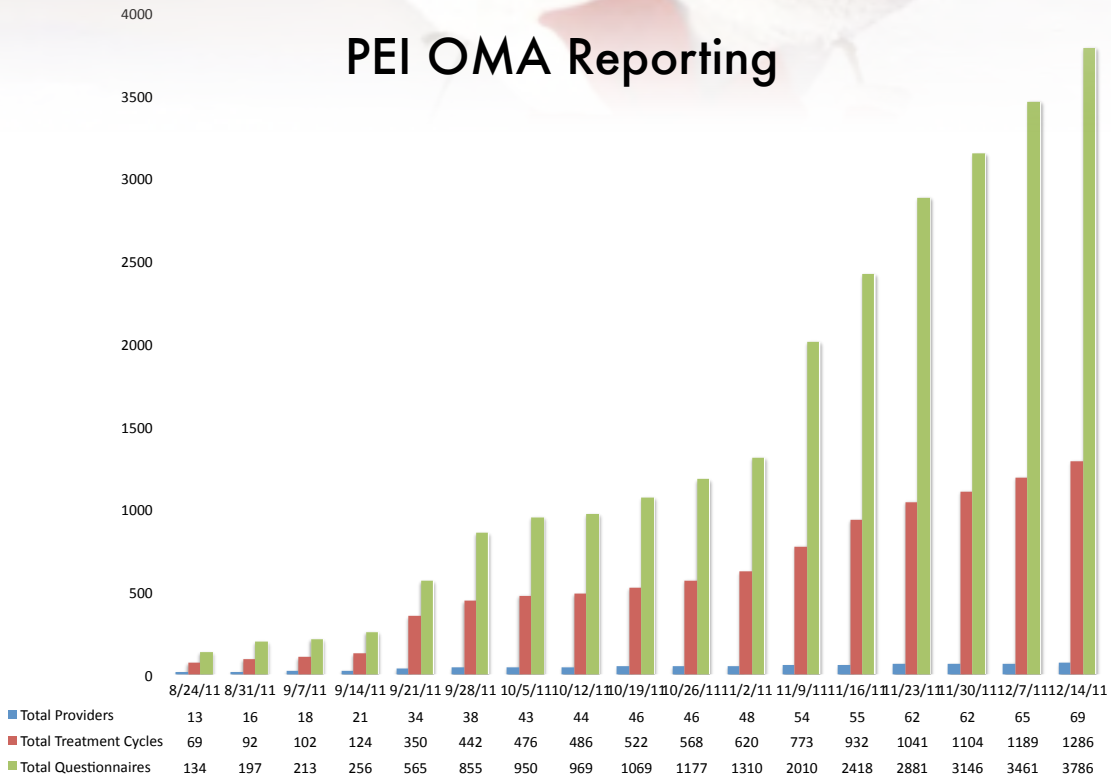
Finally, we have noticed that some users have started their clients in the wrong EBP – even the wrong reporting unit. It's always important to carefully sort all the assessments you're entering in PEI OMA, and it's important to check the top of the screen to make sure that you're entering those assessments where you mean to!

For more information about PEI Data Entry Mistakes, please check this page on our OMA wiki: www.tinyurl.com/8xbkjf7



PEI OUTCOME MEASURES APPLICATION

PEI OMA Reporting



	8/24/11	8/31/11	9/7/11	9/14/11	9/21/11	9/28/11	10/5/11	10/12/11	10/19/11	10/26/11	11/2/11	11/9/11	11/16/11	11/23/11	11/30/11	12/7/11	12/14/11
Total Providers	13	16	18	21	34	38	43	44	46	46	48	54	55	62	62	65	69
Total Treatment Cycles	69	92	102	124	350	442	476	486	522	568	620	773	932	1041	1104	1189	1286
Total Questionnaires	134	197	213	256	565	855	950	969	1069	1177	1310	2010	2418	2881	3146	3461	3786

The above graph illustrates the current statistics for PEI Outcomes. We have steadily increased the number of providers entering data into the system but only 32% of PEI OMA providers have entered data since it went live in July 2011. We hope to reach 100% with Providers' cooperation.

OMA Training is offered to all OMA users. It's a good idea to get trained or retrained if you have not attended one in the last 2 years because the system continually changes. Check the OMA Wiki for more info: http://dmhoma.pbworks.com

OMA Users Group is for our providers! Take advantage of this opportunity to dialogue with DMH folks. Next meeting: January 25, 2012 from 3:00 - 4:30 p.m. at 695 South Vermont Avenue, 15th Floor, Los Angeles, 90005

COGNOS LAB doubles as an OMA walk-in lab. Open to all OMA users who would like some one-on-one time with the Data team to tackle some data entry issues. Every other Monday, 10am - Noon. Next lab: January 16, 2012

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
Program Support Bureau
MHSA Implementation Unit
PEIOutcomes@dmh.lacounty.gov

ECBI Quick Guide

Eyberg Child Behavior Inventory®

Completed by parents/care providers of children ages 2 to 16 years, during the first and last EBP treatment sessions, for the following practices:

- Incredible Years (IY)
- Parent-Child Interaction Therapy (PCIT)
- UCLA TIES Transition Model (UCLA TTM)
- Reflective Parenting Program (RPP)
- Aggression Replacement Training (ART)
- Triple P* (PPP)
- Managing and Adapting Practice (MAP) – Disruptive Behavior* (*Currently supported by CiMH)

Purpose

- The ECBI is a 36-item care provider/parent-report questionnaire that assesses parent/care provider perceptions of disruptive behaviors in children and adolescents (such as conduct, aggression and attention problems).
- Provides information regarding the frequency and severity of problem behaviors in children and adolescents
- Is sensitive to short-term changes, thus it can be used to evaluate treatment progress through the course of treatment brief, EBP treatment

Administration

- Administered by a trained professional with a minimum of a bachelor's degree in psychology or related field.
- May be administered by phone or in a clinic, home or school setting
- Parents/ care providers should be encouraged to answer every item on both scales.

Clinical Utility

- The ECBI can be used to:
  - Measure behavior severity
  - Evaluate behavior change
  - Assess treatment progress
  - Aid in post-intervention treatment planning
- May yield important information regarding parenting styles
- May be used in conjunction with the SESBI-R for cross-informant data gathering purposes; although at this time, LAC DMH only requires the administration of the SESBI-R when the parent is not available to complete the ECBI

Scoring Information

- **Review questionnaire to ensure parent/care provider responded to all items.**

2 Scales

Intensity Scale: Measures the frequency (e.g., never to always) behaviors reportedly occur	▫ If four or more items are unanswered the scale is invalid and should not be scored. ▫ Missed responses count as 1 (Never). ▫ Total the circled responses to derive the raw score (minimum score = 36, maximum score = 252).
	▫ Raw Scores Cutoff for Clinical Significance: ≥ 131 ▫ T-Scores Cutoff for Clinical Significance: ≥ 60
Problem Scale: Allows parents to identify the degree to which the child's/youth's behavior is problematic	▫ When there are four or more missed items, the scale is invalid and should not be scored. ▫ Missed responses count as a "No" response. ▫ Total "Yes" responses to derive the raw score (minimum score = 0, maximum score = 36).
	▫ Raw Scores Cutoff for Clinical Significance: ≥ 15 ▫ T-Scores Cutoff for Clinical Significance: ≥ 60

Note: Because scores are weighted, higher scores (over clinical cutoff) reflect greater concern about the client's behaviors.

Revised: September 1, 2011

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
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PEIOutcomes@dmh.lacounty.gov

SESBI-R Quick Guide

Sutter-Eyberg Student Behavior Inventory - Revised®

Completed by teacher/daycare provider of children ages 2-16 years when parent/care provider is not available. Administered during the first and last EBP treatment sessions for the following practices:

- Incredible Years (IY)
- Parent-Child Interaction Therapy (PCIT)
- UCLA TIES Transition Model (UCLA TTM)
- Reflective Parenting Program (RPP)
- Aggression Replacement Training (ART)
- Triple P* (PPP)
- Managing and Adapting Practice (MAP) – Disruptive Behavior* (*Currently supported by CiMH)

Purpose

- LACDMH only requires the SESBI-R to be administered when a parent is not available to complete the ECBI.
- The SESBI-R is a 38-item questionnaire completed by teacher/daycare provider that assesses school-based disruptive behaviors for children and adolescents **ages 2-16** years.
- Sensitive enough to measure short-term change, thus it can be used to evaluate treatment progress at any point

Administration

- Administered by a trained professional with a minimum of a bachelor's degree in psychology or related field
- Should be completed by teacher/daycare provider in the school or residential setting
- Teachers/daycare providers rate behaviors by completing all items on both scales.

Clinical Utility

- The SESBI-R can be used for:
  - Identifying behavior severity at school/daycare
  - Evaluating behavior change
  - Assessing treatment progress
  - Treatment planning
- May yield important information regarding the teacher-student relationship
- May be used in conjunction with the ECBI for cross-informant data gathering purposes, although at this time, LAC DMH only requires the SESBI-R when the parent is not available to complete the ECBI

Scoring Information

- **Review questionnaire to ensure teacher has responded to all items on both scales.**

2 Scales

Intensity Scale: Measures the frequency behaviors reportedly occur	▫ If four or more items were skipped the scale is invalid and should not be scored. ▫ Missed responses count as 1 (Never). ▫ Total the circled responses to derive the raw score (minimum score = 38, maximum score = 266).
	▫ Raw Scores Cutoff for Clinical Significance: ≥ 151 ▫ T-Scores Cutoff for Clinical Significance: ≥ 60
Problem Scale: Allows teachers to identify the degree to which the child's/youth's behavior is problematic	▫ When there are four or more missed items, the scale is invalid and should not be scored. ▫ Missed responses count as a "No" response. ▫ Total "Yes" responses (minimum score = 0, maximum score = 38)
	▫ Raw Scores Cutoff for Clinical Significance: ≥ 19 ▫ T-Scores Cutoff for Clinical Significance: ≥ 60

Note: Because scores are weighted, higher scores (over clinical cutoff) reflect greater concern about the client's behaviors.

Revised: September 1, 2011

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Purpose

- The PHQ-9 is a valid and reliable depression questionnaire.
- It's based directly on the DSM-IV diagnostic criteria for Major Depressive Disorder.
- The PHQ-9 is useful for assessing symptom count and severity for depression at the start of treatment, and monitoring the client's symptoms over the course of treatment.

Administration

- This is a self-report measure.
- Validity is not compromised if the therapist reads the questions to the client.
- Clients should **complete every item,** based on their feelings during the **past 2 weeks.**

PHQ-9 is available in various languages at:
www.phqscreeners.com

Revised: September 1, 2011

PHQ-9 Quick Guide

Patient Health Questionnaire-9©

Administered for all clients ages 12 and above
Administered during the first and last EBP treatment sessions for the following EBPs:

- Interpersonal Psychotherapy for Depression (IPT)
- Depression Treatment Quality Improvement (DTQI)
- Group CBT for Major Depression (Group CBT-MD)
- Mental Health Integrated Program (MHIP)
- Managing and Adapting Practice (MAP)- Depression & Withdrawal* (*Currently supported by CiMH)

Advantages of the PHQ-9

- The PHQ-9 is shorter than other depression rating scales.
- Facilitates differential diagnosis of depressive disorders
- Is short enough to administer throughout treatment, should clinicians wish to monitor treatment progress more regularly
- Research has shown its effectiveness for clients as young as age 12 and through TAY (6-25), Adult (26-59) and Older Adult (60+) populations.
- Critical items, such as item #9 (e.g., suicidality), may yield important clinical information for more immediate follow up.

Scoring Information

An elevated score on the PHQ-9 is not synonymous with a diagnosis of Major Depressive Disorder, rather the information gathered from the PHQ-9 is meant to be used in conjunction with a thorough clinical intake assessment by a trained clinician.

Item Response	Score
Not at all	0
Several Days	1
More than half the days	2
Nearly everyday	3

The PHQ-9 total score is the sum of all nine items, and ranges from 0-27

GUIDE FOR INTERPRETING PHQ-9 TOTAL SCORES

Total Score	Depression Severity
0 – 4	NONE - MINIMAL
5 – 9	MILD
10 – 14	MODERATE
15 – 19	MODERATELY SEVERE
20 -27	SEVERE

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division
Prevention & Early Intervention (PEI) Evidence Based Practices (EBP) OUTCOME MEASURES

FOCUS OF TREATMENT	EBP, CDE, PP	Age	GENERAL OUTCOME MEASURE	Age	AVAILABLE LANGUAGES	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - *Anxiety & Avoidance* **	3-19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Revised Child Anxiety and Depression Scales (RCADS) - Parent Revised Child Anxiety and Depression Scales (RCADS) - Child	6-18 6-18	Chinese, English, Spanish
	Cognitive Behavioral Therapy (CBT)- Anxiety DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	18 19+	English Spanish	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Filipino
	Mental Health Integrated Program (MHIP)-Anxiety (Imp. Mood-Promoting Access to Collaborative Tx - IMPACT)	18 - 60+	[YOQ-SR / OQ are not required for MHIP]			Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Filipino
TRAUMA	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) *	3-18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Parent UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Child UCLA PTSD-Reaction Index for Children and Adolescents (UCLA PTSD-RI) – Adult	3 - 18 6 - 20 21+	Arabic, Chinese, English, Japanese, Farsi, Russian, Spanish
	Seeking Safety (SS)	13-60+						
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10-15						
	Managing and Adapting Practice (MAP) - *Traumatic Stress* **	2-18						
	Alternatives for Families-Cognitive Behavioral Therapy [formerly: Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	6 - 15						
	Cognitive Behavioral Therapy (CBT)- Trauma DIRECTLY OPERATED CLINICS	18+						
	Child Parent Psychotherapy (CPP)	0-6	Youth Outcome Questionnaire - 2.01 (Parent)	4+	English Spanish	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Chinese, English, Korean, Spanish
	Prolonged Exposure for PTSD (PE) DIRECTLY OPERATED CLINICS	18 -70	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 65	English
	Mental Health Integrated Program (MHIP)-Trauma (Imp. Mood-Promoting Access to Collaborative Tx - IMPACT)	18 - 60+	[YOQ-SR / OQ are not required for MHIP]			PTSD Checklist-Civilian (PCL-C)- Previously referred to as PTSD Screen	18+	Chinese, English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12-60+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Patient Health Questionnaire - 9 (PHQ-9)	12 +	Arabic, Chinese, English, Korean, Russian, Spanish, Filipino, Japanese
	Depression Treatment Quality Improvement (DTQI)	12-20						
	Managing and Adapting Practice (MAP) - *Depression and Withdrawal* **	8-21						
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18 +	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	18 19+	English Spanish	Patient Health Questionnaire - 9 (PHQ-9)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Filipino, Japanese
	Cognitive Behavioral Therapy (CBT)-Depression DIRECTLY OPERATED CLINICS	18+						
	Problem Solving Therapy (PST)	18-60+						
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+						
	Mental Health Integrated Program (MHIP)-Depression (Imp. Mood-Promoting Access to Collaborative Tx - IMPACT)	18 - 60+	[YOQ-SR / OQ are not required for MHIP]			Patient Health Questionnaire - 9 (PHQ-9)	18 - 64	Arabic, Chinese, English, Korean, Russian, Spanish, Filipino, Japanese
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Behavior And Symptom Identification Scale (BASIS-24)	18+	English
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectic Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	12-18 19+	English Spanish	Difficulties in Emotional Regulation (DERS)	ß+	English

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
Program Support Bureau - MHSA Implementation and Outcomes Division
Prevention & Early Intervention (PEI) Evidence Based Practices (EBP) OUTCOME MEASURES

FOCUS OF TREATMENT	EBP, CDE, PP	Age	GENERAL OUTCOME MEASURE	Age	AVAILABLE LANGUAGES	SPECIFIC OUTCOME MEASURE	Age	AVAILABLE LANGUAGES
PARENTING and FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0-18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4-17 12-18	English Spanish	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [if parent is unavailable]	2 – 16 2 – 16	ECBI: Chinese, English, Japanese, Korean, Russian, Spanish, SESBI: Arabic & Chinese
	Incredible Years (IY)	0-12						
	Parent – Child Interaction Therapy (PCIT)	0-12						
	UCLA TIES Transition Model (UCLA TIES) CDE	0-9						
	Reflective Parenting Program (RPP) CDE	0-12						
	Mindful Parenting Groups (MPG) CDE	0-3	N/A	N/A	N/A	Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m-36m	English, Spanish
	Caring For Our Families (CFOF) CDE	5-11	Youth Outcome Questionnaire - 2.01 (Parent)	4-17	English Spanish	Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5) Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)	2 – 5 6 – 18 2 – 5 6 – 18 11-18	Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese
	Nurse Family Partnerships (NFP)	11-35	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Patient Health Questionnaire – 9 (PHQ-9) Ages & Stages Questionnaires (ASQ) Parenting Stress Index, 3rd Edition (PSI)	12 – 35 3mos+ 3mos+	PHQ - 9: Arabic, Chinese, English, Spanish, Filipino, Japanese ASQ & PSI: English
	Loving Intervention Family Enrichment (LIFE) CDE	10-17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4-17 12-18	English Spanish	Child Behavior Checklist (CBCL) Teacher Report Form (TRF) Youth Self-Report (YSR)	6 – 18 6 – 18 11 - 18	Arabic, Armenian, Cambodian, Chinese, English, Japanese, Korean, Russian, Spanish, Tagalog, Vietnamese
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12-17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2¥	4-17 12-18 19+	English Spanish	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [if parent is unavailable]	2 – 16 2 – 16	ECBI: Chinese, English, Japanese, Korean, Russian, Spanish, SESBI: Arabic, Chinese, English
	Aggression Replacement Training - ***Skillstreaming*** (ART)	5-12						
	Managing and Adapting Practice (MAP) - *Disruptive Behavior*	0-21						
	Providing Alternative Thinking Strategies (PATHS)	3-12	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4-17 12-18	English Spanish	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [if parent is unavailable]	2 – 16 2 – 16	ECBI: Chinese, English, Japanese, Korean, Russian, Spanish SESBI: Arabic& Chinese
SEVERE BEHAVIORS / CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10-18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4-17 12-18	English Spanish	Revised Behavior Problem Checklist - Parent (RBPC) Revised Behavior Problem Checklist -Teacher (RBPC) [if parent is unavailable]	5 – 18 5 - 18	Cambodian, English
	Multidimensional Family Therapy (MDFT)	11-18						
	Strengthening Families Program (SFP)	3-16						
	Functional Family Therapy (FFT)	10-18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4-17 12-18	English Spanish	Developer Required: Clinical Services System Client Outcome Measure Therapist Outcome Measure	10-18	English
	Multisystemic Therapy (MST)	11-17				Developer Required: Therapist Adherence Measure Supervisor Adherence Measure	11-17	English

* Outcome collection for TF-CBT should have begun in December 2010 (MHSA Implementation Memo, dated 12/14/2010).

** Providers should have begun collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).

¥ Outcome Questionnaire 45.2 is available in the following languages: Arabic, English, Russian and Spanish

PEI EBPs that are not entered into PEI OMA are shaded.

Los Angeles County
Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

June 28, 2012

Marvin J. Southard, DSW
Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Southard:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
2012 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On June 28, 2012 the Chairman and a quorum of the Los Angeles County Mental Health Commission (Commission) made the following motion at the Public Hearing of the Mental Health Services Act Annual Update (Plan):

MOTION: The Los Angeles County Mental Health Commission moves to approve the Plan, as presented this 28th day of June 2012, contingent that the comments that were made at this Public Hearing, whether they are verbal or in written form, are incorporated into the final Plan.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Year 2012/13 Annual Update posted on May 30, 2012 and presented at the Public Hearing on June 28, 2012.

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

Sincerely,

Larry Gasco

Larry Gasco, PhD, LCSW
Chairman

LG:DIG:tl

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