LAC DMH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH 500 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

ROBIN KAY, PH.D.
Acting Director

DENNIS MURATA, M.S.W.
Acting Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

29 September 20, 2016

LORI GLASGOW
EXECUTIVE OFFICER

September 20, 2016

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

Dear Supervisors:

ADOPT THE DEPARTMENT OF MENTAL HEALTHS MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2016-17 (ALL SUPERVISORIAL DISTRICTS) (3 VOTES)

SUBJECT

Request adoption of the Department of Mental Health's Mental Health Services Act Annual Update for Fiscal Year 2016-17.

IT IS RECOMMENDED THAT THE BOARD:

Adopt Department of Mental Health's (DMH) Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2016-17 (Attachment). The MHSA Annual Update has been certified by the County Mental Health Acting Director and the County Auditor-Controller to meet specified MHSA requirements in accordance with Welfare and Institutions Code (WIC) Section 5847.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Adoption of the MHSA Annual Update is necessary in order for the DMH to submit the Annual Update for FY 2016-17 to the Mental Health Services Oversight and Accountability Commission (Commission) and is required by WIC Section 5847. Recent amendments to the MHSA require that the MHSA Three-Year Program and Expenditure Plan and the Annual Updates be adopted by the County Board of Supervisors. Additionally, it is required that the Three-Year Program and Expenditure Plan and the Annual Updates be certified by the County Mental Health Acting Director and the County Auditor-Controller attesting that the County has complied with all

fiscal accountability requirements as directed by the State Department of Health Care Services and that all expenditures are consistent with the MHSA requirements. Under the MHSA, a draft Three-Year Program and Expenditure Plan and the Annual Updates must be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans. Additionally, the MHSA requires that the Mental Health Commission conduct a Public Hearing on the draft Three-Year Program and Expenditure Plan and the Annual Updates at the close of the 30-day comment period.

In order to fulfill the latter requirements, DMH posted the MHSA Annual Update on its website for 30 days for public comments on March 22, 2016. DMH also convened a Public Hearing on April 28, 2016, where DMH presented the update, addressed public questions, and any concerns. The Mental Health Commission voted to approve the MHSA Annual Update for FY 2016-17 at its meeting on May 26, 2016.

Implementation of Strategic Plan Goals

The recommended action supports the County's Strategic Plan Goal 3, Integrated Services Delivery.

FISCAL IMPACT/FINANCING

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

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Assembly Bill (AB) 1467, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB1467 requires each county mental health program to prepare and submit a Three-Year Program and Expenditure Plan and the Annual Updates, adopted by the County Board of Supervisors and submitted to the Commission. It also requires that the Three-Year Program and the Annual Updates be certified by the County Mental Health Acting Director and the County Auditor-Controller. This includes the County Mental Health Acting Director's certification as to the requisite stakeholder participation and compliance with MHSA non-supplantation provisions.

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

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

The MHSA Annual Update for FY 2016-17 builds upon the Department's approved MHSA Three-Year Program and Expenditure Plan for each MHSA component. It contains a summary of MHSAprograms for FY 2014-15, including clients served by MHSA program and Service Area and program outcomes. In addition, the Annual Update Plan also describes the Department's ongoing planning process and progress on implementing the program expansions from the Three-Year Program and Expenditure Plan for FYs 2014-15 through 2016-17.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Board adoption of the MHSA Annual Update for FY 2016-17 will ensure compliance with AB 1467 requirements.

Respectfully submitted,

Robin Kay, Ph.D

ROBIN KAY, Ph.D.
Acting Director of Mental Health

RK:DM:DIG:RC:jv

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

ATTACHMENT

Los Angeles County - Department of Mental Health

Mental Health Services Act

Annual Update

Fiscal Year 2016-17

Los Angeles County Board of Supervisors
Adopted ____

Robin Kay, Ph.D.
Acting Director

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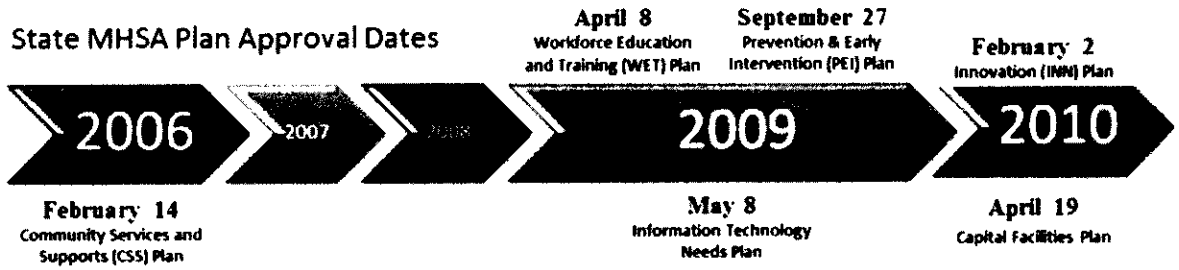
  http://psbqi.dmh.lacounty.gov/providerdirectory.htm

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

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

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



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

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

Any questions or comments should be directed to:

Debbie Innes-Gomberg, Ph.D.
District Chief, MHSA Implementation and Outcomes Division
Los Angeles County Department of Mental Health
(213) 251-6817 or DIGomberg@dmh.lacounty.gov

Fiscal Year (FY) 2014-15 at a Glance

Community Services and Supports Plan

The number of unique clients receiving a direct mental health services in Community Services and Supports programs, 102,088, did not deviate from the unique client count in FY 2013-14. Similarly, ethnicity and primary language counts did not deviate either. Of the 102,088 clients served, 32,705 were new to the county's outpatient mental health system. This represents a 56% increase over FY 2013-14.

FSP programs across age groups continue to produce impressive outcomes particularly in relation to decreasing homelessness and psychiatric hospitalizations and increasing living independently. As we have seen in prior years, FSP programs are particularly effective at reducing the days spent homeless or psychiatrically hospitalized and increasing the days that an FSP partner lives independently. Of particular note are increases in FSP client employment, over previous years, including:

- 55% increase in the number of days competitively employed
- 93% increase in the number of days spent in supported employment
- 141% in the number of clients receiving supported employment services
- 93% increase in the number of days clients had with paid in-house employment
- 41% increase in the number of clients in paid in-house employment

The Department's commitment to housing is evident throughout the CSS plan.

- Housing specialists provided housing placement services to 1,555 adult clients and 847 transition age youth clients.
- The MHSA Housing program funded 4 housing projects that opened during FY 14-15, for a total of 167 units.
- FSP programs dramatically reduced homelessness after enrollment, including reducing days homeless for adult clients by 71%, 76% for children and their families, 62% for older adult clients and 49% for transition age youth clients served through FSP.
- FSP programs increase both the number of clients living independently and the number of days they live independently after enrollment, including a 46% increase in adult clients living independently and a 48% increase in days lived independently for adults and a 32% increase in the number of transition age youth living independently and a 25% in the number of days they live independently after enrollment.

Prevention and Early Intervention

55,094 clients were served in prevention and early intervention services, 48% of whom were new clients to our outpatient mental health system. Latino clients continue as the majority ethnic group served through PEI, representing 64% of clients served.

The Suicide Prevention Center hotline responded to 66,231 calls, chats and texts, including 3,744 Spanish language calls. 37% of callers identified themselves as between the ages of 15-24. Self-rated suicidal intent was reduced for those identified as low, medium and high risk.

Symptom improvement after completion of an evidence-based, promising or community-defined evidence practice is strong, exceeding 40% for several practices including:

- *Trauma:* Alternatives for Families: Cognitive Behavioral Therapy, individual Cognitive Behavioral Therapy, Trauma Focused Cognitive Behavioral Therapy,
- *Conduct disorders:* Brief Strategic Family therapy
- *Disruptive behaviors:* Managing and Adapting Practice
- *Anxiety and Depression:* Mental Health Integration Program
- *Parenting difficulties:* Parent-Child Interaction Therapy, Triple P Positive Parenting Program

Innovation

Innovation 1 tested out three (3) distinct models of care integration and found statistically significant reductions in mental health, physical health and substance use symptoms. The 4th Innovation 1 model tested out peer delivered respite care and peer delivered supportive services.

Innovation 2, Building Trauma Resilient Communities through Community Capacity Building, was approved by the Mental Health Services Oversight and Accountability Commission on May 28, 2015 and is in the Request for Services solicitation development phase at the time of this posting.

Fiscal Year 2016-17- The Year Ahead

As the Department enters its 10th year of Mental Health Services Act programs, the MHSA has provided an architectural structure for a continuum of services that have sought to address the need for alternatives to inpatient or emergency department care, utilized FSP to implement Assisted Outpatient Treatment as well as to serve clients with significant histories of homelessness, justice involvement, co-morbid medical, substance use and medical conditions as well as children involved with the child welfare system.

The Department will continue to leverage MHSA funds to create a full continuum of services and supports for individuals with mental illness by working with County and City Departments and communities in general to collectively address the mental health needs of individuals in Los Angeles County.

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

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

- The 50 member System Leadership Team (SLT) is the Department's stakeholder workgroup to inform the implementation and monitoring of MHSA programs. The composition of the expanded SLT is as follows:
  - *LA County Chief Executive Office*
  - *Service Area Advisory Committee (SAAC) leadership*
  - *Consumer and family member representation, including NAMI, self-help and the LA County Client Coalition*
  - *Department of Public Social Services*
  - *Health Care, including the Hospital Association and LA County Department of Public Health, LA County Department of Health Services*
  - *LA Police Department*
  - *Probation*
  - *Housing development*
  - *Older Adult service providers and LA County Community and Senior Services*
  - *Under-Represented Ethnic Populations, including Asian Pacific Islanders, American Indian, African American, Latino*
  - *Clergy*
  - *City of Long Beach*
  - *Veterans*
  - *LA County Mental Health Commission*
  - *Unions*
  - *Co-Occurring Joint Action Council*
  - *Education, including the LA Unified School District, universities and charter schools*
  - *Lesbian, Bisexual, Gay, Transgender and Questioning (LBGTQ)*
  - *LA Department of Children and Family Services*
  - *LA County Commission on Children and Families*
  - *Junior blind*
  - *Statewide perspective*

- The efforts of the SLT are guided by standing committees formed to address specific issues such has planning, budget mitigation, outcomes. These standing committees are comprised of volunteers from the SLT and Department managers with responsibility for planning, implementing and managing MHSA programs. The standing committee represented diverse perspectives and was a microcosm of the larger SLT. The standing committee was activated to inform the plan to expand CSS services by $84 million. A standing committee was also convened to begin to consider consolidation of MHSA CSS Work Plans that would map to levels of care. This work will continue within the SLT and the standing committee into FY 2016-17.
- The Service Area Advisory Committees (SAAC) continued their planning, aided by service utilization and outcome information for MHSA funded services in their Service Areas.

The SLT's work during FY 2015-16 has been to review progress in implementing services added through the MHSA 3 Year Program and Expenditure Plan as well as allocate $84 million in MHSA CSS expansion funding. Throughout this process, the SLT has been reviewing the Department's MHSA by understanding how programs and serves fit into a service continuum

The Department provides training to new System Leadership Team members on the MHSA, the roles and responsibilities of SLT members and DMH services. The most recent orientation was conducted in August, 2015.

The SLT heard a summary of data and information from the Annual Update on March 16, 2016. The plan was publically posted on the Department's website on March 22, 2016 and remains publically posted.

The Public Hearing was convened by the Mental Health Commission on April 28, 2016 and the plan was approved on May 26, 2016.

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County: Los Angeles

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

Local Mental Health Acting Director	County Auditor-Controller
Name: Robin Kay, Ph.D.	Name: John Naimo
Telephone Number: (213) 738-4108	Telephone Number: (213) 974-8484
E-mail: RKay@dmh.lacounty.gov	E-mail: jnaimo@auditor.controller.gov

Local Mental Health Mailing Address:

County of Los Angeles - Department of Mental Health
Program Support Bureau - MHSA Implementation and Outcomes Division
695 S. Vermont Avenue, 8th floor
Los Angeles, CA 90005

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

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

Robin Kay, Ph.D.
Local Mental Health Acting Director

Signature _____ Date 6/9/16

I hereby certify that for the fiscal year ended June 30, 2016, the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892 (f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/15/15 for the fiscal year ended June 30, 2015. I further certify that for the fiscal year ended June 30, 2016, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891 (a), in that local MSHA funds may not be loaned to a county general fund or any other county fund.

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

John Naimo
County Auditor-Controller (PRINT)

Signature _____ Date 6/9/16

[1]Welfare and Institutions Code Sections 5847 (b)(9) and 5899 (a)
Three-Year Program and Expenditure Plan, Annual Update County/City Certification

Mental Health Commission Approval Letter

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Mark Ridley-Thomas
Second District
Sheila Kuehl
Third District
Don Knabe
Fourth District
Michael D. Antonovich
Fifth District

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Chairman
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CALMHBC Representative
Vacant
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Los Angeles County
Mental Health Commission

"Advocacy, Accountability and Oversight in Action"

June 1, 2016

Robin Kay, Ph.D.
Acting Director
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Kay:

MENTAL HEALTH SERVICES ACT PUBLIC HEARING
FISCAL YEAR 2016-17 ANNUAL UPDATE
NOTICE OF PLAN APPROVAL

On May 26, 2016 the Chairman and a quorum of the Los Angeles County Mental Health Commission (Commission) made the following motion following the Public Hearing of the Mental Health Services Act Fiscal Year 2016-17 Annual Update conducted at St. Anne's in Los Angeles County:

MOTION: The Los Angeles County Mental Health Commission moves to approve the Fiscal Year 2017-16 Annual Update.

It is, therefore, with pleasure that the Commission approve your Department's submission of the Fiscal Year 2016-17 Annual Update, which was publically posted on March 22, 2016 and presented at the April 28, 2016 Public Hearing. We would also like to commend the Department for continuing to engage the Service Area Advisory Committees in the ongoing planning and implementation of the Mental Health Services Act and on the outcomes you are achieving.

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

Sincerely,

Larry Gasco

Larry Gasco, Ph.D., LCSW
Chairman

LG:DIG:TGL

550 South Vermont Avenue, 12th Floor, Los Angeles, California 90020 – Phone: 213 738 4772 – Fax: 213 738 2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://wcmprd1.ds.lacounty.gov/10039/wps/portal/dmh/about_commission

LAC
DMH
MENTAL HEALTH
Board of
Adopted Letter

Acronyms and Definitions

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

Acronyms & Definitions

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

Acronyms & Definitions

PCIT:	Parent-Child Interaction Therapy
PDAT:	Public Defender Advocacy Team
UREP:	Under-Represented Ethnic Populations
USC:	University of Southern California
TSV:	Targeted School Violence
VALOR:	Veterans' and Loved Ones Recovery
WCRSEC:	Women's Community Reintegration Service and Education Centers
WET:	Workforce Education and Training
YOQ:	Youth Outcome Questionnaire
YOQ-SR:	Youth Outcome Questionnaire – Status Report
YTD:	Year To Date
UCLA:	University of California, Los Angeles
UCLA TTM:	UCLA Ties Transition Model

Adult Age Group: Age range is 26 to 59 years old.

Child Age Group: Age range is 0 to 15 years old.

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

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

New Community Services and Supports clients may have received a non-MHSA mental health service.

New Prevention and Early Intervention clients may have received a non-MHSA mental health service.

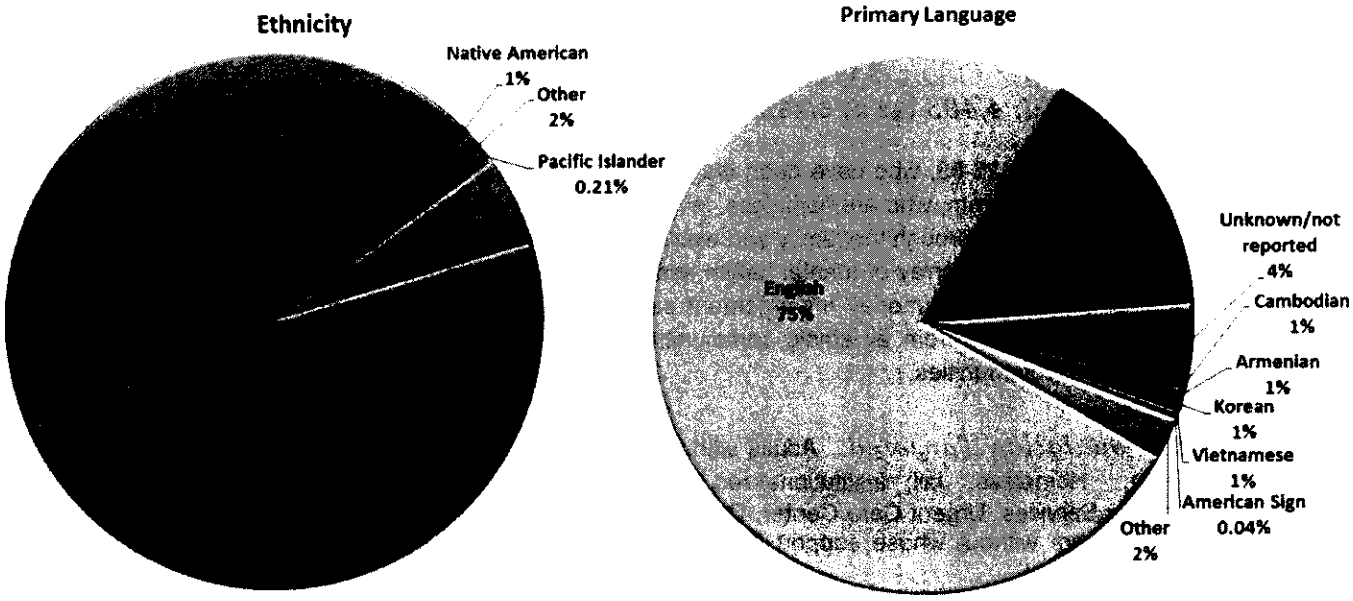
Older Adult Age Group: Age range is 60+.

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

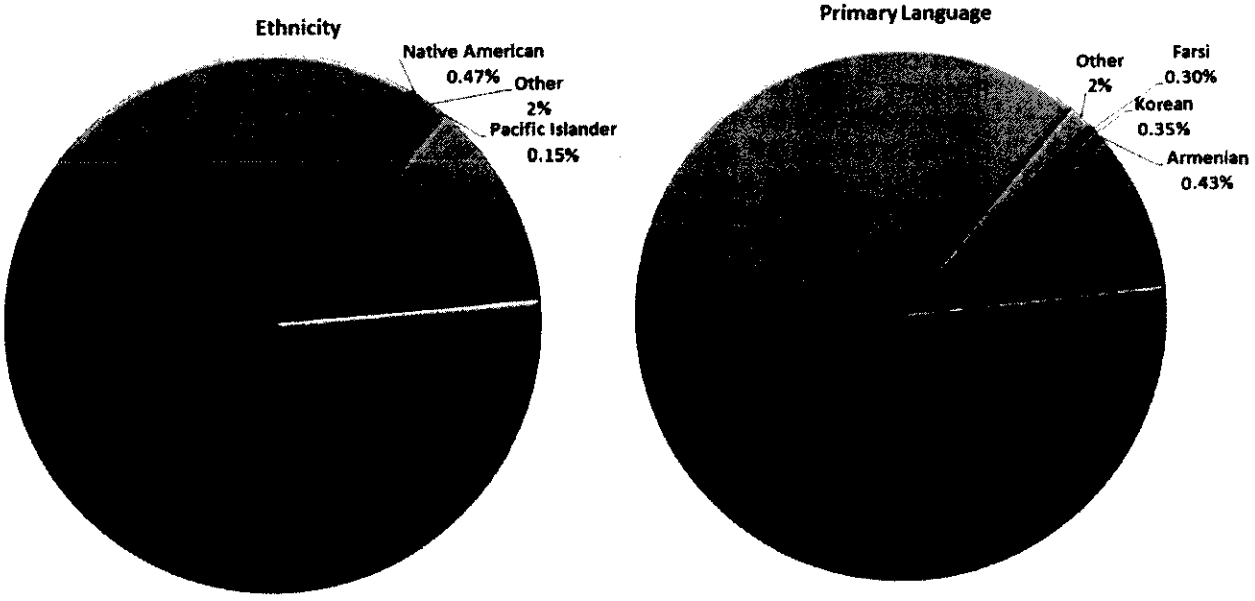
Total client cost calculation is based on Mode 15 services, inclusive of Federal Financial Participation (FFP) & Early Periodic Screening, Diagnosis, and Treatment (**EPSDT**) Program. Not inclusive of community outreach services or client supportive services expenditures. Data as of January 4, 2016

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

The number of unique clients receiving a direct mental health service through the Community Services and Supports (CSS) Plan for Fiscal Year 2014-15: **102,088**



The number of new clients receiving CSS services Countywide with no previous MHSA service: 32,705



Adult Full Service Partnership: A-01

Unique Clients Served: 5,103
Cost: $ 55,400,776
Average Cost per Client: $ 10,857
Slots Allocated: ***4,485*** (as of 6/26/2015)

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

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

Full Service Partnership (FSP) Integration Pilot Project: As part of a 2 year pilot, six (6) adult mental health providers and two (2) older adult providers fiscally and programmatically integrated Field Capable Clinical Services (FCCS, level 3) into Full Service Partnership (FSP, level 4) services so that all clients are considered FSP, as long as each client meets FSP criteria as defined in the MHSA CSS regulations.

- Each client receiving services from a pilot agency is rated monthly on the Milestones of Recovery Scale (MORS) to determine level of recovery as well as rated on eight (8) care determinants that are matched to level of service need.
- Providers collect FSP outcome data on all clients.
- FCCS funding was transferred to FSP on each agency's financial summary, to be used consistent with FSP services and consistent with the Recovery Model.
- The Older Adult Pilot was initiated in April, 2013 and the Adult pilot started in July, 2013.
- All clients in the pilot are eligible for Client Supportive Services funding, based on LAC DMH Client Supportive Services Guidelines.
- Priority populations aligned with service area needs.

Pilot Goals:

- Reducing distinct financial service categories, broadening the FSP target populations to those defined in regulation will enhance service packages for clients of varying service intensity to best meet client needs.
- Increase access to FSP services.
- Provide the appropriate type and amount of service the client needs in a data-informed manner.

- Increase client program flow (to both improve client functioning and increase service capacity) and determine optimal length of treatment.
  - Flow into the pilot
  - Flow between levels of care
  - Determinants used to inform readiness for transition to a lower level of service
- Ensure services are cost effective.

Assessing Pilot Success:

- Each month providers receive a dashboard report outlining focal population percentages, client ethnicity, number of new enrollments and disenrollments and reason for disenrollments, MORS score summaries, percent of enrolled clients with level 4 service needs vs. level 3, percent of clients endorsing each of eight service determinants, living arrangement and employment status of enrolled clients.
- The determinants of level of care are:
  1. Client's current MORS score.
  2. Client is unable to manage his/her own financial resources and requires formal or informal money management.
  3. The client is not ready or is unable to coordinate his/her own transportation needs to and from appointments, education and occupation activities, and or other meaningful life activities.
  4. The client requires formal or informal assistance with two (2) or more of the following Assisted Daily Living Skills (ADLs): hygiene, shopping, feeding, household chores, preparing meals, transferring, walking.
  5. The client requires at least once per week contact with staff to coordinate his/her care.
  6. The client requires formal or informal assistance or support to manage his/her medication.
  7. The client requires assistance or support to manage community relations and minimize disruptive behaviors.
  8. The client has been stable at the current MORS score for less than six (6) months.

The Impact of the Pilot:

Through the work of the providers in this pilot, clinical decision-making that was once guided by the MORS as a stand-alone measure has evolved to the use of the determinants as a more comprehensive guide. The determinants have the potential to serve as a guide to informing service packages at different levels of care and guide the transition from one level of care or need to another.

Elements of Success in Transitioning Clients from Level 4 to 3:

- Stable housing.
- Access to a variety of treatment options for substance use.
- Family reintegration and the role of the FSP team as either a broker or family finder.
- Stable medication through establishing shared decision making, client preparation and trust building, client education.
- Employment/education and increasing meaningful roles for clients through creating a menu of options, IPS Supported Employment, employing job developers, increasing client motivation to work, addressing the risk of loss of SSI.
- Improving physical health through service co-location, peer health navigation, provider screening and identification of health issues.
- Creating stable income.
- Establishing some form of health insurance.
- Transportation options for clients, including educating peers on options.

- Recreational opportunities- identify client preferences, community resources and establish peer support and partnerships.
- Create social connections via cultural celebrations and opportunities in communities.
- Identify spiritual interests and options.

The Pilot's Impact on Enrollment and Disenrollment:

- Clients enrolled August, 2013 to March, 2015: 701
- Clients disenrolled August, 2013 to March 19, 2015: 853
- Clients disenrolled due to meeting goals or moving to lower level of care: 300 (35%)
  - Out of the 300, 88 moved to a lower level of care
  - Out of the 300, 212 met goals and moved to lower level of care

The Department and SLT endorsed removing the "pilot" status of the project and it is now considered a specialized FSP program serving level 4 and 3 clients who meet FSP criteria.

Significant Changes for FY 2016-17

In FY 2016-17, Adult System of Care (ASOC) expects to focus on ensuring individuals participating in FSP programs meet their goals and are able to graduate to lower levels of care. This will be done by conducting monthly case reviews in collaboration with each service area navigator and provider.

ASOC will continue to place great emphasis 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, outreach/engagement, graduation rates and disenrollments. The goal will be to maintain an accurate accounting of consumer flow and encourage providers to move consumers to lower levels of care. Finally, FY 2016-17 will focus on increased training and support for delivering services to the forensic population.

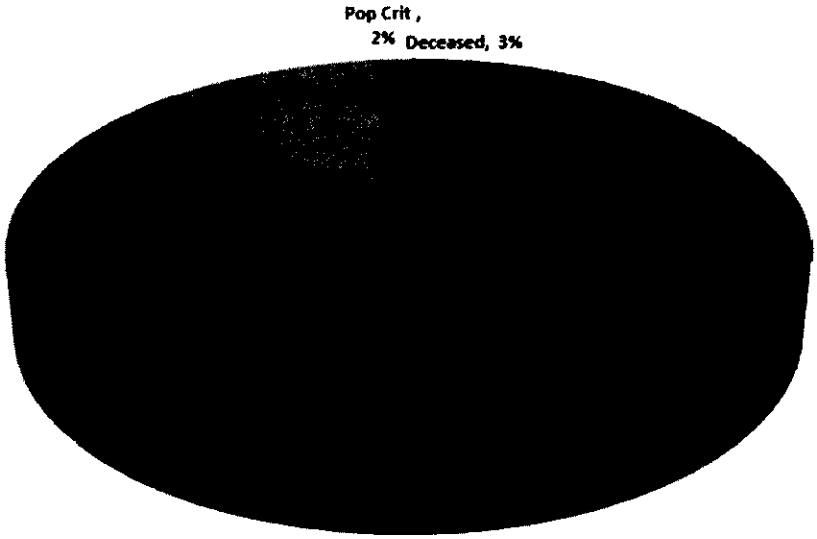
Status on Community Services and Supports Program Expansion

(See Appendix 1 for a complete description of proposals)

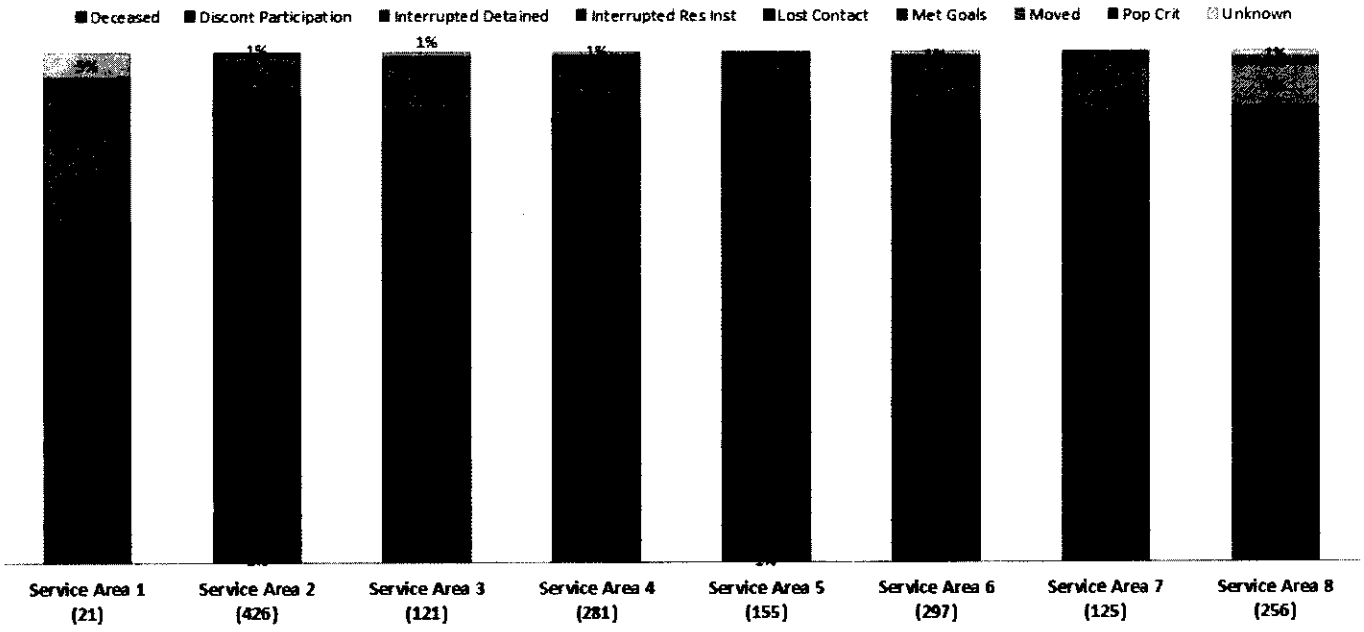
Proposal	Status	Implementation Date (Estimated)
Implementation of Laura's Law/Assisted Outpatient Treatment (AOT) Program	First AOT referral was received on July 7, 2015.	July 2015
AOT Evaluation	County Counsel and the Chief Executive Office are in the process of reviewing the proposals.	March 2016
Expand the number of slots for the Adult Full Service Partnership Services	Providers in Service Areas I and V have been selected.	June 2016
Slots will be added to providers who demonstrated success with their Innovation program, which ended June 30, 2015	Providers in Service Areas IV and V received FSP slots.	July 2015
Forensic FSP Services	Services will be split between contracted and directly operated clinics. The directly operated clinics have been identified. Solicitation is being drafted.	June 2016
Increase the capacity of Adult FSP * Expansion originally approved for Field Capable Clinical Services. System Leadership Team approved shift from FCCS to FSP on November 17, 2015.	Five directly operated providers will expand their FSP services	January 2016

*Disenrollment**

- Total of 1,696 disenrollments
- 40% of disenrolled clients met their goals



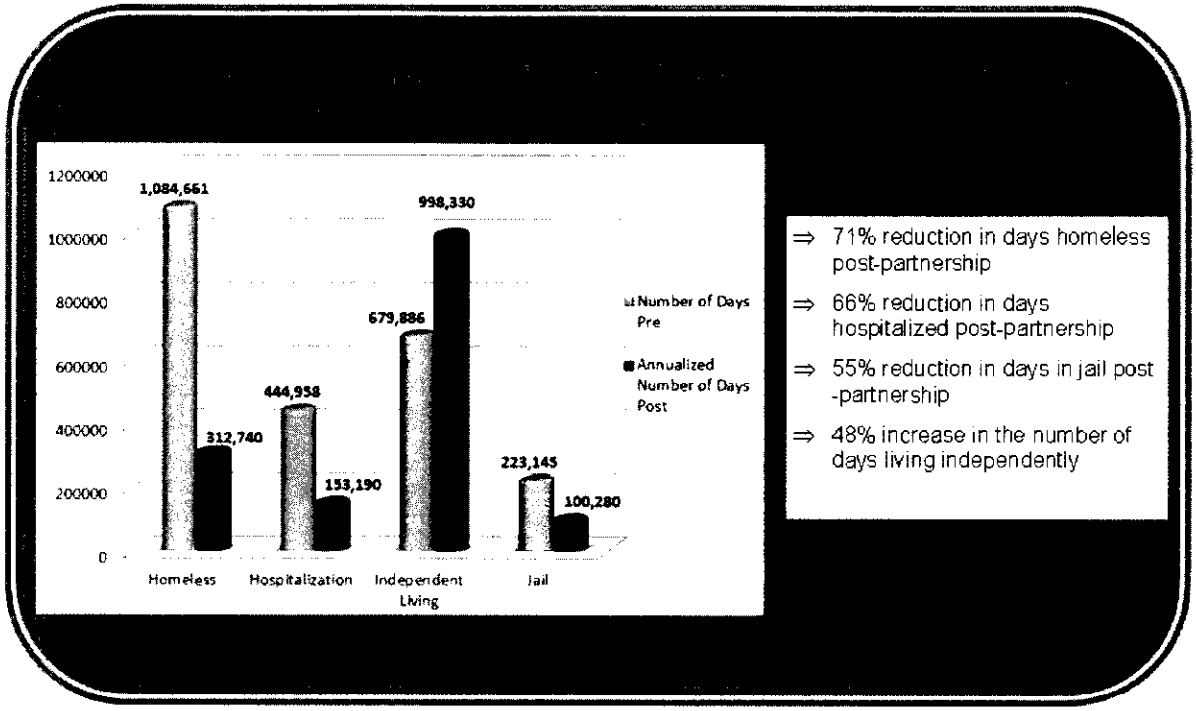
Adult Full Service Partnership Disenrollments

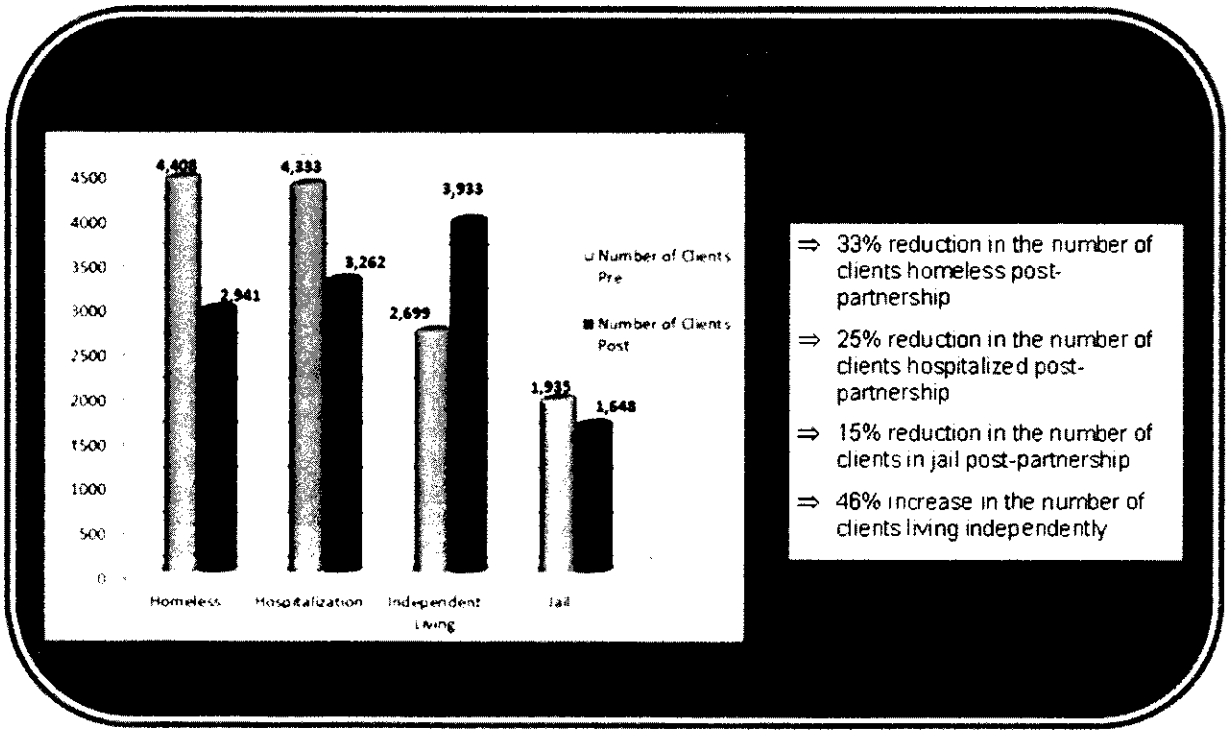


*Data extracted from the FSP authorization application on February 3, 2016 and represents disenrollments for Fiscal Year 2014-15. See Appendix II for an explanation of disenrollment reasons.

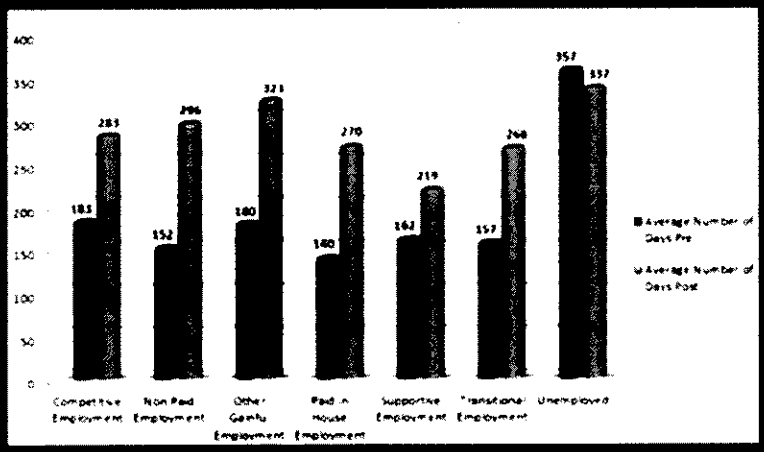
Outcomes

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





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



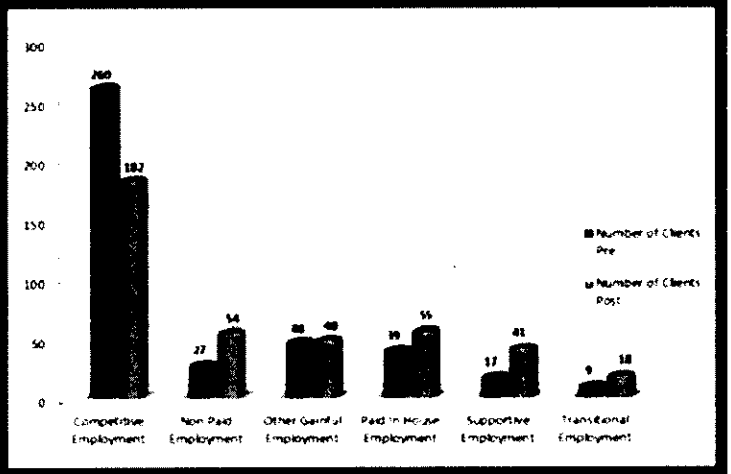
⇒ 55% increase in the number of days spent in competitive employment

⇒ 95% increase in the number of days spent in non-paid employment

⇒ 79% increase in the number of days spent in other gainful employment

⇒ 93% increase in the number of days spent in supportive employment

⇒ 70% increase in the number of days spent in transitional employment



⇒ 100% increase in the number of clients in non-paid employment

⇒ 4% increase in the number of clients in other gainful employment

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

⇒ 141% increase in the number of clients in supportive employment

⇒ 100% increase in the number of clients spent in transitional employment

⇒ 30% decrease in the number of clients spent in competitive employment

Wellness/Client Run Center: A-02

Unique Clients Served: **54,521**

Client Contacts: **85,843** *(Services provided at Peer-Run Centers)*

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

Significant Changes for FY 2016-17

For FY 2016-17, the Wellness Program will remain the largest program serving the adult population. The focus will be on the collaboration and integration of healthcare and substance abuse services. Wellness Programs will continue with the expansion of peer supports with treatment teams in both paid and volunteer roles. A major emphasis will be placed to hire DMH social workers and peers who will use Individual Placement and Support (IPS), an Evidence-Based Practice, to provide employment services to Wellness Centers.

Community Services and Supports Program Expansion

(See Appendix I for a complete description of proposals)

Proposal	Status	Implementation Date (Estimated)
Adjunct services for clients in Wellness Centers	Providers have been providing services.	2014
The addition of Peer Staff to Wellness Centers	Contracts have been amended. Directly operated clinics have started hiring.	Contractors: February 2015 Directly Operated: November 2015
Expand Client Run Centers	Client run centers will be added to Service Areas I and III. Request for Services is being drafted. The Adult System of Care Administration is continuing to work with the Contract's Division to move the solicitation process forward.	June 2016
Supported Employment in Wellness Centers	Rio Hondo Mental Health Center and San Fernando Mental Health Center will participate in a pilot project implementing a supported employment model.	December 2016
Housing Specialists in Wellness Centers	In the process of developing a housing specialist training.	Contractors: July 2015 Directly Operated: December 2015
Pilot Employment Program	A Request for Statement of Qualifications has been released.	July 2016

Describe the Impact the CSS Expansion has had on this Program:

CSS expansion has provided additional opportunities to increase services to address the needed support for Wellness/Client Run Centers. ASOC has added several positons and programs through the CSS expansion. A total of 69 new Wellness Housing Retention positions were added countywide, to both directly-operated and contracted agencies, with one position designated to each Wellness Program. These housing specialists have provided advocacy and skill building for consumers, who lived in the community with their families, and independent living settings. These housing specialists will also provide housing retention support to consumers. There was also the expansion of Peer Support staff, who will focus on employment and specific peer support needs, these positions will expand peers by an additional 69 positions.

The CSS expansion also included the hiring of DMH social workers and peers support staff, who will implement two IPS pilot programs at San Fernando and Rio Hondo Mental Health Centers, in order to provide specialized employment services to Wellness consumers and train Wellness staff in the IPS model.

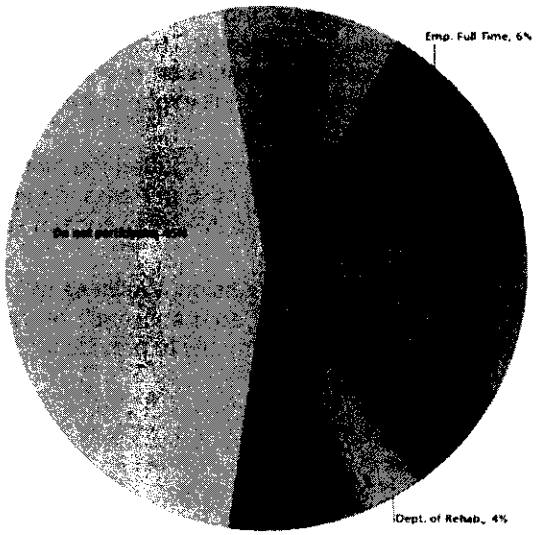
Through the CSS expansion, Wellness will expand the Client Run Centers in Service Areas III and VI, which will result in Client Run Centers in each of the eight Service Areas countywide. This increase has allowed peer support staff the opportunity to provide increased services to communities and consumers.

Outcomes

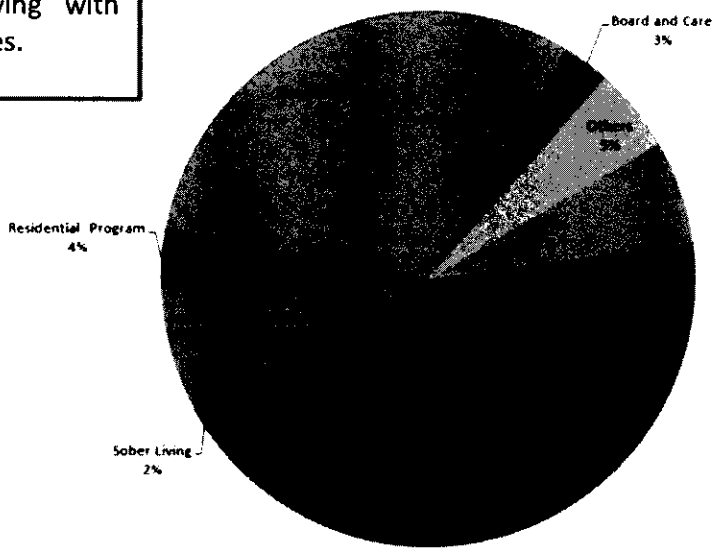
According to a sample survey from 13 providers and 2,017 clients, Wellness/Client Run Centers' consumers reported improvement in their daily lives, and experienced the following:

- 71% usually or sometime did well in work/ school/ preferred activities.
- 83% usually or sometime made progress in wellness/ recovery goals.
- 16% worked part or full time
- 86% usually or sometime able to manage symptoms.
- 82% usually or sometime felt welcomed and respected by staff.
- 72% usually or sometime have opportunities to join social, spiritual, and/ or recreational activities in their life.
- 50% involved in meaningful activities.
- 79% usually or sometime satisfied with their role in making decisions about their care.
- 73% reported living in their own place (house, apartment, etc.), living with family, or living with roommates.

Current Employment/Education Activity
N=2,017



Current Living Situation
N=2,017



IMD Step-Down Facilities: A-03

Client Contacts: 998

IMD Step-Down

IMD Step-down 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, substance abuse treatment and supportive services.

Achievements/Highlights in FY 2014-15

In FY 14-15 IMD Step-down programs expanded by 82 beds. Twenty-two (22) beds were added to expand services for individuals being released from County hospitals. Sixty (60) beds were developed and implemented for full implementation of Laura's Law/Assisted Outpatient Treatment. In FY 14-15 IMD Step-down programs authorized 780 clients for admission and in FY 14-15 linked 188 clients to Full Service Partnership programs. Of the 780 clients authorized for treatment, 11% of those were admitted to hospitals and 3 % were incarcerated in FY 14-15.

Countywide Resource Management liaisons continue to use the Multnomah Community Ability Scale – Revised (MCAS-R) to assess a client's level of functioning during the course of treatment. The MCAS-R has been instrumental in monitoring a client's progress and assesses readiness for discharge.

Community Services and Supports Program Expansion

(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date
Implementation of Laura's Law/Assisted Outpatient Treatment Program	First AOT referral was received on June 25, 2015.	June 2015
Expand the number of beds for the IMD Step-Down Facilities	Expanded the number of beds by 22.	May 2015

Significant changes for FY 2016-17

DMH now refers to IMD Step-down Programs as Enriched Residential Services (ERS). Specialized ERS programs will be developed to serve justice involved individuals being released from jails and prisons as a result of changes in the criminal justice system. DMH now refers to IMD Step-down Programs as Enriched Residential Services (ERS). Specialized ERS programs will be developed to serve justice involved individuals being released from jails and prisons as a result of changes in the criminal justice system.

Project 50

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

Achievements/Highlights in FY 2014-15

Fifteen (15) new residents moved into the Charles Cobb Apartments, the shelter-plus-care building in which Project 50 is located. Of the 15 new residents, five (5) were receiving SSI at the time of move-in and ten were receiving general relief. Project 50 staff helped six (6) of these 10 residents submit an SSI application based on their mental disability, four (4) of whom have been awarded SSI benefits to-date. Four (4) of 15 new residents had no medical insurance at the time of move-in. Project 50 staff worked to enroll these four (4) new residents in the Medi-Cal program. Seventeen Project 50 participants were assisted in obtaining and successfully utilizing portable Section 8 housing vouchers made available through the federal government via the Housing Authority for the City of Los Angeles. All 17 former residents are now residing in their own apartment outside of the Skid Row area and have been connected to mental health services in their new community. Four (4) Project 50 participants actively sought re-employment by taking classes and participating in formal vocational rehabilitation (Los Angeles Trade Tech College, interning at the Claire Foundation, interning at Step-Up on Second, etc.). Two (2) Project 50 participants attended the Peer Advocacy Training Certificate Program offered by Skid Row Housing Trust and have become Peer Advocates for the Trust. Project 50 continues to provide individual therapy, group therapy, medication management, and community reintegration and rehabilitative services with subject matter including utilizing public transportation, healthy choice and budget-friendly grocery shopping, accessing substance abuse recovery programs in the community, and increased community contact via field trips into the greater Los Angeles area.

Significant changes for FY 2016-17

Project 50 staff will continue to assist participants in obtaining financial benefits including general relief and when appropriate, social security. Staff will continue to ensure that every participant has health coverage. Residents who meet criteria for a referral to the Housing Authority for a portable Section 8 housing voucher will be assisted in the Housing Authority voucher application process and eventually with working to obtain a Section 8 apartment. Project 50 staff will continue to work to provide mental health, medical, and substance abuse care from an integrated clinic model framework.

Adult Housing Services: A-04

Client Contacts: 1,555

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

MHSA Housing Program

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

Below is a list of projects that opened during fiscal year 2014-15 through the MHSA Housing Program:

Project Sponsor	Project Name	SA	SD	Target Population	MHSA Units	Total Units	Date of Occupancy	MHSA Capital Committed	MHSA Subsidy Committed	Total Committed
L A FAMILY HOUSING	Louis Apartments	2	5	Single Adults 18+	11	46	July 15, 2014	$ 1,133,000		$ 1,133,000
SCHARP	Figueroa Apartments	6	2	Tay (16-25); 18+ ; Adults 60+	18	19	October 1, 2014	$ 1,559,918	$ 1,744,000	$ 3,303,918
A COMMUNITY OF FRIENDS	Avalon Apartments	6	2	Families	37	61	January 1, 2015	$ 3,558,944		$ 3,558,944
METAPATH VENTURES	Long Beach & 21st Street	8	4	Seniors	21	41	May 15, 2015	$ 1,897,450	$ -	$ 1,897,450
				Total Number of Units	87	167	Total	$ 8,149,312	$ 1,744,000	$ 9,893,312

The following report has been prepared by the Countywide Housing, Employment & Education Resource Development (CHEERD). CHEERD provides administrative oversight, management and technical support for Housing Policy and Development, Federal Housing Subsidies, Temporary Shelter Program, and Employment and Education Resouces. CHEERD also provides training and advocacy and develops new housing, employment and education resources for the mental health system and the community. The CHEERD Division's services are considered essential to supporting hope, wellness and the recovery of consumers as they reclaim their hopes, dreams and aspirations.

The Work of the Los Angeles County Department of Mental Health to End Homelessness

Dr. Marvin J. Southard, Director, DMH, Darrel Steinberg, California State Senator, and Robin Kay, Chief Deputy Director, DMH, at the 5th Anniversary of the MHSA Housing Program at Villas of Gower

Background

DMH is committed to ending homelessness and assisting those in need with accessing Permanent Supportive Housing (PSH). We consider the acquisition of housing crucial in helping individuals achieve self-sufficiency and reaching their full potential, an approach that is consistent with the Substance Abuse and Mental Health Services Administration's declaration that having a stable and safe place to live is integral to supporting a life in recovery. DMH has worked to end homeless by:

- Developing specialized community-based programs that are equipped to serve the complex needs of homeless individuals with mental illness;
- Increasing housing resources including PSH that will expand the available and desirable housing options for our clients and
- Implementing programs and managing resources that target clients that are homeless.

LAC DMH *Partnering with Clients, Families and Communities to Create Hope, Wellness and Recovery*

Community-Based Programs Targeting the Homeless Population

Homeless Outreach Mobile Engagement (HOME)

A DMH directly-operated team that collaborates with City and County agencies to conduct outreach in a coordinated manner in Service Areas 4 and 6. HOME actively links individuals to on-going mental health services including housing services.

Homeless Family Solutions System

A county-wide coordinated system of care for homeless families, that provide rapid re-housing and ongoing case management services to assist families with obtaining permanent housing and supportive services. Families enter the system through regionally-based Family Solutions Centers (FSCs) where DMH staff are co-located to provide mental health services to homeless CalWORKS Welfare-to-Work families.

Full Service Partnership Programs

These child, Transition Age Youth, adult and older adult programs located throughout the County serve clients with intensive needs including those who are homeless, and provide a full array of field-based and intensive mental health services that support recovery.

Integrated Mobile Health Teams – Full Service Partnership Programs (IMHT-FSP)

These specialized FSP programs include a Federally Qualified Health Center partner and target a highly vulnerable homeless population with complex mental health, and health and substance use needs. The multidisciplinary teams provide outreach and engagement and field-based integrated mental health, physical health and substance use services in Santa Monica/Venice, Long Beach and Skid Row, East LA, Service Area 6. The goal of the IMHT-FSP program is to assist clients with obtaining and retaining housing.

Senate Bill 82 DMH Mobile Triage Teams (MTT)

These DMH directly-operated teams, one in each Service Area are comprised of mental health staff and peer advocates. The MTTs provide field-based outreach and engagement, assessment and short-term case management services to individuals/families that are homeless. Each team participates in their local Coordinated Entry System (CES) to coordinate outreach, assess for acuity and housing needs and assist them with obtaining permanent supportive housing. The goal of the teams is to actively link eligible individuals to appropriate on-going services including housing services.

Metropolitan Transit Authority–Crisis Response Unit (MTA-CRU)

DMH clinicians partner with LASD deputies to provide crisis services, WIC 5150 evaluations, transportation to acute psychiatric hospitals and linkage to mental health services.

Law Enforcement Teams (LET)

DMH clinicians partner with officers from 18 law enforcement agencies in LA County to respond to calls from 911 or patrol, many of which involve homeless persons. These law enforcement jurisdictions utilize these teams to provide WIC 5150 evaluations and linkage to mental health services.

Assisted Outpatient Treat–LA (AOT-LA)

DMH clinicians conduct extensive outreach and engagement to individuals, many of whom are homeless, with a serious mental illness and a history of unwillingness to participate in treatment. Individuals that voluntarily accept services are enrolled in an AOT-FSP program and access to a crisis residential bed if needed. If the individual is unwilling to accept treatment, AOT-LA develops court petitions and manages the court process to connect AOT enrollees with AOT-FSP programs.

Menlo Family Apartments Grand Opening, March 7, 2013. Dean Matsubayashi, Little Tokyo Service Center, Sean Rogan, Community Development Commission, Johng Ho Song, Koreatown Youth and Family Center, Dr. Robin Kay, LACDMH

Project 50 Programs

These teams provide outreach and engagement, permanent housing, and integrated mental health, physical health and substance use treatment services to chronically homeless mentally ill individuals living in Skid Row, Venice, Santa Monica, Hollywood, and the San Fernando Valley. Ten percent of the program services are dedicated to veterans. One specialized program serves homeless women with children in need of residential co-occurring substance use/ mental health treatment prior to connecting them to PSH.

LAC+USC Street to Home Project

Outreach and engagement services that assist individuals that have a mental illness and are chronically homeless that are living on or in close proximity to the campus of LAC+USC Medical Center to access permanent supportive housing. The provider of this program also operates the Psychiatric Urgent Care Center (UCC) across the street from LAC+USC. The UCC serves as a staging facility to connect these individuals with immediate co-occurring mental health and substances use treatment services and to temporary housing.

Single Adult Model (SAM)

A multi-departmental collaborative that includes DMH, DHS, Department of Public Social Services, Department of Public Health and Community Development Commission that targets single adults that are homeless and assists them with obtaining permanent housing. SAM has the following two components:

Projects for Assistance in Transition (PATH) Multidisciplinary Integrated Teams (MITS)

The MITs are a component of the County's Single Adult Model and is a collaboration with Department of Health Services who provides a registered nurse to each of the multidisciplinary teams. The MITS provide street-based outreach and engagement and a full range of mental health services in each SA to the most vulnerable homeless population with mental illness. Each MIT participates in their local CES to coordinate outreach, assess for acuity and housing needs and assist them with obtaining permanent supportive housing. The MITs assist clients with obtaining permanent housing and then provide supportive services using the evidenced-based practice Critical Time Intervention.

General Relief (GR) Participants

The target population is single adults that are GR recipients, homeless and high utilizers of DMH and/or DHS services. The goal of SAM is to permanently house these individuals and to provide the supportive services needed to help them retain their housing.

Veterans and Loved Ones Recovery (VALOR) Program

A DMH directly-operated program that provides a full range of mental health and housing services to veterans and their families, in a supportive environment, regardless of formal Veterans' Administration (VA) eligibility status and military discharge.

Housing Resources Fact Sheet

(As of October 2015)

Temporary Shelter Program

This program provides short-term basic living support services to consumers and their families who are homeless or at risk of becoming homeless.

- LACDMH contracts with 18 providers.
- 27 different shelter sites throughout the county.
- In FY 2013-14, 410 unique clients were served through the TSP.
- In FY 2014-15, 500 unique clients were served through the TSP.
- In FY 14-15 of those clients that left the shelter, 46% transitioned to permanent housing.

Federal Housing Subsidies

This program secures grants from the City and County Housing Authorities that provide Shelter Plus Care certificates, Tenant Based Supportive Housing, and Homeless Section 8 vouchers for PSH for LACDMH clients that meet the Housing and Urban Development (HUD) definition of homelessness. LACDMH currently has 13 grants with the City and County of Los Angeles Housing Authorities for Shelter Plus Care, Tenant Based Supportive Housing, Homeless Section 8, and Homeless Veterans Initiative as indicated below:

- 1,200 Shelter Plus Care certificates.
- 200 Homeless Section 8 vouchers.
- 250 Tenant Based Supportive Housing vouchers.
- 50 Homeless Veterans Initiative vouchers
- In FY 2013-14, LACDMH assisted 197 clients with submitting applications to the Housing Authorities. Federal sequestration was in effect most of this year which resulted in a suspension of the Homeless Section and Tenant Based Supportive Housing Programs until April, 2014.
- In FY 2014-15, LACDMH assisted 377 clients with submitting applications to the Housing Authorities.
  - 94% Chronically Homeless
  - 77% Individuals
  - 23% Families
- 93% retention rate for Shelter Plus Care

Housing Assistance Program

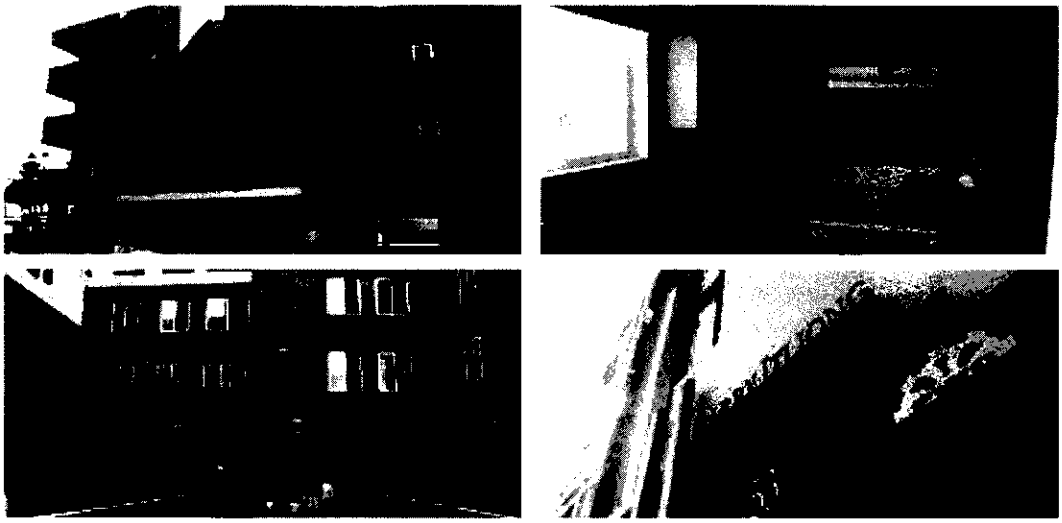
This program provides funding for security deposits, household goods and eviction prevention for DMH clients who are homeless or at risk of homelessness and have limited or no income.

- In FY 2013-14, 932 were provided housing assistance.
- In FY 2014-15, 940 were provided housing assistance.

Mental Health Services Act (MHSA) Housing Program

This program provides capital and operating funds for the development of PSH dedicated to DMH clients.

- The original investment of $115 million in 2008 has increased to $145,011,192 in 2015.
- $118.4 million of the funding is currently obligated.
- 42 projects total, 29 of which are occupied.
- Estimated leverage of over $550 million of local, state and federal funding.
- Partnered with 27 different housing developers.
- Projects targeting families, transition age youth, adults and older adults.
- Regionalization achieved with projects in all 8 Service Areas and all 5 Supervisorial Districts.
- Increase of 2,254 total units of affordable housing, 934 of which are MHSA-funded Permanent Supportive Housing units dedicated to those who are homeless and have mental illness.
- In 2014 154 DMH clients that were homeless moved into PSH through the MHSA Housing Program.



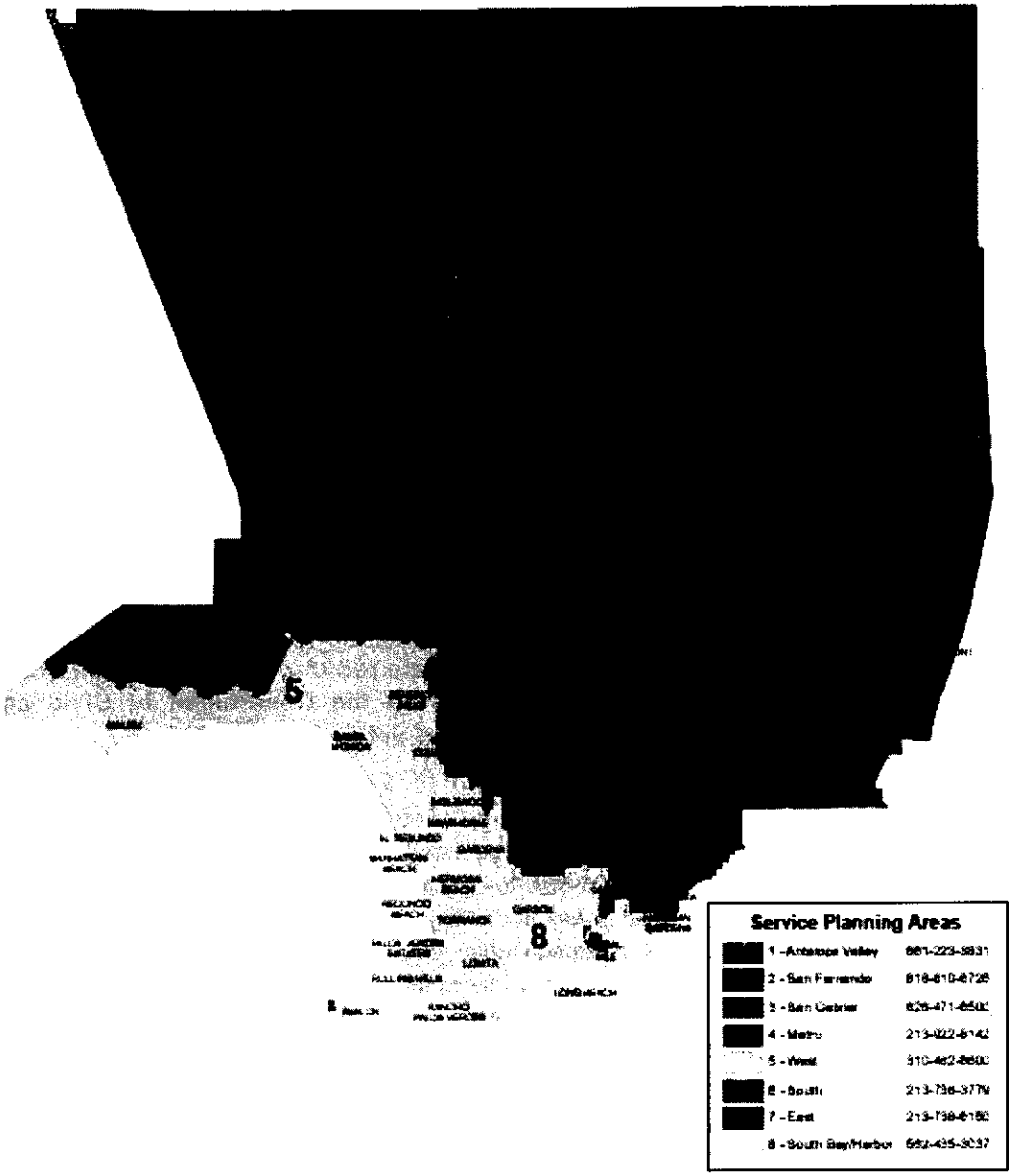
MHSA HOUSING PROGRAM PROJECTS		
Age Group	**Number of Projects**	**Number of Units**
Transitional Age Youth (TAY)	9	111
Adults (Including Older Adult Units)	18	462
Older Adults	7	162
Families (Including Single Adults & TAY)	4	116
Families	4	83
Total	**42**	**934**

MHSA Housing Trust Fund: This funding is used to provide supportive services to DMH clients living in Permanent Supportive Housing (PSH) throughout LA County.

MHSA HOUSING TRUST FUND PROJECTS		
Age Group	**Number of Projects**	**Number of Units**
Transitional Age Youth (TAY)	1	10
Adults (Including Older Adult Units)	10	322
Older Adults	1	40
Families (Including Single Adults & TAY)	4	117
Total	**16**	**489**

In 2014, 55 DMH clients that were homeless moved into PSH through the Housing Trust Fund Program.

Mental Health Homeless Referral Contact Phone Numbers



Phones will be answered Monday – Friday, 8:00 a.m. – 5:00 p.m.
Referrals made outside of those hours will be addressed during the next business day.

Jail Transition & Linkage Services: A-05

Client Contacts: 27,441

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

Women's Reintegration Program

Historically, the Women's Community Reintegration Services and Education Center (WCRSEC) had been under the oversight of DMH's Jail Mental Health Services. As of April 2015, the Department of Mental Health Adult System of Care (ASOC) has assumed responsibility of WCRSEC. This program was established over nine years ago with the intent to serve women with co-occurring mental health and substance use disorders being released from the Women's Lynwood Jail. During the fiscal year in review, the program has additionally provided services to women walking in from the community-at-large or referred through other County Departments co-located in the same building as WCRSEC such as the Department of Child and Family Services (DCFS) and Department of Public Supportive Services (DPSS).

Achievements/Highlights in FY 2014-15

Between April 2015-June 2015, ASOC has initiated a needs assessment process to review the current programing and services being provided at WCRSEC to ensure requisite models of care are in place for women struggling with histories of persistent mental illness and substance abuse, repeated arrests and incarcerations, physical health disorders, homelessness, unemployment, financial instability and domestic and community violence. During this time, WCRSEC has served over 350 women seeking mental health services in the form of medication support, groups to assist with their DCFS cases, individual therapy; substance abuse services, and linkage to temporary or permanent housing. ASOC/WCRSEC has begun the process of assessing and improving the volunteer program (including the role of the Wellness Outreach Workers) to create opportunities for the women to develop skills whilst volunteering at the center which can enhance their resume for future employment opportunities, including peer-led recovery based services. WCRSEC reopened the Community Room to provide women and volunteers the opportunity to participate in gainful activity in the hopes of obtaining future employment. ASOC also began training clinical staff in best practices such as Seeking Safety, Crisis Oriented Recovery Services, and Cognitive Behavioral Therapy to improve the quality of therapeutic services.

Significant changes for FY 2016-17

In conjunction with and under the support of ASOC, WCRSEC intends to fully engage in needed jail in-reach efforts, establish WCRSEC as an education and training center for a variety of integrated care providers and fully integrate the center into the local community stakeholder network of services. This will include the implementation of best practices demonstrating positive outcomes with the forensic (aka justice-involved) population; including Moral Reconation Therapy, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and peer-led recovery based services

Mental Health Court Program

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

1) The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery based program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The Court Liaison Program further aims to provide ongoing support to families and to educate the court and the community at large regarding the specific needs of these individuals. Participation is voluntary and available to those 18 and above. Services include on-site courthouse outreach to defendants , individual service needs assessment, informing consumers and the Court of appropriate treatment options, developing diversion, alternative sentencing, and post-release plans that take into account best fit treatment alternatives and Court stipulations, Linking consumers to treatment programs and expediting mental health referrals, advocating for the rnental health needs of consumers throughout the criminal proceedings, and supporting and assisting to defendants and families in navigating the court system.

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

Achievements/Highlights in FY 2014-15

- The Mental Health Court Linkage Program successfully shifted to a contract with Social Model Recovery's River Community to provide the much needed residential services for criminally involved consumers with a dual diagnosis. This change will expand ability to service dually diagnosed individuals at a residential level of care as an alternative to incarceration.

- The Mental Health Court Linkage Program became engaged with and is directly servicing and administering the San Fernando Van Nuys Courts Diversion and Alternative Sentencing Pilot Program. This innovative approach to diversion is based upon a housing first model, and provides for permanent housing upon successful completion.

Significant Changes for FY 2016-17

County-wide diversion efforts will be overseen by the newly established Office of Diversion and Re-Entry in the Department of Health Services. This change is expected to bring forth better coordination among different County departments and enhance the services being provided by the Mental Health Court Linkage Program.

Community Services and Supports Program Expansion

(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date
Men's Community Reintegration Program (Men's Jail Integration Program)	Location for new services identified. Newly hired staff is currently housed at the Women's Community Reintegration Program.	June 2016

Adult Field Capable Clinical Services: A-06

Unique Clients Served: 8,504
Cost: $ 39,669,864
Average Cost per Client: $ 4,665

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

Achievements/Highlights in FY 2014-15

The Adult System of Care Bureau (ASOC) staff has provided numerous program trainings, technical support visits, and ongoing technical consultation to ensure program implementation. In addition, FCCS providers have made significant efforts to establish community partnerships with local agencies and groups, including community centers, churches and substance abuse programs, to further aid in addressing the cultural disparities which exist in engaging underserved populations.

Significant Changes for FY 2016-17

In the coming fiscal year, FCCS will be further refined as a step-down level of care for the FSP program. Fiscal Year 2016-17 will also focus on increased training and support for serving the forensic population.

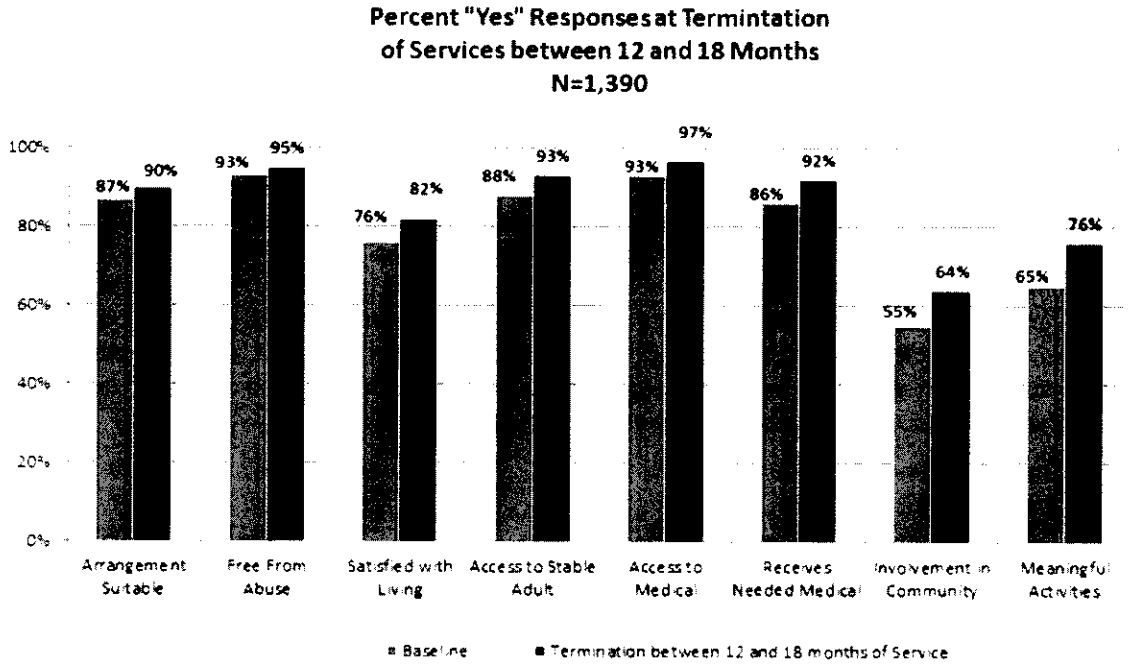
Community Services and Supports Program Expansion

(See Appendix 1 for a complete proposal description)

Proposal	Implementation Date
FCCS Service Expansion in Skid Row	October 2015
Increased capacity to outreach, engage and serve Under-Represented Ethnic Populations (UREP) communities	October 2015

Outcomes (as of 2/10/16)

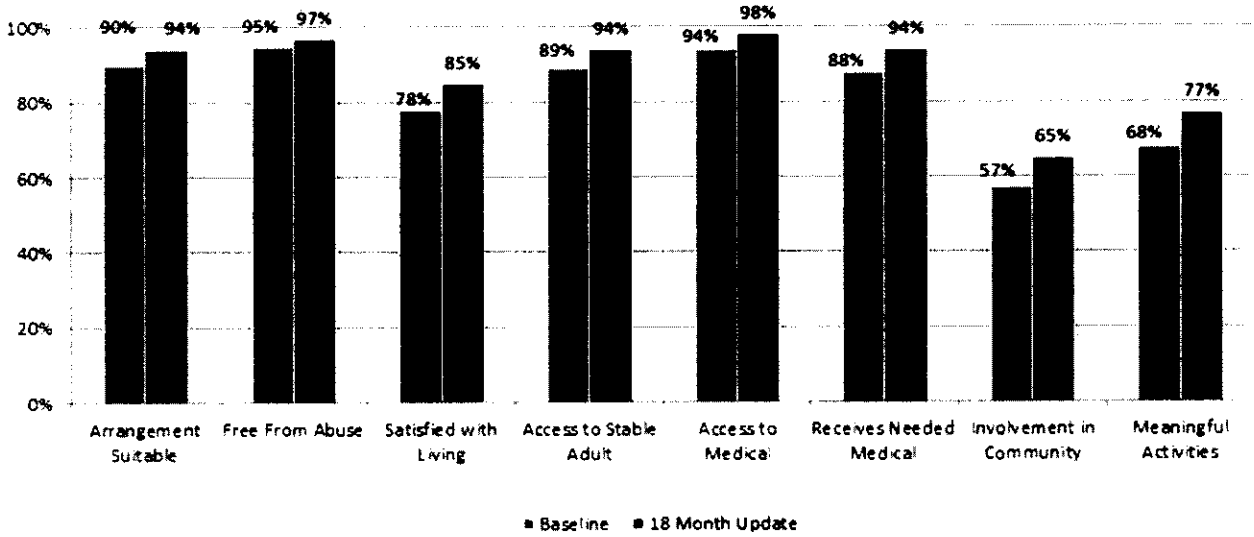
Client's baselines are excluded when data does not meet reporting requirements. See Appendix III for a list of reasons data does not meet reporting standards.



For those terminating between12-18 months of services, adult FCCS clients showed a positive change in the following areas:

- 16% increase with their involvement in the community
- 17% increase in their participation in meaningful activities
- 8% increase with those satisfied with their living arrangement
- 7% increase in clients receiving needed medical services

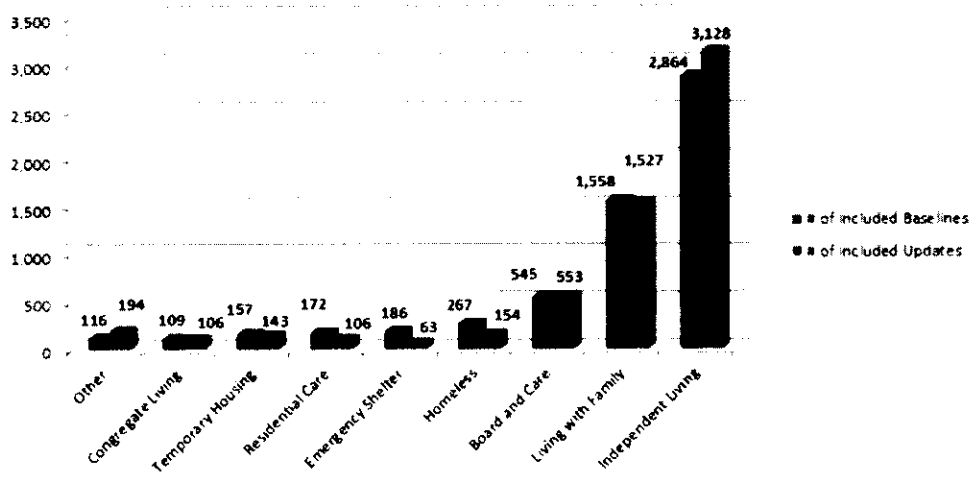
Percent "Yes" Responses at 18 Month Update
N=3,901



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

- 14% increase with their involvement in the community
- 13% increase in their participation in meaningful activities
- 9% increase with those satisfied with their living arrangement
- 7% increase in clients receiving needed medical services

Residential Status at 18 Month Update
N=5,974



After 18 months of services:

- 42% reduction in the number of clients homeless
- 9% increase in the number of clients living independently

Children's Full Service Partnership: C-01

Total Unique Clients Served: 3,006

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

Children's FSP Program

Unique Clients Served: 2,258

Cost: $ 30,928,200

Average Cost per Client: $ 13,697

Slots Allocated: 1,771 (as of 7/10/2015)

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

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

Achievements/Highlights in FY 2014-15

Parent satisfaction is important to Children's System of Care (CSOC) and we strive to have on-going communication with the Child FSP participants, their families and the mental health providers to evaluate the program's effectiveness. Each year CSOC conducts a countywide survey on an area of interest and collects success stories to highlight the impact of Child FSP.

For Fiscal Year 2014-2015, CSOC conducted a telephone survey with parents/caregivers of children ages birth to five years. The survey participants were randomly selected from a mix of currently and previously enrolled clients. CSOC successfully completed 106 interviews. Respondents reported that participating in Child FSP helped parents/caregivers to learn new parenting skills (87%), decreased parenting stress (89%), and increased their confidence in caring for their child (85%). Furthermore, the survey participants informed CSOC of areas where additional assistance was necessary, including more psycho-education, parent support groups, and parenting-skill building activities. These findings were shared with all Child FSP providers to make them aware of parents' suggestions and guide their efforts to improve services.

To explore the impact of FSP on children and families, the mental health providers were invited to share success stories for children graduating from FSP in FY 2014-2015. Several Child FSP agencies provided success stories, including some written by the parents. All highlighted the positive outcomes that FSP services had on the families. A parent wrote "I think the FSP program has helped [my daughter] because she has less tantrums. I learned to set limits with her." Another parent reported "his grades are now mostly A's and B's with the occasional C, whereas at this time last year he was failing almost all of his courses. He graduated from a boot camp program through LAPD with highest honors receiving and MVP award for his graduation class." The stories also emphasized additional services which support the child's success including, but not limited to, individual counseling for the parent through Family Support Services (FSS), resume building and job search, and assistance in establishing benefits, such as Medi-Cal. Some of these stories were shared with providers through CSOC's annual newsletter.

Significant Changes for FY 2016-17

There are many upcoming changes for Child FSP, in particular, the expansion of specialty mental health services for Katie A. Subclass members enrolled in Child FSP. FSP providers received an increase in funds to provide Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to Katie A. Sub-class children and their families. To ensure a successful implementation of these services, CSOC Administration will be conducting trainings throughout the rest of FY 2015-2016 into FY 2016-2017.

To continue our quest for quality improvement during FY 2016-2017, CSOC Administration will focus on children with juvenile justice involvement, in particular, what FSP can do differently to prevent these children from entering or having recurring involvement with the juvenile criminal court system. To do this, CSOC Administration has looked closely at the available data, collaborated with the Transitional Age Youth (TAY) Division to review the types of offenses our FSP enrolled children and TAY are being charged with and will conduct family surveys for children that have juvenile justice involvement. The hope is to develop a greater understanding the needs and issues impacting these children and derive best practices to be utilized throughout all Child FSP programs.

CSOC Administration will continue communicating with Child FSP providers and families (i.e. client satisfaction surveys, bi-annual Roundtable meetings for providers, monthly navigator meetings) in order to improve services and better meet the needs of children and their families.

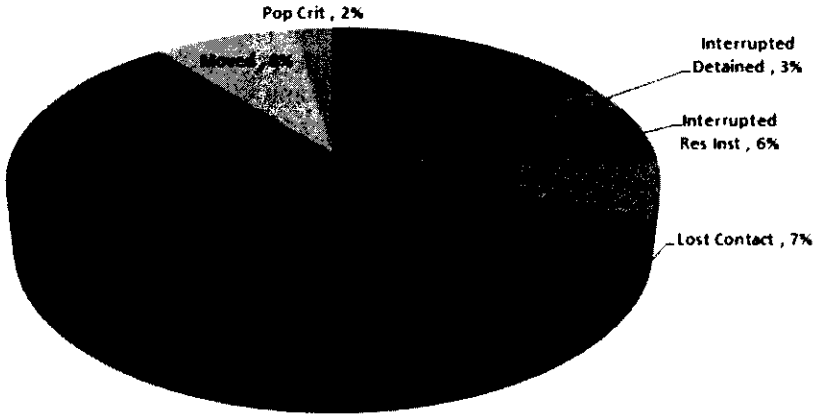
Community Services and Supports Program Expansion

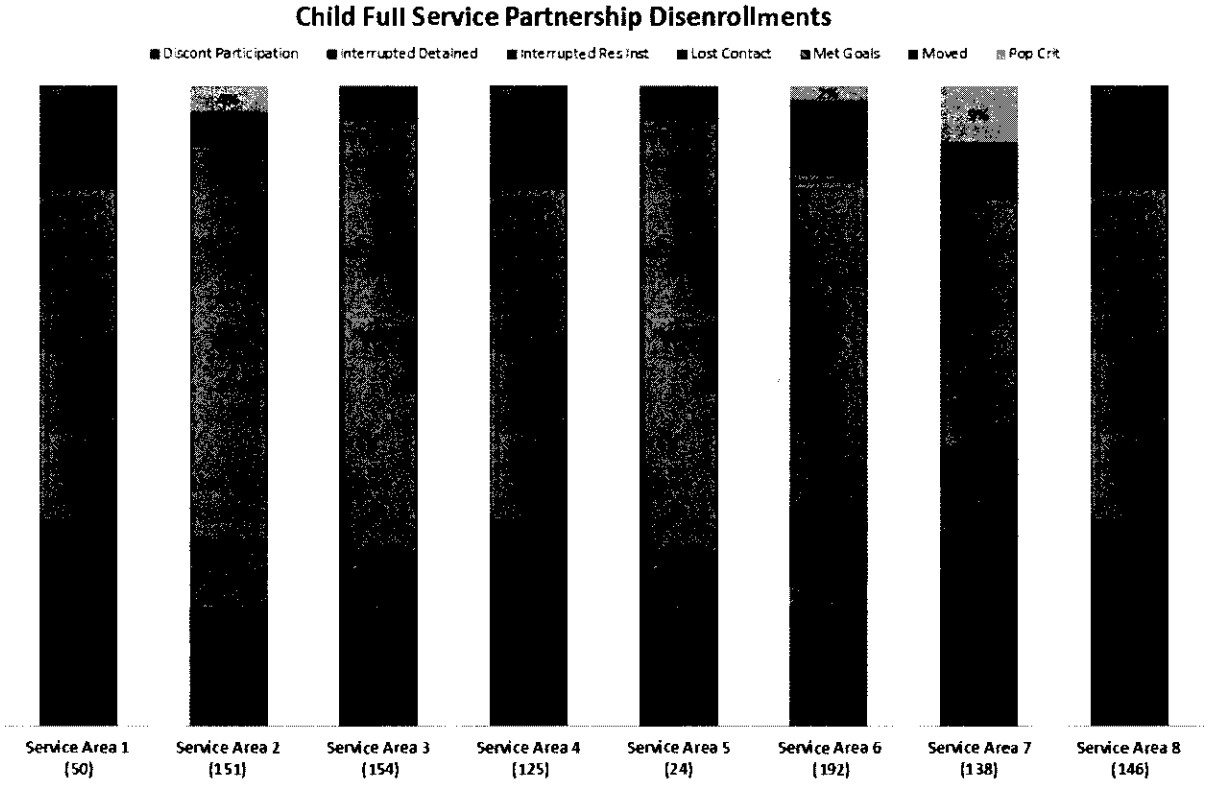
(See Appendix I for a complete proposal description)

Proposal	Implementation Date
Katie A. – Intensive Care Coordination Services for FSP	December 2015

*Disenrollment**

- Total of 992 disenrollments
- 57% of disenrolled clients met their goals

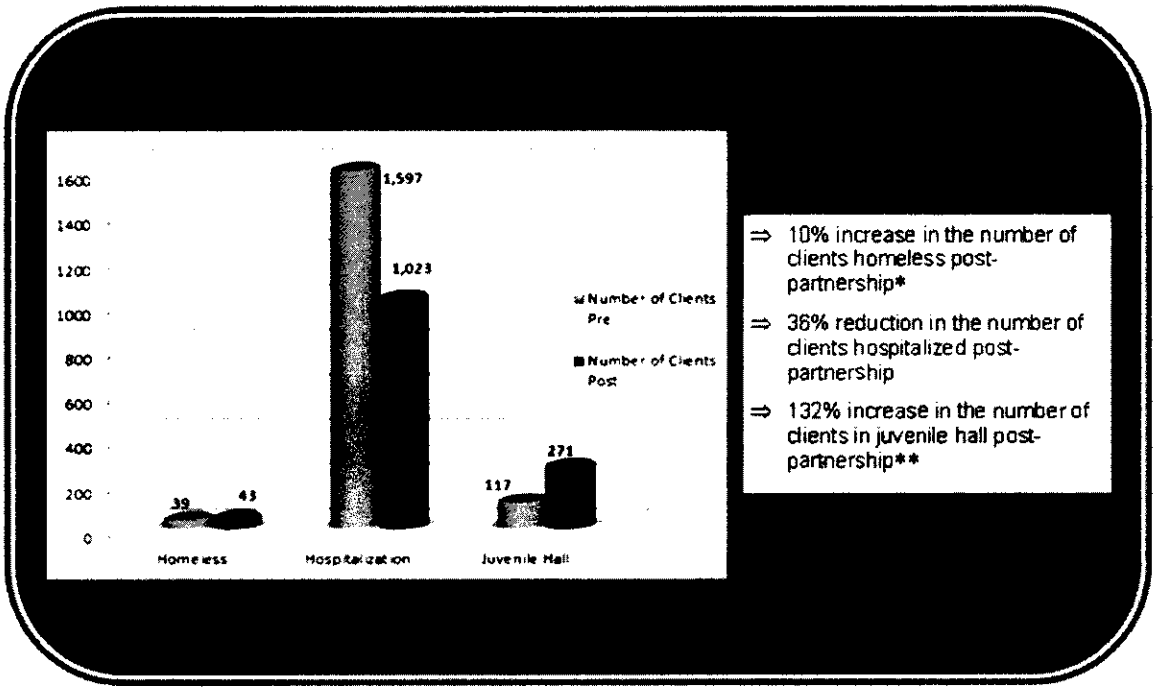




*Data extracted from the FSP authorization application on February 3, 2016 and represents disenrollments for Fiscal Year 2014-15. See Appendix II for an explanation of disenrollment reasons.

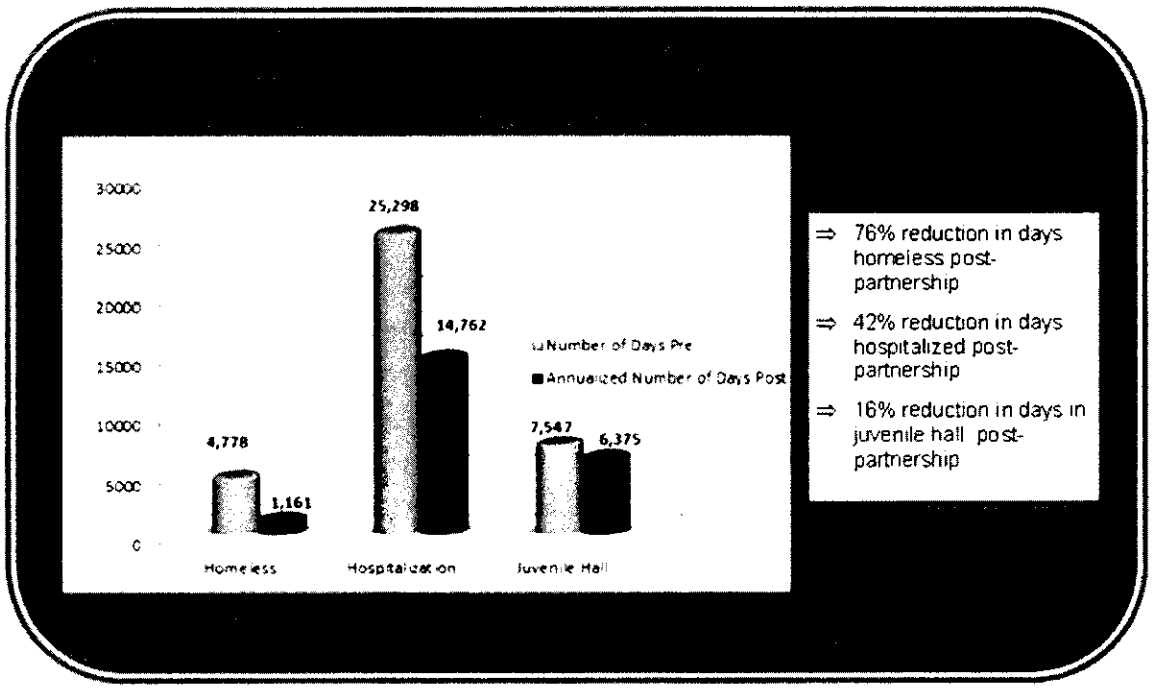
Outcomes

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



* There was a 10% increase in the number of clients homeless post-partnership. Data indicates 39 child FSP clients (approximately 0.51% of the child baselines included) reported being homeless 365 days prior to partnership and 43 child FSP clients (approximately 0.56% of the child baselines included) after partnership was established.

** There was a 132% increase in the number of clients in juvenile hall post-partnership. Data indicates 117 child FSP clients (approximately 2% of the child baselines included) reported being in juvenile hall 365 days prior to partnership and 271 child FSP clients (approximately 4% of the child baselines included) after partnership was established.



Children's Wraparound FSP Program

Unique Clients Served: 781

Cost: $ 9,451,454

Average Cost per Client: $ 12,102

Slots Allocated: 523

The Wraparound FSP Child program is an intensive mental health program providing Wraparound services and support to children, ages 0-15, and their families.

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

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

Achievements/Highlights in FY 2014-15

Caregiver Satisfaction: The Wraparound program evaluates how satisfied the participants are with the program. During FY 2014-15, the Wraparound Program Administration conducted telephone survey interviews to assess the level of satisfaction reported by a random sample of caregivers of children participating in the Wraparound program. The parent satisfaction surveys were a part of our Wraparound annual technical reviews of FSP providers. The satisfaction surveys consisted of items that measured both fidelity to the Wraparound program, and client satisfaction with various dimensions of that program. Of the 109 respondents, thirty two parents/caregivers with a child in Wraparound FSP were interviewed. Their responses to the satisfaction questions showed consistently high levels of caregiver satisfaction.

ICC/IHB Implementation: During FY 2014-15, the Wraparound Program Administration launched the countywide use of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) as important steps toward implementing the Shared Core Practice Model (CPM). As of January, 2014, DMH expanded the use of the ICC and IHBS services to make these available to FSP program participants. In FY 2014-15, the Los Angeles Training Consortium, in partnership with DMH, provided countywide coaching and training on the CPM (which incorporates ICC-IHBS services) to 13 out of 14 Wraparound FSP providers.

Elimination of Wraparound Tiers: At the end of FY 2014-15, the two-tier Wraparound administrative structure was eliminated. One ramification of eliminating the Tiers is that the pool of potential clients who may be referred to a Wraparound FSP Child, or FSP TAY programs will be enlarged. Eliminating Wraparound Tiers has contributed to a broadening of the range of clients referred to Wraparound FSP programs. For example, clients with needs for more intensive mental health interventions, are now included among all of our FSP program recipients.

Unmet Needs: During FY 2014-15, the Child Welfare Division launched countywide trainings based on a model of "underlying needs" that emphasizes the relationship between stressors (including traumatic stressors); their impact on the coping process; and the resulting unmet needs for a variety of resources that may have protective effects on traumatized children. All of the Wraparound FSP program providers have attended or have had an opportunity to attend an unmet needs training. Completing the training and assessing the clients unmet needs accurately is likely to improve the plan of care, and treatment interventions developed by CFT members.

Achievements/Highlights in FY 2015-16

Caregiver Satisfaction: Out of 14 FSP providers, 5 of them have already expanded sites across the County, increasing Wraparound FSP sites by 9. It is expected that once all these sites are open and servicing clients, there will be a total of 32 Wraparound FSP sites across the County.

New Monthly Activity Tracking Report: During FY 15-16, the Wraparound Program Administration designed and distributed a new Wraparound Child FSP Activity Tracking Report, and a Wraparound TAY Activity Tracking Report. Both Activity Tracking Reports are completed by program staff, and provide selected demographics and information on Wraparound FSP slot utilization. Information collected using these forms is enhancing the capability of the Wraparound Program Administration to monitor and track the slot capacity of each Wraparound FSP provider. Finally, these forms assist in the monitoring of client outcomes.

Enhanced OMA Tracking Process: Client information collected on the Activity Tracking Report forms is subsequently entered into a new Wraparound Tracking spreadsheet also developed in FY 15-16. The data entered in this spreadsheet is then used to monitor and to carry out the timely completion of clients' Outcome Measures Application (OMA) forms as required by the MHSA.

Significant Changes for FY 2016-17

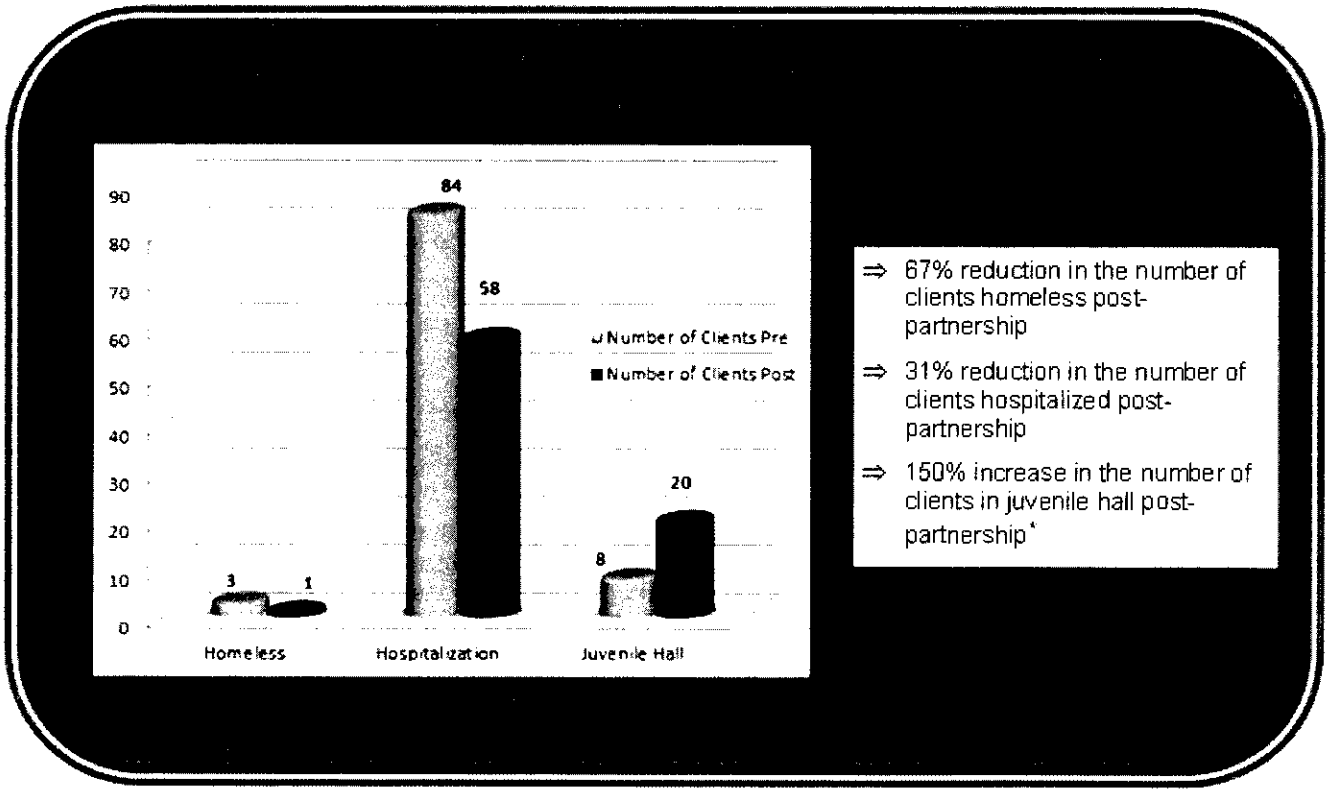
For the Wraparound Child and TAY FSP programs, many developments are anticipated as DMH takes responsibility for the contract administration of the Wraparound program. Expansion of new Wraparound sites has changed the geographic location of several Wraparound FSP programs which allows us to more effectively access the Wraparound FSP focal populations.

Continued use of the monthly Wraparound FSP Tracking Report and the Wraparound FSP Tracking spreadsheet implemented in FY 2015-16, will facilitate more effective monitoring and, hence more stringent utilization of slots for clients in different age-ranges.

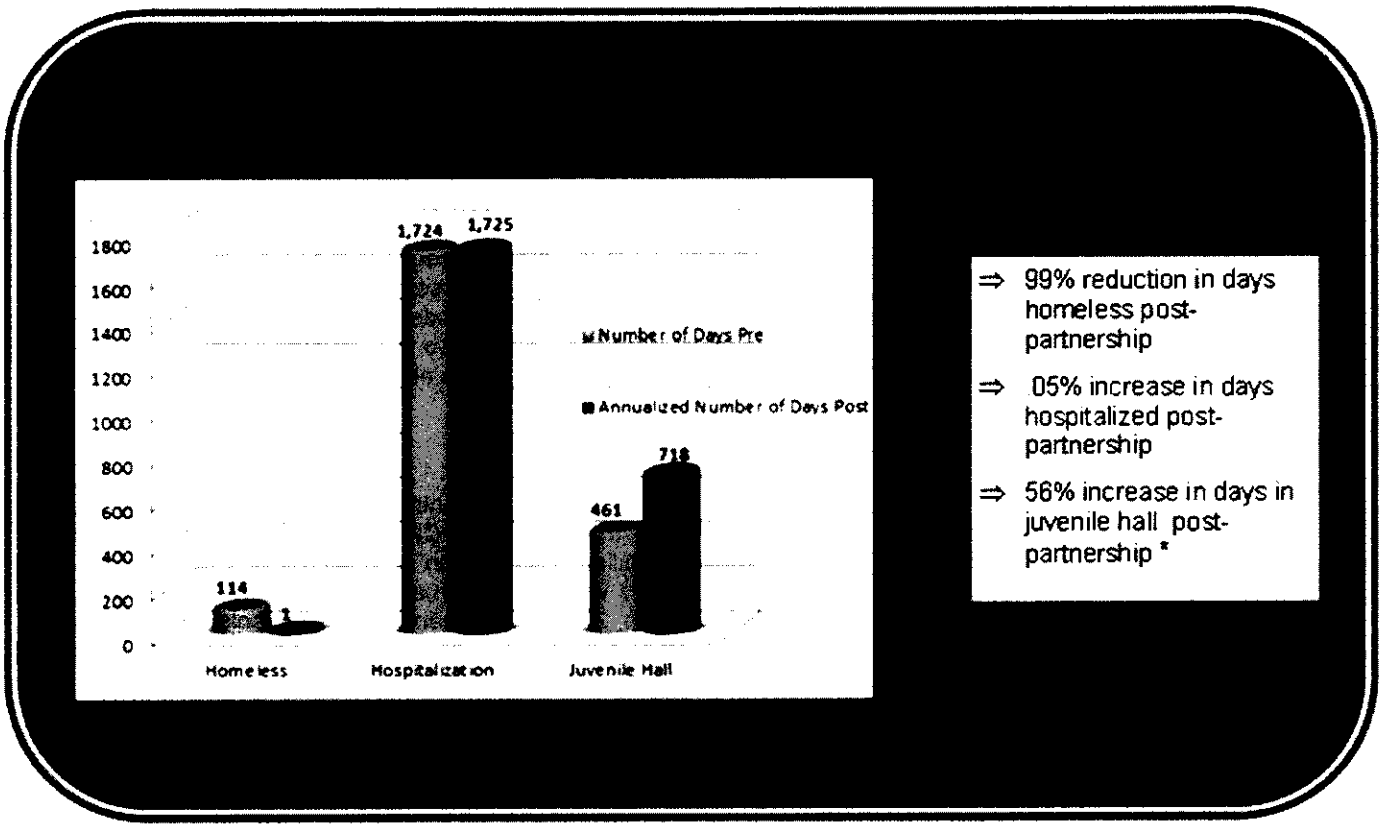
Previous client and caregiver satisfaction surveys of Wraparound FSP have been administered by Wraparound Program Administration staff. In FY 2016-17, additional satisfaction surveys will be implemented by Service Area staff. This will allow the Wraparound Program Administration to evaluate the quality of services even more effectively because we anticipate greater numbers of completed surveys

Outcomes

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



* There was a 150% increase in the number of clients in juvenile hall post-partnership. Data indicates 8 child Wraparound FSP clients (approximately 0.50% of the child wraparound baselines included) reported being in juvenile hall 365 days prior to partnership and 20 child FSP clients (approximately 1% of the child baselines included) after partnership was established.



* There was a 56% increase in the number of days child Wraparound FSP clients spent in juvenile hall post-partnership. Data indicates 461 days (0.27% of total tenure) were reported spent in juvenile hall 365 days prior to partnership and 718 days (0.42% of total tenure) were reported spent in juvenile hall after partnership was established for child Wraparound FSP clients. Total tenure is 170,969 days for all included baselines.

Family Support Services: C-02

Client Contacts: 294

Family Support Services (FSS) provide access to mental health services such as individual psychotherapy, couples/group therapy, psychiatry/medication support, crisis intervention, and co-occurring disorders services to parents, caregivers, and/or other significant support persons of Full Service Partnership's (FSP) enrolled children who need services, but who do not meet the criteria to receive their own mental health services. The Enhanced Respite Care Pilot was launched in April 2013 as a new opportunity to provide support for parents/caretakers of children enrolled in FSP through the use of FSS Funds.

The purpose of the pilot was to provide short-term relief to parents/caregivers that provide care for an FSP enrolled child or youth between the ages of 0-15 years old. These services allow parents/caregivers the opportunity to address their personal and/or other familial care needs. Eight (8) Child FSP agencies participated in the pilot with an allocation amount of $189,131. Eighty-two (82) children received Respite Care Services during Fiscal Year (FY) 2014-2015, sixty-four (64) of which were new enrollees.

Achievements/Highlights in FY 2014-15

Families participating in the Respite Care Pilot were surveyed to identify the strengths, areas in need of improvement, and trends of the services provided in this program. Children's Systems of Care (CSOC) Administration reached out to all 64 newly enrolled families. Thirty-seven of these families participated in the survey. The results indicated that 25% of new enrollees were living with a relative caregiver or were in foster care (one of our target populations), 70% spoke English, 29% spoke Spanish and 1% spoke other languages. Parents/caretakers reported that respite services allowed them more time to focus on personal needs (73%) and more than half reported significant stress reduction due to respite services (60%).

Parents'/caregivers' statements included comments about the staff, "she was fantastic" and "the services were great help because the attention [the worker] provided to my child." In addition, they provided suggestions, "expand the services for 'us' (relative caregivers)" and "increase time availability for services." The Respite Care Services Program that is set to launch in FY 2016-2017 will target relative caregivers for services, and will ensure that services are available during those times when families most need them.

Significant changes for FY 2016-17

The Respite Care Services program solicitation process was completed and the program will begin during FY 2016-2017. The program will be available for children 0--15 years of age who are currently receiving public mental health services through Full Service Partnerships (FSP) or Field Capable Clinical Services (FCCS). The program will increase to $1,000,000 for the span of two fiscal years and approximately 600 children will receive respite care services annually. CSOC Administration will continue to monitor the program and provide feedback to stakeholders regarding the implementation process. Furthermore, CSOC Administration will provide technical assistance and support to ensure the success of the program.

Children Field Capable Clinical Services: C-05

Unique Clients Served: 9,135
Cost: $ 50,129,582
Average Cost per Client: $ 5,488

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

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

Achievements/Highlights in FY 2014-15

During FY 2014-2015, the IFCCS program served a total of 206 subclass members with intensive mental health needs throughout Los Angeles (LA) County. Of all referrals received, 70% originated from psychiatric hospitals, 12% from the Children and Youth Welcome Centers, 3% from Exodus Urgent Care Centers, 2% from the Field Response Operation Team and 13% were Administrative Exceptions. Administrative Exceptions include: a) child/youth that meet IFCCS criteria, but the child/youth were not seen at one of the referral "hotspots", b) the youth may be older than the criteria age but meets all other criteria or c) Child/youth does not meet IFCCS criteria, however, without intensive services the child/youth would quickly deteriorate. IFCCS teams have served 15 CSEC youth and 11 children birth to 5 years of age.

IFCCS utilizes the Program Improvement Review (PIR) process, which is an adaptation of the Quality Service Review (QSR), to ensure quality of service provision and evaluate fidelity to the Shared Core Practice Model. The second round of reviews was completed in August 2015. Strengths were noted in the areas of Engagement, Intervening, Supports and Services, Assessment and Understanding, and Voice and Choice. This round of reviews reflects the increased understanding that the providers have around the Shared Core Practice Model and fidelity to the IFCSS model.

Significant changes for FY 2016-17

The IFCCS Program is set to expand from 100 slots to 1,500 slots in FY 2016-2017. This expansion will increase the services for the Katie A. Subclass Members. Unlike other Service Area (SA) based intensive mental health services, IFCCS will follow the clients throughout LA County to ensure continuity of care and promote stabilization. The continued success of IFCCS has allowed for the program to continue growing and the Department will continue to ensure it meets the ongoing needs of this vulnerable population.

Community Services and Supports Program Expansion

(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date (Estimated)
Increase capacity of Child Field Capable Clinical Services	Intensive Field Capable Clinical Services' providers had contracts amended.	May 2015
Katie A. – FCCS expansion for Intensive Care Coordination (ICC) and Intensive In-Home Behavioral Services	Contracts have been amended.	June 2016

Describe the Impact the CSS Expansion has had on this Program:

The Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for Fiscal Years (FY) 2014-2015 through 2016-2017, determined that the capacity of FCCS, across all age groups, should expand to meet the needs of the community. Due to the success of the Intensive Field Capable Clinical Services (IFCCS) Program, it was decided to transform Child FCCS slots into IFCCS slots.

In April 2015, IFCCS expanded by 40 slots. The expansion focused on service delivery for the Commercially Sexually Exploited Children (CSEC) and children birth to 5 years of age. IFCCS services are specifically intended to address the more intensive mental health needs of Katie A. subclass members and ensure that these youth receive medically necessary mental health services. The Katie A. subclass members are defined as children with open DCFS cases, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligibility, and:

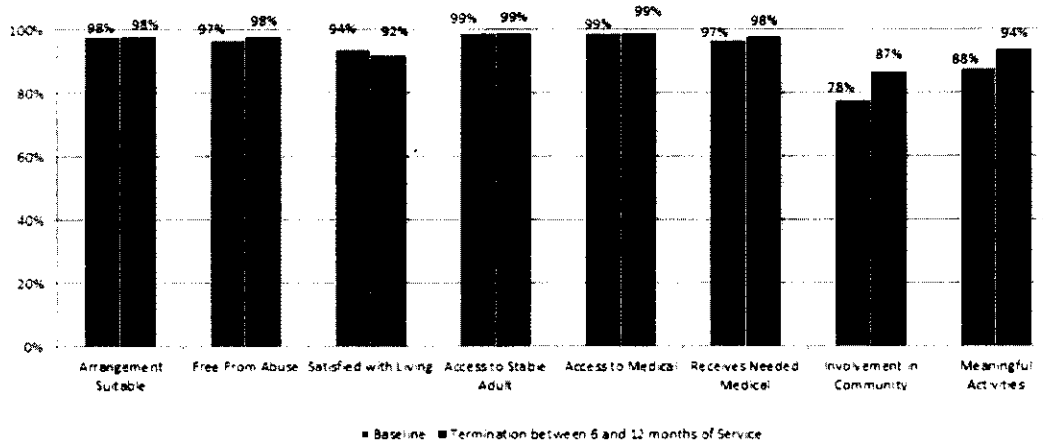
a. Are in or being considered for: Wraparound, Therapeutic Foster Care or other intensive services, Therapeutic Behavioral Services, specialized care rate due to behavioral health needs or crisis stabilization/intervention; or

b. Are currently in or being considered for a group home (RCL 10 or above), a psychiatric hospital or 24 hour mental health treatment facility, or has experienced his/her 3rd or more placement within 24 months due to behavioral health needs.

Outcomes (as of 2/10/16)

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

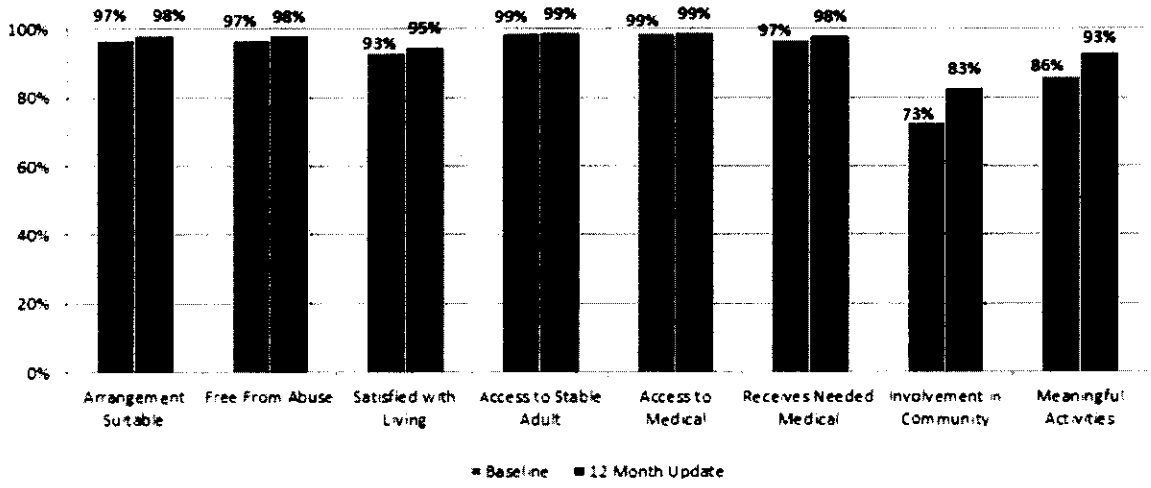
Percent "Yes" Responses at Termintation of Services between 6 and 12 Months N=5,387



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

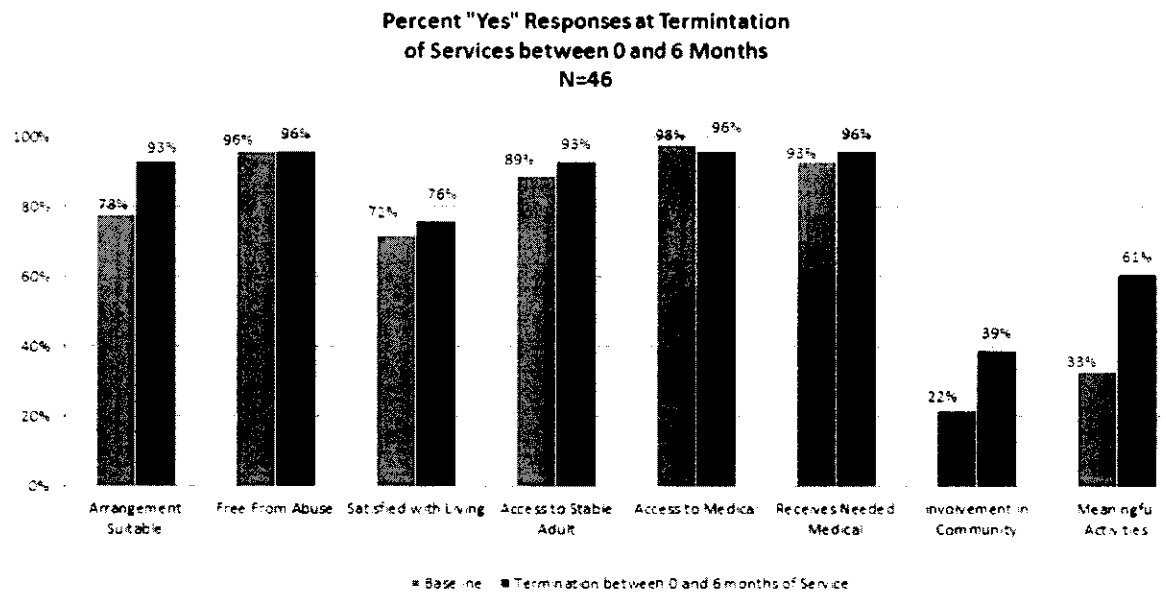
- 12% increase with their involvement in the community
- 7% increase in their participation in meaningful activities

Percent "Yes" Responses at 12 Month Update N=2,943



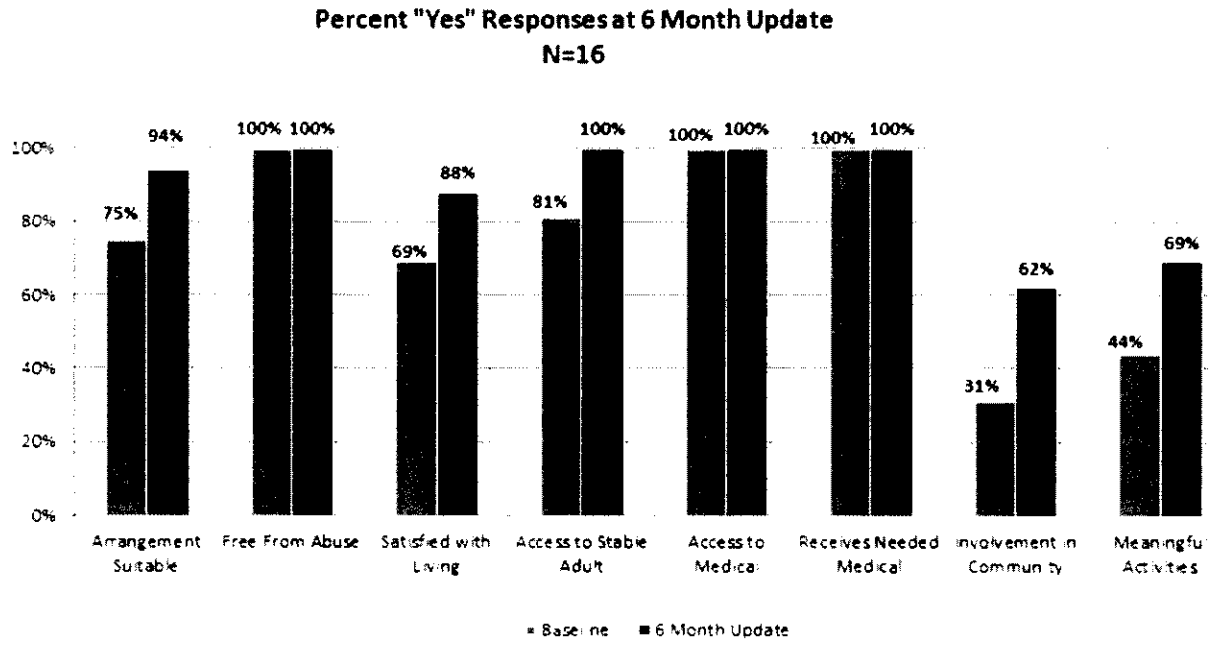
After 12 months of child FCCS services, clients showed a positive change in the following areas:

- 14% increase with their involvement in the community
- 8% increase in their participation in meaningful activities



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

- 12% increase with their involvement in the community
- 7% increase in their participation in meaningful activities



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

- 100% increase with their involvement in the community
- 57% increase in their participation in meaningful activities

Older Adult Full Service Partnership: OA-01

Unique Clients Served: 896
Cost: $ 7,567,878
Average Cost per Client: $ 8,446
Slots Allocated: 709 (as of 6/30/2015)

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

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

Achievements/Highlights in FY 2014-15

- An expansion during FY 14-15 increased the OA FSP slots countywide by 124 during this fiscal year, bringing the total number of FSP slots to 709 as compared to 585 slots from FY 13-14. This expansion occurred mid fiscal year.
- In FY 2014-15 the providers engaged in the pilot project are Heritage Clinic (which joined the OA FSP Pilot Program at its beginnings) and Telecare Corporation, which joined the pilot in September 2014.
- Providers continue to complete a 24 Month + Utilization Review form which examines client's current functioning and achievements through FSP, continuing needs, barriers to treatment, and plans to transition from FSP. OA System of Care Bureau reviewed 94 cases between July 2014 and June 2015, almost double the number of clients who were reviewed in FY 13-14. Of those reviewed, 38% were either stepped down to lower level of care or were disenrolled as a result of this review process.

Significant changes for FY 2016-17

Continue to monitor program effectiveness which will improve the access to services as well as flow within the Older Adult System of Care. Our current focus on justice-involved Older Adults will also impact the clients who are seen in our field-based programs and strengthen our ability to reach the most vulnerable Older Adults.

Community Services and Supports Program Expansion
(See Appendix I for a complete proposal description)

Proposal	Implementation Date (Estimated)
Expand the number of slots for the Older Adult Full Service Partnership Program	2014

Describe the Impact the CSS Expansion has had on this Program:

- The number of OA FSP slots countywide increased by 124 during this fiscal year, bringing the total number of FSP slots to 709 as compared to 585 slots from FY 13/14, and increasing access to OA consumers.
- The slot increase has made room for openings in FSP for justice-involved older adults exiting the system, thereby increasing services to a population much in need of mental health and case management assistance.

Success Stories

[redacted]

Client enrolled in the FSP Older Adult program in November 2009 after spending years being homeless and in and out of IMDs. She was conserved and needed assistance with most activities of daily living. Upon enrollment in FSP, client moved into a board and care and started to learn how to live more independently. She learned the importance of taking her medications on a regular basis and took advantage of the many groups that provider had to offer. She was very active in developing her goals and expressed a desire to eventually move out of the board and care and live on her own. Due to her motivation and her commitment to her treatment goals, she is no longer conserved and is living on her own in a low income senior apartment. She cooks for herself, utilizes public transportation on her own, pays her bills and attends a senior center where she participates in different activities with other seniors. She recently graduated from the provider's Wellness Center and gave a very inspirational speech where she reflected on her growth since starting at the agency. Client now only receives medication services from provider and is able to access all her other needs out in the community. She is a true inspiration and we are all so proud of her!

[redacted]

Client is 66 years old and referred to provider's older adult FSP in 2013 after a 2-year admission at an IMD. She immigrated to the US with her family when she was 9 yrs old and much of her growing up years were relatively stable and she graduated with her high school diploma. Young adulthood brought many challenges as growing up as a flower child in the 60's she was a free spirit who abused alcohol and drugs while masking feelings of severe depression, anxiety and mania. Her first marriage ended in divorce and of her leaving her young son in the care of his father, while she impulsively traveled for adventure and what she thought was love with another man. Years of domestic violence and undiagnosed mental illness with her second husband heightened her addiction to alcohol/drugs and triggered a slow downward spiral of her life; eventually ending in homelessness around the country, uncontrolled addiction and numerous psychiatric

hospitalizations for suicidal ideations, paranoia and hallucinations; which lead to an eventual LPS conservatorship.

Client has suffered many losses in her life as both her mother and younger brother passed away unexpectedly in the late 90's while she lived with them. Also the loss of her relationship with her son has haunted client since the day she left and she greatly desires to rebuild this lost relationship. Living as a transient on the streets for many years, she lost much of her possessions and identity. Because of her disorganized thoughts, paranoia and poor recollection of her traumatic past, for many years she was untrusting of social service providers with her personal information which hindered their ability to assist her to re-apply for her Green Card to establish financial benefits. Upon enrollment to the FSP program in 2013, FSP staff has worked tirelessly with client to build trust, rapport and confidence in order to acquire information needed to regain her immigration papers and apply for financial benefits.

In the past year, client has slowly began to share her story and information which lead to successfully obtaining her birth certificate, CA ID card, death and marriage certificates and divorce decrees which resulted in her successfully obtaining her Green Card and submit her application for SSI benefits. In addition, with her mental health symptoms stabilized by the assistance of the correct medication and positive relationship with her FSP psychiatrist, she successfully appeared in mental health court and was released from LPS conservatorship which was a proud moment for client in her journey to recovery. Client has started taking walks in the neighborhood, began becoming more social, meeting friends at coffee shops periodically, she likes to attend live music shows, go to the library, read art books and attend free yoga classes at the local senior center.

Client's next goals are directed towards reconnecting with her younger brother and son who is now in his 40's who she has lost all contact. She realizes that her family may not accept her back given her tumultuous past, but she dreams of one day rekindling her relationship with her son. The team has helped her research and locate her son and she has made efforts to slowly reach out. She hopes that one day she will have a conversation with her son to express her apologies and love. Client's recovery journey continues, but this time she is headed in the right direction.

[redacted]

Client has a long well-documented history of mental illness and hospitalizations dating back to the early 1990's. After her most recent hospitalization at an IMD, client was enrolled in FSP program on 5-10-2013. Since that time, she has been living in an assisted living facility. Since her enrollment into the FSP program, client has been able to cope with her symptoms while living in the community and has not had any episodes of re-admittance into an inpatient psychiatric facility. She has collaborated with the FSP team in creating an overall goal of living independently. Part of that goal includes living in an apartment on her own and an objective that attends to her physical health, such as losing weight. According to the FSP team, client blamed her weight gain on her psychiatric medication.

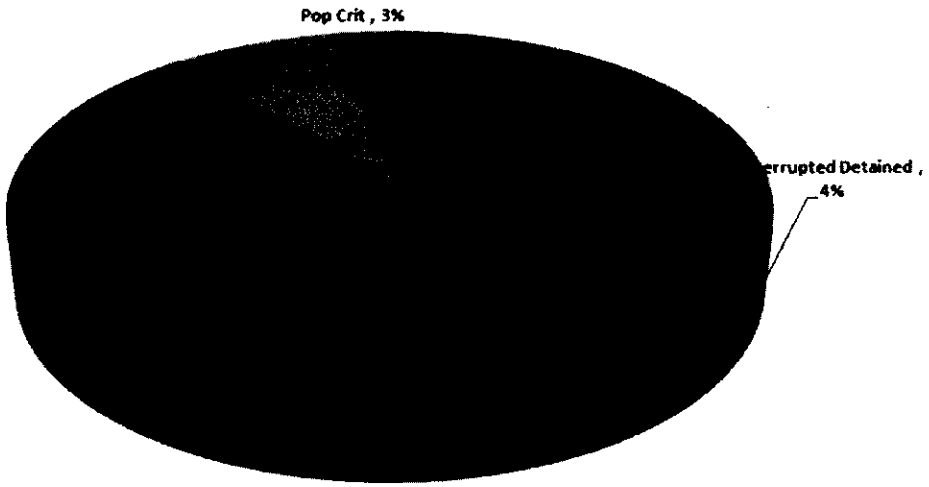
Over the past 2 years, the FSP team utilized the recovery model tools of the Recovery Centered Clinical System (RCCS) to begin exploring and developing a plan on how to achieve client's goal. Also, the FSP team began to educate client on the positive effects of the psychotropic medication and how the medicine benefited her in reaching her goal of independent living. Client continued to receive medication injections during her time within the program and this appears to have helped give her structure with compliance. Client reported that when she was not taking the injections, her compliance with the medication was not as consistent which led to her decompensating more frequently. Her symptoms of paranoia have seemed to decrease during the time she has participated in the FSP program.

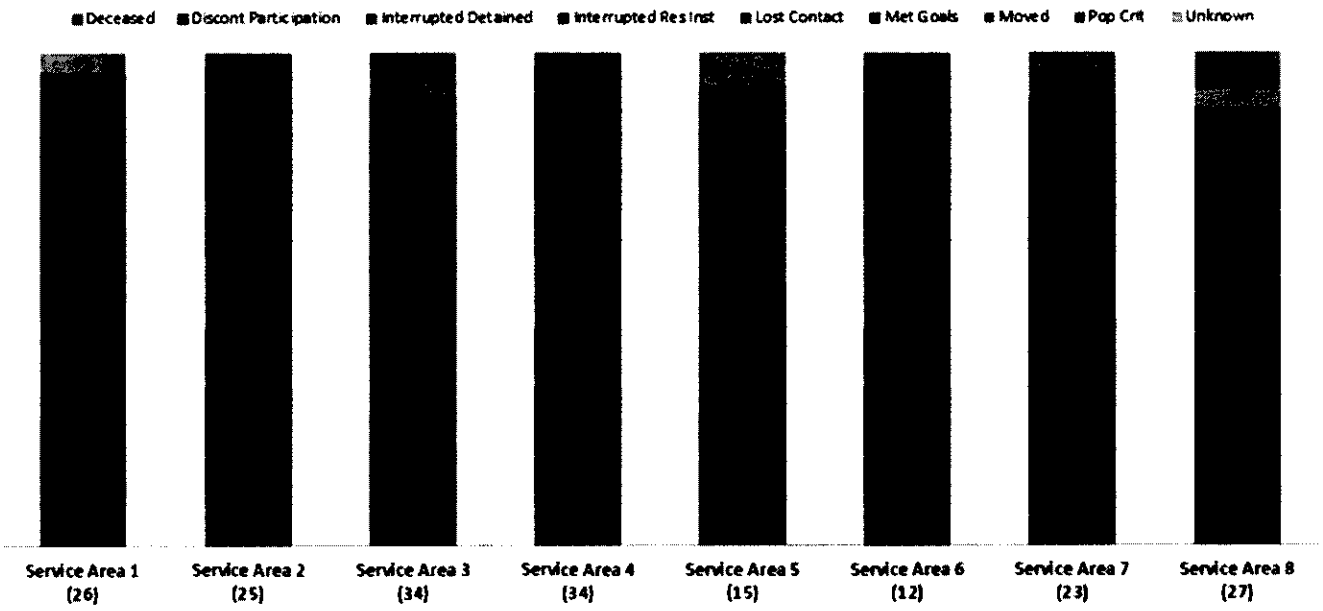
Using the RCCS tools, the FSP team began by attempting to instill hope, find purpose, and encourage client to participate in social activities such as: Holiday parties, the Santa Ana zoo, and bowling. Also, the FSP team began to work with client on exploring going back to school by taking a computer class to help her marketability in searching for employment. She also was connected to a community employment prep class that taught basic skills. Additionally, client enrolled into a French class to follow her passion of learning a foreign language. Client was also linked with supports that centered on her spirituality, she is able to travel to a church in Los Angeles to attend services and build a support network within the congregation.

In order to reach her goal, the FSP team explored the opportunity of searching for employment to help client become more independent and afford an apartment on her own. However, the FSP team was able to link client with a low cost senior housing which she could afford on her social security benefits. The FSP team also linked her with a low cost cell phone to help her communicate. Additionally, by linking client to a local food bank and taught client to utilize public transportation; she has been able to independently provide for herself and is moving towards her goal of independence.

*Disenrollment**

- Total of 197 disenrollments
- 26% of disenrolled clients met their goals

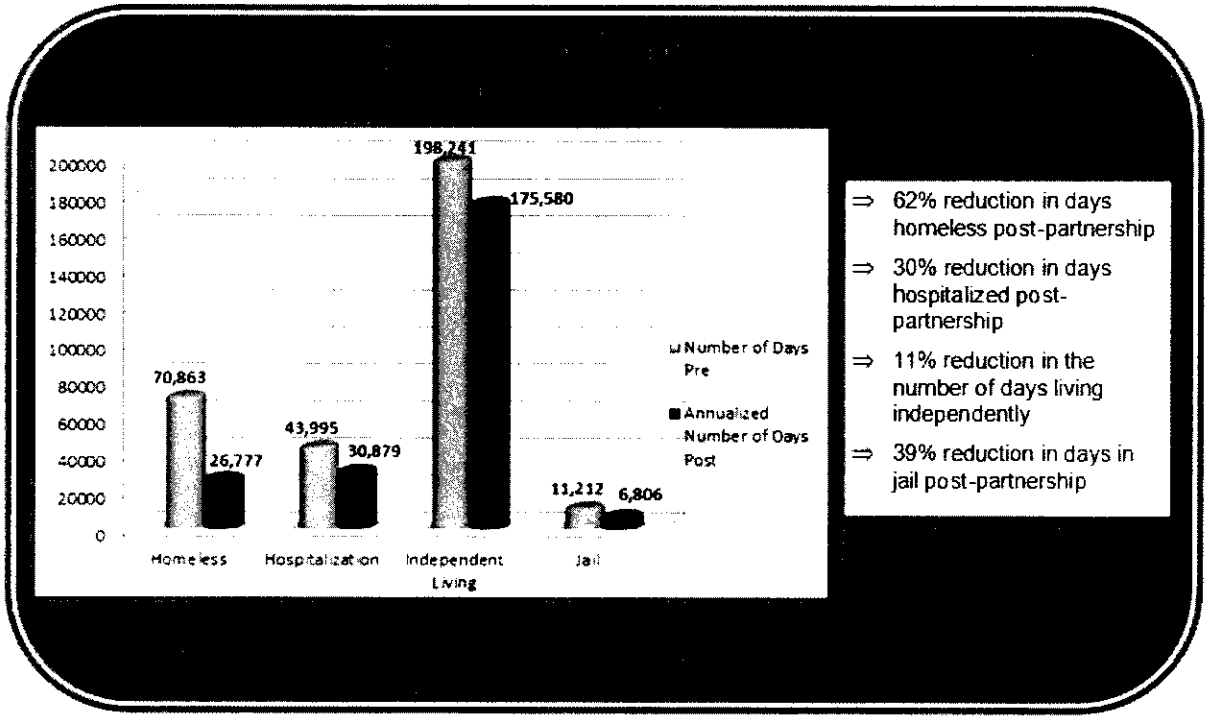


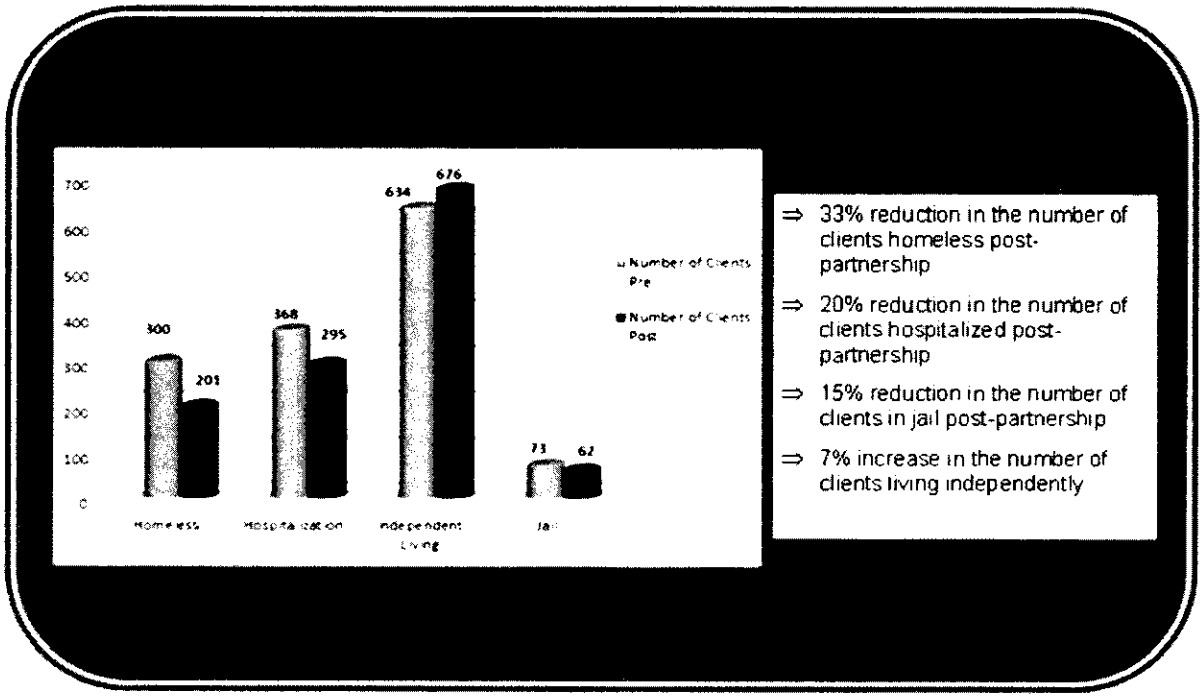


*Data extracted from the FSP authorization application on February 3, 2016 and represents disenrollments for Fiscal Year 2014-15. See Appendix II for an explanation of disenrollment reasons.

Outcomes (as of 2/10/16)

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





Transformation Design Team: OA-02

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

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

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

Achievements/Highlights in FY 2014-15

The OA Transformation Team compiled and analyzed data that assisted in the decision-making process in determining new slots and increased allocation for the MHSA expansion. This process increased capacity of our Older Adult field-based programs. The transformation team continues to provide highly skilled and specialized technical support to the Older Adult MHSA programs. Examples of such support include:

- Complete Service Request Forms (SRF).
- Complete 403 packets to shift funds.
- Complete Provider File Adjustment Requests (PFAR).
- Extract a myriad of reports using various data sources.
- Regularly track and monitor MHSA funds for the Older Adult contract providers.

Field Capable Clinical Services: OA-03

Unique Clients Served: 2,581
Cost: $ 14,350,076
Average Cost per Client: $ 5,560

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

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

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

Achievements/Highlights in FY 2014-15

- 58% of overall FCCS services were provided in the field, well within the 40-60% benchmark.
- Spanish, Farsi, Korean, Cantonese, Japanese, Armenian, Russian, Tagalog, Vietnamese, and Mandarin are among the languages spoken by FCCS clients and staff.
- The first annual consumer satisfaction survey was completed mid fiscal year. There was a 33% response rate which is relatively low; however the fact of it being the first year of the survey may have accounted for the low rate. 76% stated they were satisfied with the services being offered in their home. 94% reported that FCCS staff was responsive to their needs when they required assistance. 96% reported they were receiving services in a language they were most comfortable speaking.

Significant changes for FY 2016-17

Continue to monitor program effectiveness which will improve the access to services as well as flow within the Older Adult System of Care. Our process during site visits is designed to review clients who have been receiving services for longer than 24+ months, and we will continue to do so to enhance capacity. Our current focus on justice-involved Older Adults will also impact the clients who are seen in our field-based programs and strengthen our ability to reach the most vulnerable Older Adults.

Community Services and Supports Program Expansion

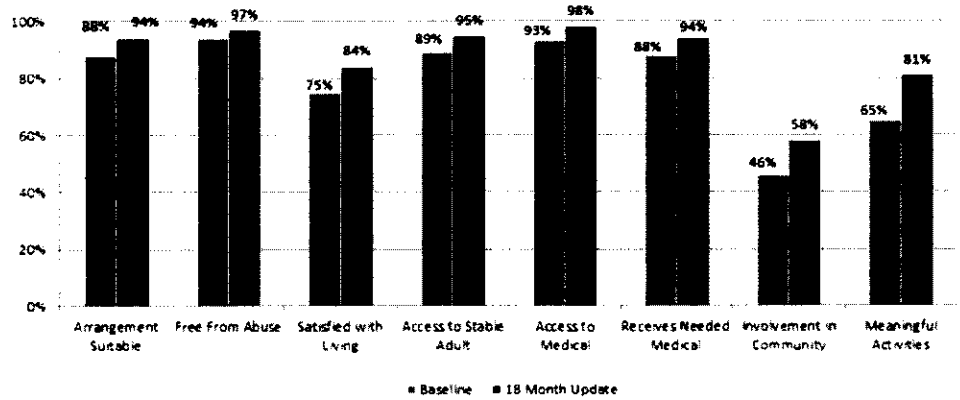
(See Appendix I for a complete proposal description)

Proposal	Implementation Date (Estimated)
Increase the capacity of Older Adult Field Capable Clinical Services	2014

Outcomes (as of 2/10/16)

Baselines are excluded when data does not meet reporting requirements. See Appendix III for a list of reasons data does not meet reporting standards.

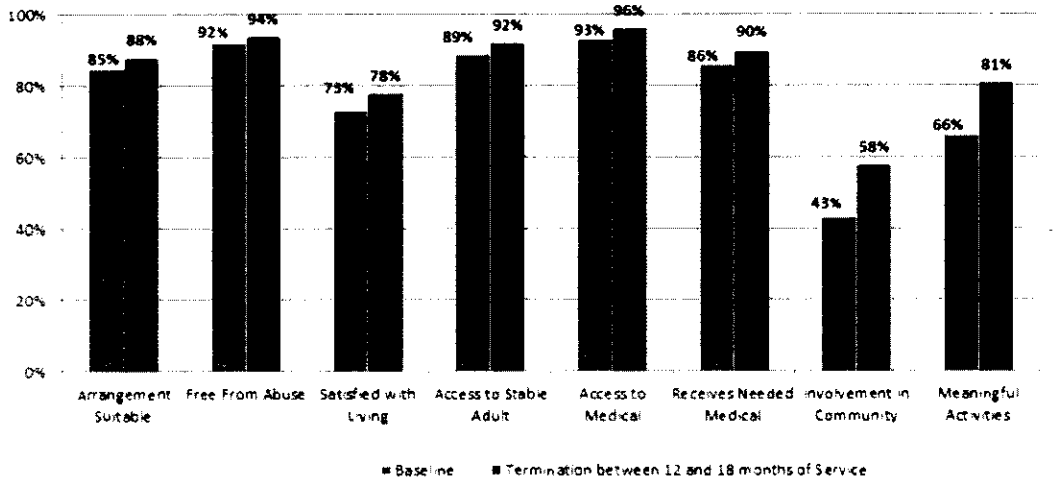
Percent "Yes" Responses at 18 Month Update
N=1,468



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

- *26% increase with their involvement in the community*
- *25% increase in their participation in meaningful activities*

Percent "Yes" Responses at Termintation of Services between 12 and 18 Months
N=355



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

- 35% increase with their involvement in the community
- 23% increase in their participation in meaningful activities

Service Extenders: OA-04

Stipend Recipients: 30

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

Achievements/Highlights in FY 2014-15

- As of June 2015, there were 28 Service Extenders working in our directly-operated and contracted agencies.
- Languages spoken other than English are Spanish, Tagalog, Mandarin, Cantonese, Khmer, Vietnamese, Korean and Farsi.
- Service Extenders continue to meet on a quarterly basis with the OASOC program head where issues and concerns about their placements are discussed in a supportive atmosphere. This meeting also provides an opportunity for the Service Extenders to network and learn from each other. This meeting has a consistent attendance of at least 15 Service Extenders and always includes lively discussion and feedback. Topics explored include boundaries, cultural competency, working within the FCCS team, as well as resource and linkage information.
- Two of our Service Extenders were hired by DMH as full-time employees in the SB 82 program. Their position is Mental Health Advocate.
- Five of our ten directly-operated OA FCCS programs have at least one Service Extender.

Significant changes for FY 2016-17

- Plan and implement a Service Extender Academy to train a new group of volunteers as Service Extenders.
- Continue to encourage and support the five remaining OA FCCS directly-operated clinics to take on at least one Service Extender.

Older Adult Training: OA-05

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

Achievements/Highlights in FY 2014-15

The Older Adults Systems of Care (OASOC) training calendar had several highlights for FY 2014-15:

- **Focus Group/Presentation Project:** Stigma of Mental Health in Older Adult Members of Under Represented Ethnic Populations (UREP) purpose was to explore the role of stigma as a barrier to selected under-represented ethnic populations (UREP) accessing mental health care and to put forward recommendations that would package mental health psycho-educational presentations in a relevant and culturally competent manner to the intended audience.
- **Older Adult Consultation Medical Doctor's (OACT-MD) Series:** OA Systems of Care conducted OACT-MD Series for training and consultation for psychiatrist, nurse practitioners, nurses & mental health clinicians to improve the accessibility and quality of mental health services for Older Adults.
- **Public Speaking Club Graduate Curriculum:** OASOC held Speaker Club graduate programs for consumers who successfully completed Public Speaking curriculum to enhance and practice on their public speaking skills.
- **OA MMSE/MoCA:** The purpose of this training is to provide an overview of cognitive screening tool(s) using The Mini Mental State Exam (MMSE)/MoCA.
- **Outreach and Engagement Strategies:** OASOC conducted training workshop to examine outreach and engagement strategies with an emphasis on Older Adult UREP populations.
- **Interpersonal Psychotherapy Training (IPT): IPT** This course is designed to instruct participants in the theory and practice of Interpersonal Psychotherapy (IPT). In addition:
  (1) 10 bi-weekly 1-hour telephone consultation calls for up to 8 clinicians per cohort for a total of 5 cohorts
  (2) Review of 2 portfolios for each of 20 clinicians; 40 audio recording reviews of IPT sessions of participants.
  (3) After completion of audio recording reviews, clinician is eligible for booster training.
- **Co-Morbidity Training:** This training introduced providers to the prevalence of prescription medication misuse and abuse in older adults
- **14th Annual Gero-Psychiatric Breakfast:** L.A. County Department of Mental Health in collaboration with L.A. Care, and Health Net, provided the 14th Annual Geropsychiatry Breakfast a free continuing medical education activity for primary care physicians and psychiatrists focusing on adult behavioral health.
- **Problem Solving Therapy (PST):** PST training included a brief intervention approach that is evidence-based for those experiencing mild to moderate depression and anxiety.
- **Screening, Brief Intervention, and Referral to Treatment for Older Adult Clients (SBIRT):** SBIRT was a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with co-occurring substance use disorders and those at risk of developing these disorders.

- **Grief & Loss:** The purpose of this workshop was to gain an understanding of the great variety of ways individuals grieve the loss of a loved one.
- **Creating Safe Spaces for Lesbian, Gay, Bisexual and Transgender Seniors:** The training included positive aspects of LGBT aging as well. Examples include: Continual development of social support networks and how to foster that development, and benefits of non-adherence to societal gender roles and crisis competence.
- **IPT Booster Training:** Booster Training (8.0 hr) (Advanced Community Training Course) for participants.
- **Hoarding Forum:** The primary goal of this training is to provide tools and strategies for the treatment of compulsive hoarding.

Significant changes for FY 2016-17

OASOC in FY 2016-2017 will continue to provide more culturally competent and evidenced based practices for Older Adults service providers. We are focusing on training our staff to address justice-involved Older Adult clients, as well as implementing a grief & loss support group curriculum. Additionally we continue with our suicide prevention trainings of which OASOC is the lead for the other age groups, hoarding forum, and OACT-MD.

Transitional Age Youth Full Service Partnership: T-01

Total Unique Clients Served: 1,893

TAY FSP Program

Unique Clients Served: 1,772

Cost: $ 19,933,844

Average Cost per Client: $ 11,249

Slots Allocated: 1,300 (as of 6/30/2015)

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

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

Achievements/Highlights in FY 2014-15

- Expanded capacity to provide FSP services to TAY in Independent Living Program (ILP). Developed and maintained tracking logs of clients in the three ILPs to monitor the demand/need for services and gain feedback of program's effectiveness. The ILP-FSP program had proven to be successful in meeting the youth's need for higher level of care.
- Finalized SEI to expand slot capacity in SA 1 TAY FSP, allowing for opportunity to meet the dire need for intensive level of services in this highly impacted service area.
- The TAY Division finalized the analysis of the Telephonic Client Satisfaction Survey of TAY FSP clients. The results highlighted methods that contribute to effective service delivery and shed light on areas in need of improvement. Overall, the overwhelming majority of TAY surveyed (84%) indicated being satisfied with FSP services.
- Started implementation of the Service Request Tracking System (SRTS), which allows for the monitoring/tracking of the time it takes for the referral to be processed at each step of the authorization. This gives an indication of the timeliness of the process.

Significant changes for FY 2016-17

- Continue to enhance efforts to outreach and engage target populations and communities in effort to connect them with FSP services as appropriate.
- Arrange for site visits at designated FSP agencies for providing an oversight of service delivery.
- Conduct an updated/revised Telephonic Client Satisfaction Survey to gain insight on program improvement and effectiveness.

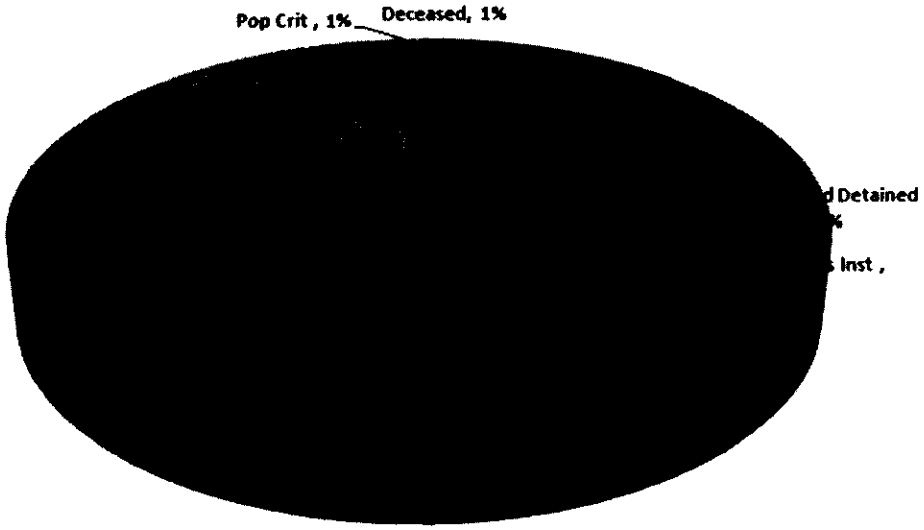
Community Services and Supports Program Expansion

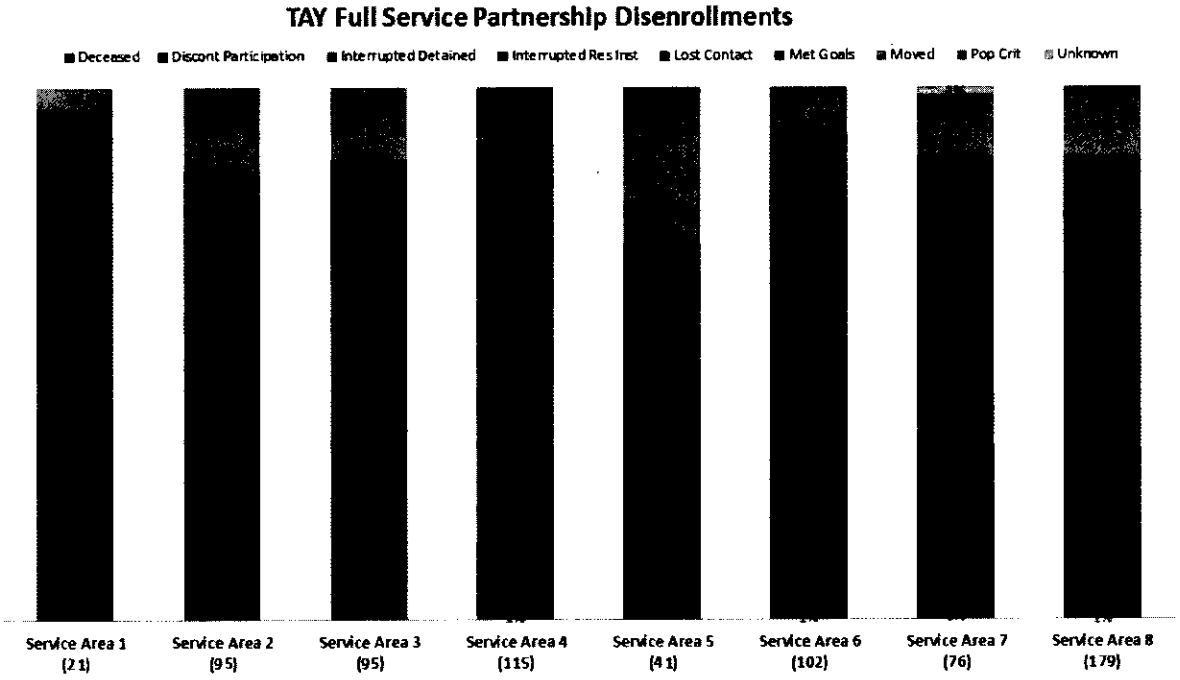
(See Appendix I for a complete proposal description)

Proposal	Implementation Date
Expand the number of slots for the TAY Full Service Partnership Program	2014

*Disenrollment**

- Total of 740 disenrollments
- 36% of disenrolled clients met their goals

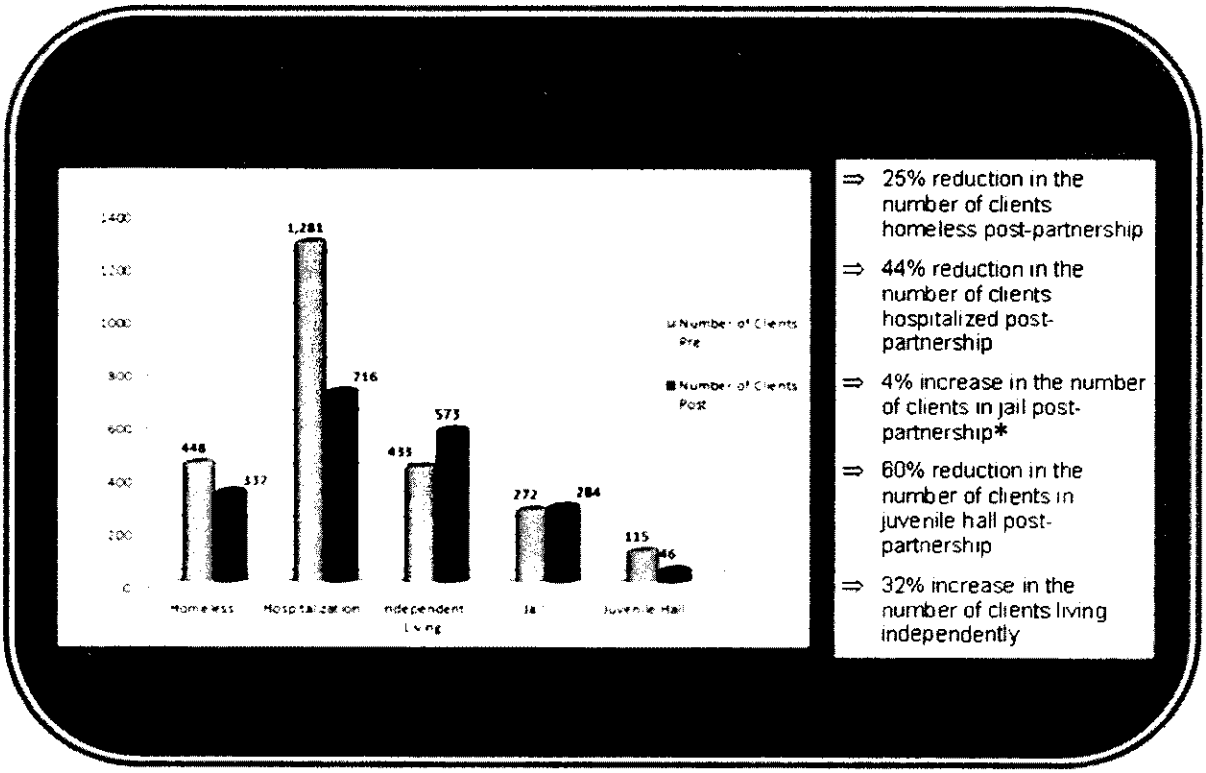




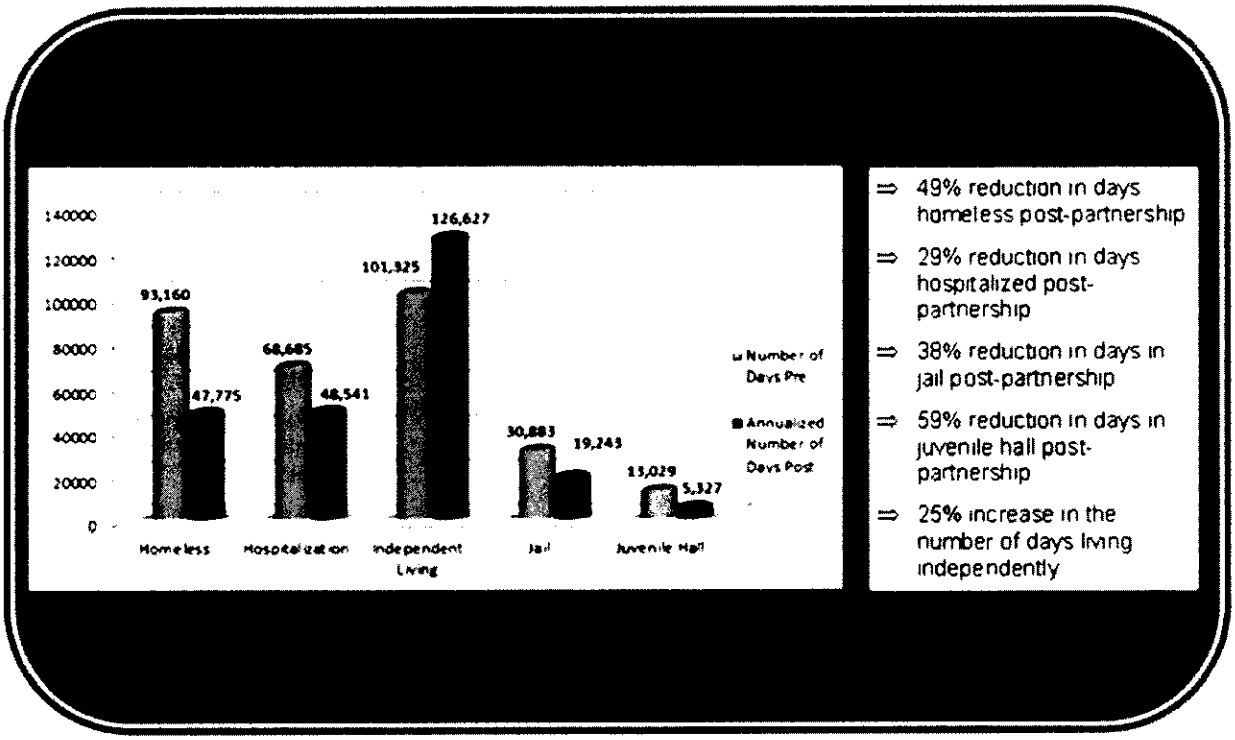
*Data extracted from the FSP authorization application on February 3, 2016 and represents disenrollments for Fiscal Year 2014-15. See Appendix II for an explanation of disenrollment reasons.

Outcomes

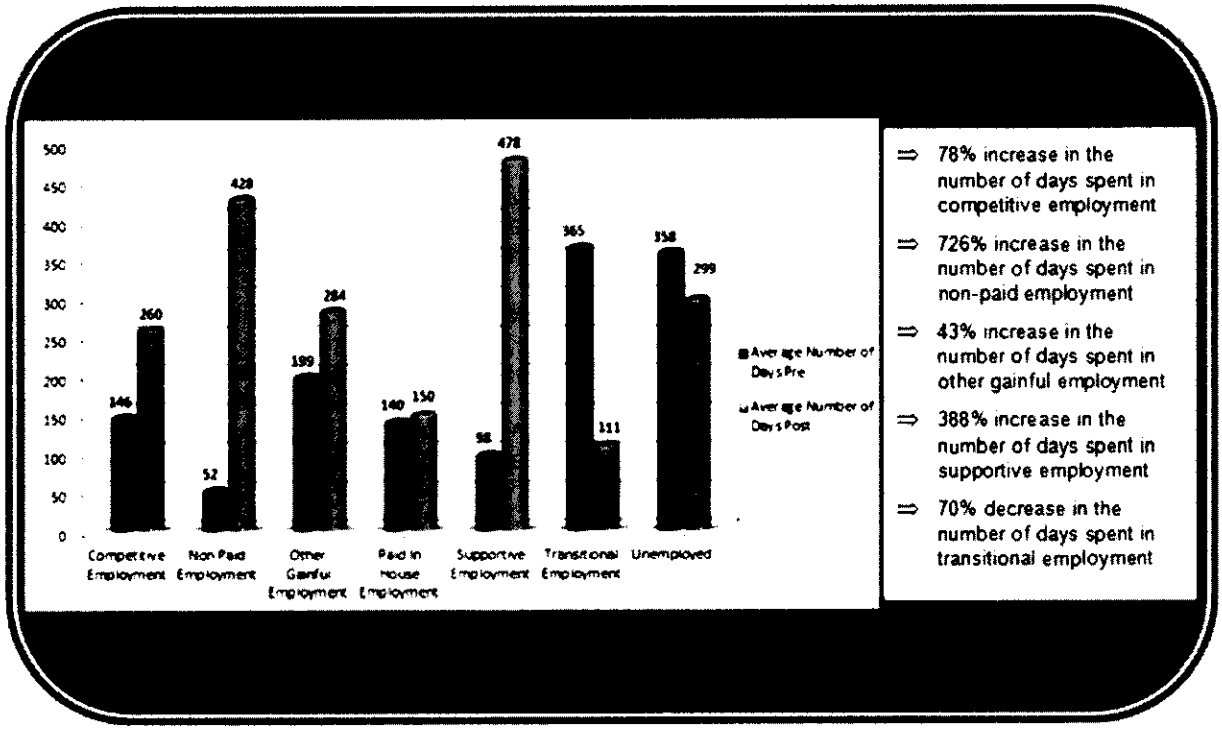
Client's baselines are excluded when data does not meet reporting requirements. See Appendix III for a list of reasons data does not meet reporting standards.

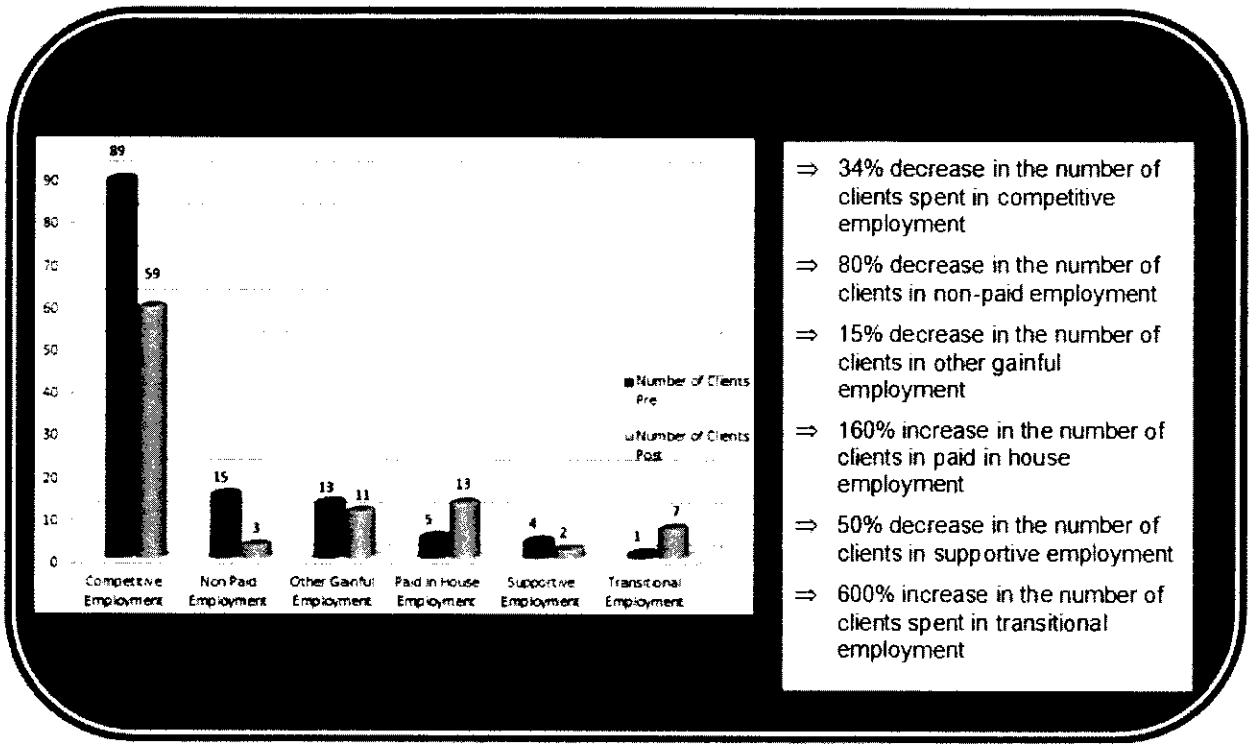


* There was a 4% increase in the number of clients incarcerated post-partnership. Data indicates 272 TAY FSP clients (approximately 7% of the TAY baselines included) reported being in jail 365 days prior to partnership and 284 TAY FSP clients (approximately 7% of the TAY baselines included) after partnership was established.



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





TAY Wraparound FSP Program

Unique Clients Served: 123

Cost: $ 1,092,626

Average Cost per Client: $ 8,883

Slots Allocated: 226

The Wraparound FSP Transition Age Youth (TAY) program is an intensive mental health program providing Wraparound services and support targeting youths between ages 16-25, with serious emotional disturbance. The Department of Mental Health has allocated 226 FSP treatment slots for Wraparound services.

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

Wraparound also provides access to an array of mental health services including individual psychotherapy, intensive-care coordination, and intensive home-based services. In addition, 24/7 crisis intervention is

provided. Service delivery objectives are to assist youth in returning home and successfully remaining home, preventing out of home care/placement, symptom reduction, and overall improvement of family functioning, successful school adjustment, and prevention of psychiatric hospitalizations.

Achievements/Highlights in FY 2014-15

Caregiver Satisfaction: The Wraparound program evaluates how satisfied the participants are with the program. During FY 2014-15, the Wraparound Program Administration conducted telephone survey interviews to assess the level of satisfaction reported by a random sample of caregivers of children participating in the Wraparound program. The parent satisfaction surveys were a part of our Wraparound annual technical reviews of FSP providers. The satisfaction surveys consisted of items that measured both fidelity to the Wraparound Program, and client satisfaction with various dimensions of that program. Of the 109 respondents, thirty two parents/caregivers with a child in Wraparound FSP were interviewed. Their responses to the satisfaction questions showed consistently high levels of caregiver satisfaction.

ICC/IHB Implementation: During FY 2014-15, the Wraparound Program Administration launched the countywide use of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) as important steps toward implementing the Shared Core Practice Model (CPM). As of January, 2014, DMH expanded the use of the ICC and IHBS services to make these available to FSP program participants. In FY 2014-15, the Los Angeles Training Consortium, in partnership with DMH, provided countywide coaching and training on the CPM (which incorporates ICC-IHBS services) to 13 out of 14 Wraparound FSP providers.

Elimination of Wraparound Tiers: At the end of FY 2014-15, the two-tier Wraparound administrative structure was eliminated. One ramification of eliminating the Tiers is that the pool of potential clients who may be referred to a Wraparound FSP Child, or FSP TAY programs will be enlarged. Eliminating Wraparound Tiers has contributed to a broadening of the range of clients referred to Wraparound FSP programs. For example, clients with needs for more intensive mental health interventions, are now included among all of our FSP program recipients.

Unmet Needs: During FY 2014-15, the Child Welfare Division launched countywide trainings based on a model of "underlying needs" that emphasizes the relationship between stressors (including traumatic stressors); their impact on the coping process; and the resulting unmet needs for a variety of resources that may have protective effects on traumatized children. All of the Wraparound FSP program providers have attended or have had an opportunity to attend an unmet needs training. Completing the training and assessing the clients unmet needs accurately is likely to improve the plan of care, and treatment interventions developed by CFT members.

Achievements/Highlights in FY 2015-16

Caregiver Satisfaction: Out of 14 FSP providers, 5 of them have already expanded sites across the County, increasing Wraparound FSP sites by 9. It is expected that once all these sites are open and servicing clients, there will be a total of 32 Wraparound FSP sites across the County.

New Monthly Activity Tracking Report: During FY 15-16, the Wraparound Program Administration designed and distributed a new Wraparound Child FSP Activity Tracking Report, and a Wraparound TAY Activity Tracking Report. Both Activity Tracking Reports are completed by program staff, and provide selected demographics and information on Wraparound FSP slot utilization. Information collected using these forms is enhancing the capability of the Wraparound Program Administration to monitor and track the slot capacity of each Wraparound FSP provider. Finally, these forms assist in the monitoring of client outcomes.

Enhanced OMA Tracking Process: Client information collected on the Activity Tracking Report forms is subsequently entered into a new Wraparound Tracking spreadsheet also developed in FY 15-16. The data entered in this spreadsheet is then used to monitor and to carry out the timely completion of clients' Outcome Measures Application (OMA) forms as required by the MHSA.

Significant changes for FY 2016-17

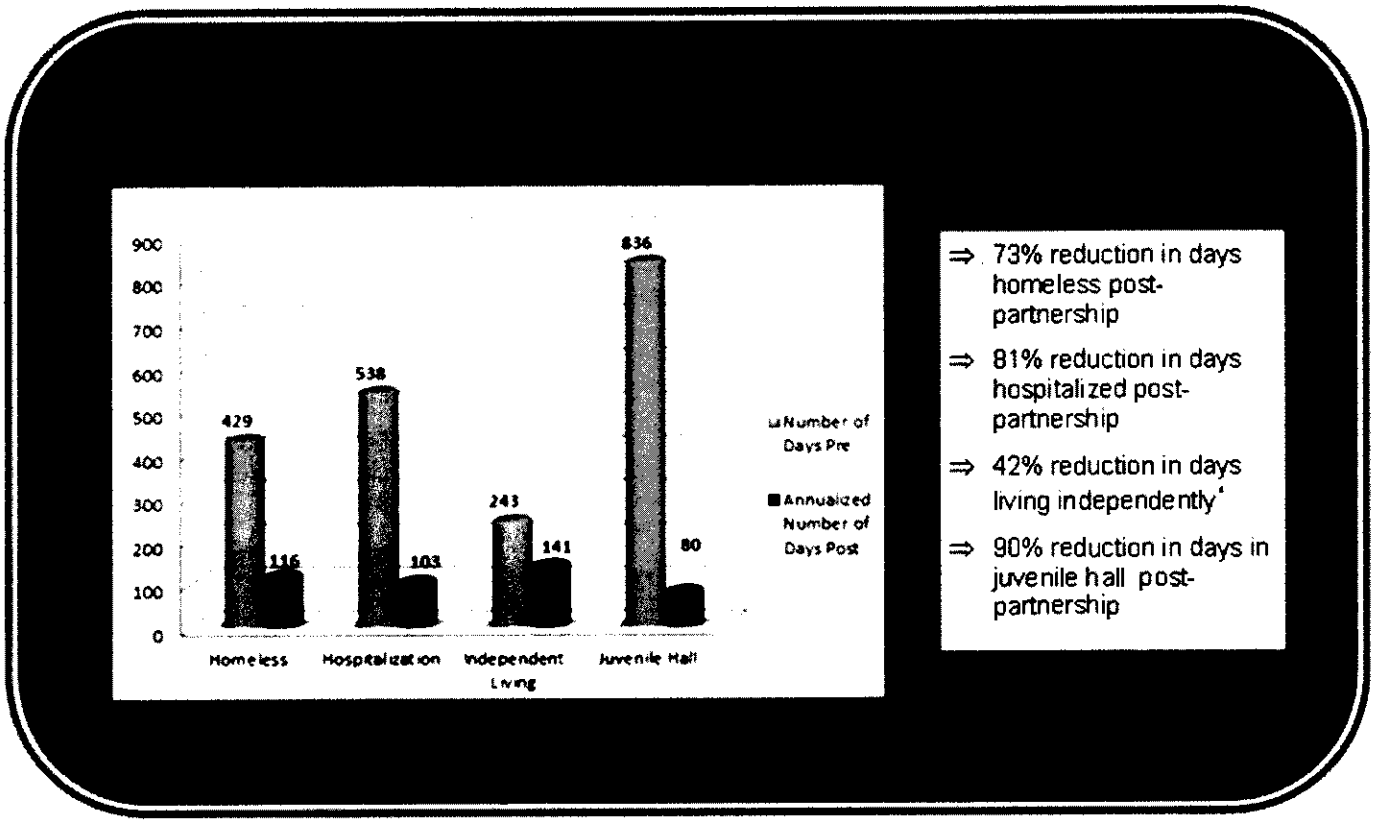
For the Wraparound Child and TAY FSP programs, many developments are anticipated as DMH takes responsibility for the contract administration of the Wraparound program. Expansion of new Wraparound sites has changed the geographic location of several Wraparound FSP programs which allows us to more effectively access the Wraparound FSP focal populations.

Continued use of the monthly Wraparound FSP Tracking Report and the Wraparound FSP Tracking spreadsheet implemented in FY 2015-16, will facilitate more effective monitoring and, hence more stringent utilization of slots for clients in different age-ranges.

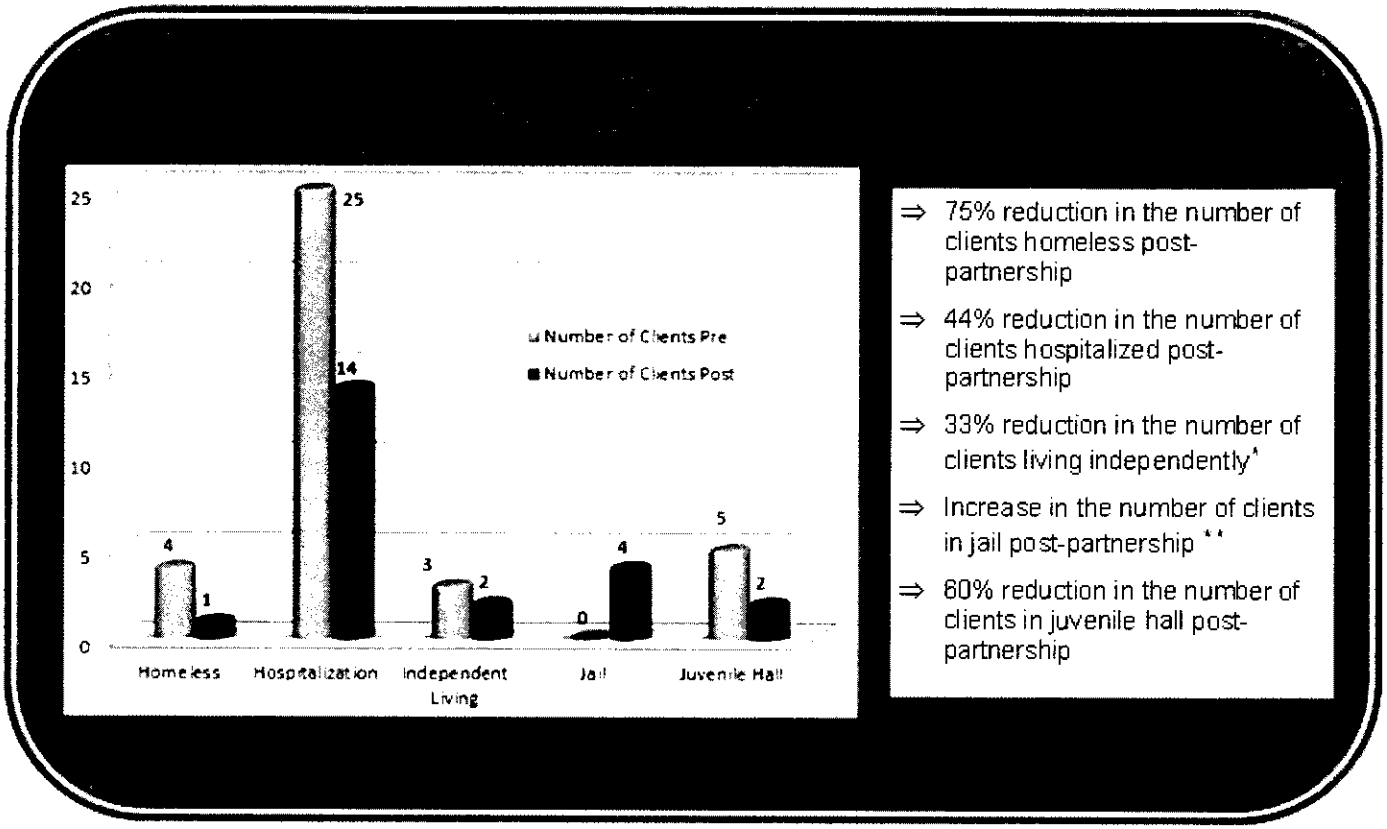
Previous client and caregiver satisfaction surveys of Wraparound FSP have been administered by Wraparound Program Administration staff. In FY 2016-17, additional satisfaction surveys will be implemented by Service Area staff. This will allow the Wraparound Program Administration to evaluate the quality of services even more effectively because we anticipate greater numbers of completed surveys.

Outcomes

Baselines are excluded when data does not meet reporting requirements. See Appendix III for a list of reasons data does not meet reporting standards.



* There was a 42% reduction in the number of days TAY Wraparound FSP clients spent living independently post-partnership. Data indicates 243 days (0.01% of total tenure) was reported spent living independently 365 days prior to partnership and 141 days (0.01% of total tenure) were reported spent in living independently after partnership was established for TAY Wraparound FSP clients. Total tenure is 29,837 days for all included baselines.



* There was a 33% reduction in the number of clients living independently post-partnership. Data indicates three TAY Wraparound FSP clients (approximately .01% of the TAY Wraparound baselines included) reported living independently 365 days prior to partnership and two TAY Wraparound clients (approximately .01% of the TAY Wraparound baselines included) after partnership was established.

** There was an increase in the number of clients incarcerated post-partnership. Data indicates zero (0) TAY Wraparound FSP clients reported being in jail 365 days prior to partnership and four TAY Wraparound clients (approximately .01% of the TAY Wraparound baselines included) after partnership was established.

Transitional Age Youth Drop - In Centers: T-02

Client Contacts: 935

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

Achievements/Highlights in FY 2014-15

- Implemented the third MHSA funded TAY Drop-In Center in Santa Monica – Daniel's Place (Step-Up on Second Street, Inc.).
- Drop-in Center consumers gained opportunities to be linked with mental health services, substance treatment centers, and connected with employment opportunities thru job fairs.

Significant changes for FY 2016-17

- Plan to have drop-in centers countywide increasing the number of unique clients being served

Community Services and Supports Program Expansion

(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date (Estimated)
TAY Drop-In Center expansion	The Orientation for evaluators and facilitators was held on 1/14/16. Proposals have been reviewed, evaluated, and scored. Contracts Division is reviewing scoring.	June 2016

Transitional Age Youth Housing Services: T-03

Client Contacts: 847

Housing related systems development investments for the TAY population include:

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

Achievements/Highlights in FY 2014-15

- A new shelter was implemented, called Women Shelter of Long Beach, a domestic violence shelter serving men, women and transgender individuals.
- EESP enhanced the quality of services to TAY by increasing the frequency of the life skills counseling and healthy living groups.

Significant changes for FY 2016-17

DMH plans to implement additional EESP shelters to more service areas to meet the growing need of the homeless TAY population struggling with mental illness.

Transitional Age Youth Probation Camps: T-04

Client Contacts: 1,415

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

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

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

. Achievements/Highlights in FY 2014-15

Within the Probation Camp system, a Multi-Disciplinary Team (MDT) process has been fully developed and successfully implemented that includes, Probation, DMH, JCHS, LACOE, parents/caregivers, outside school districts, among other interested parties. An initial MDT in conducted within 10 days of arrival at camp and develops a joint case plan for the youth, along with framing aftercare plans. A transition MDT is conducted 30-45 days prior to release and refines the Aftercare Plan for the youth. As a result, youth leave the Probation Camps with well-developed plans for returning to the community. The field probation officer participates in these MDTs so that there is a smooth coordinated plan for return.

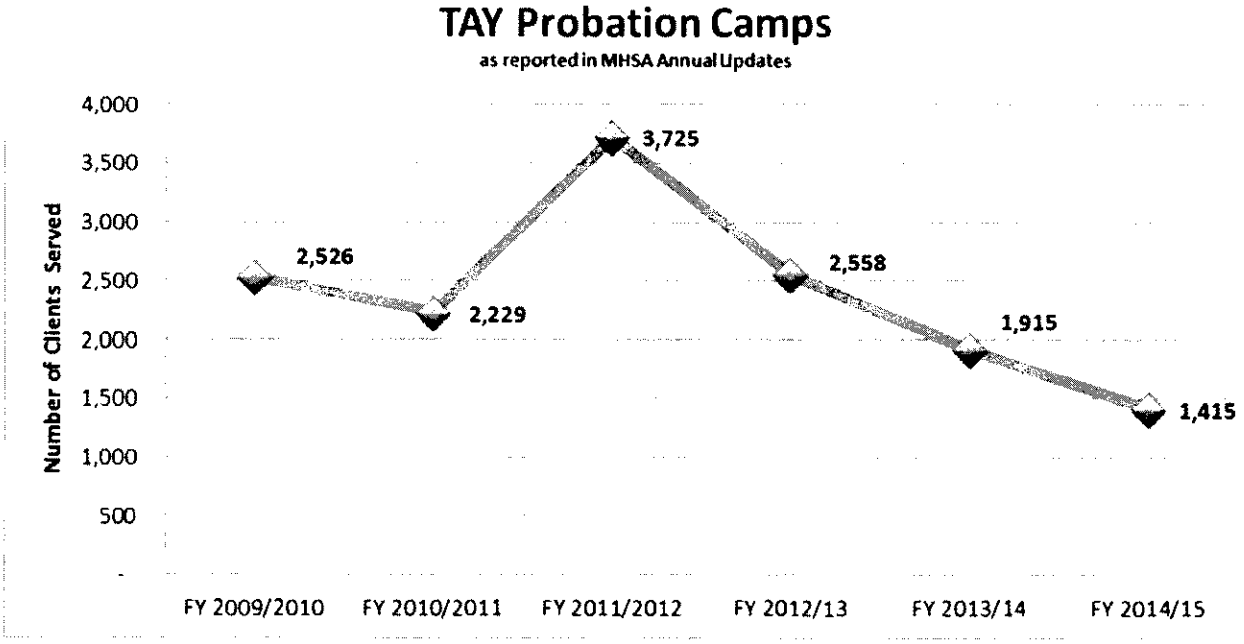
DMH and Probation also co-facilitate evidence based groups within the camps. This helps to ensure a consistent therapeutic approach and clear expectations for youth. DMH also facilitates 5 or 10 week evidence-based substance abuse/co-occurring disorder groups for the vast majority of youth in camp. In addition, MHSA funded DMH clinic drivers bring families to the camps to participate in MDTs, Individual Education Plans and family therapy. This helps to preserve the connection to family during the time that a youth is in camp. .

Significant changes for FY 2016-17

Planning is underway for the new facility currently under construction in Malibu to replace Camp Kilpatrick. Numerous workgroups are developing plans for the programming, staffing, training, recruitment, education and research/outcomes for the new LA model which will be implemented in the new facility. The state of the art building will enable all the positive changes in the camps over the past few years to develop and solidify even further. The facility is scheduled to be completed in April 2017.

The Probation Camps track a number of important outcomes, including the percentage of youth treated and the number of youth linked to services upon release. Adherence measures are used for the evidence-based practices and pre-post tests are used to determine the effectiveness of the substance abuse groups.

Perhaps the most telling outcome is the tremendous reduction in the overall population of the Probation Camps over the past few years. This reflects that youth are able to better reintegrate into their families and communities when they return.



Transitional Age Youth Field Capable Clinical Services: T-05

Unique Clients Served: 2,766
Cost: $12,953,911
Average Cost per Client: $4,683

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.

Achievements/Highlights in FY 2014-15

- FCCS has been utilized to a great extent in assisting TAY who had graduated from an FSP program and requires a lower level of care. It has bridged the gap between the intensive nature of an FSP program and a less intensive level of service offered by an outpatient treatment program.
- Expanded capacity to provide FCCS services to TAY in Independent Living Program (ILP). Developed and maintained tracking logs of clients in the three ILPs to monitor the need for services and gain feedback of program's effectiveness. The ILP-FCCS program had proven to be successful in meeting the youth's need for intensive mental health care.
- Finalized SEI to expand slot capacity in SA 1 TAY FCCS, allowing greater access for TAY to this comprehensive, intensive mental health program.
- FCCS has been of great value for its provision of services in the field or community-based settings, as TAY is often unwilling or unable to access mental health services in a traditional mental health clinic setting.

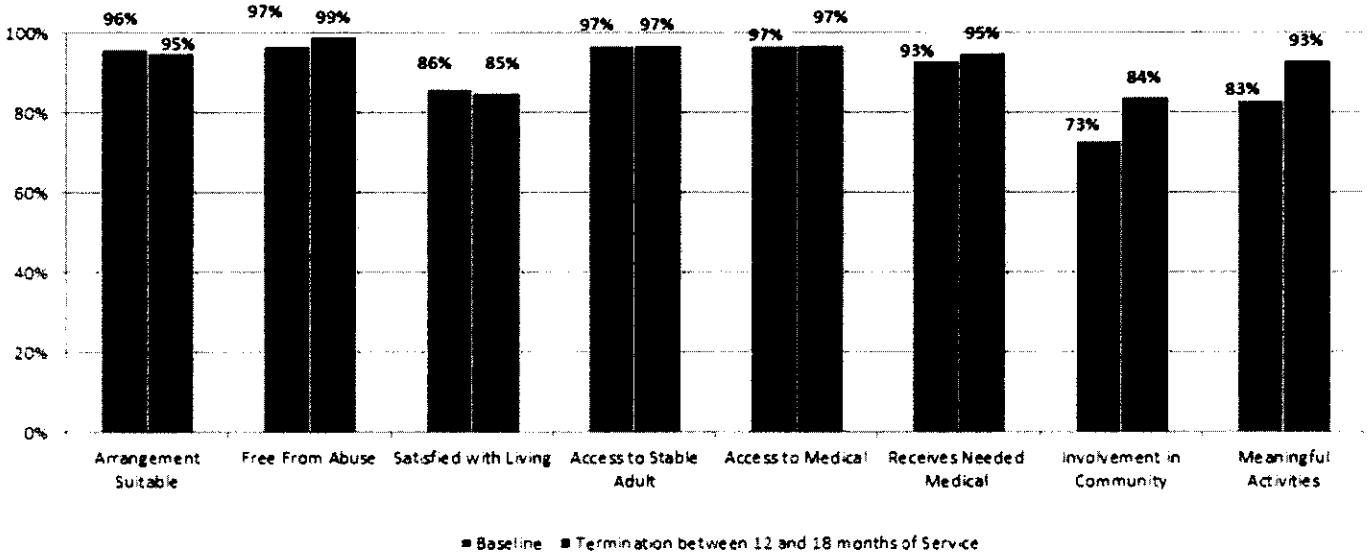
Significant changes for FY 2016-17

- The number of TAY clients receiving FCCS services will grow significantly.
- Providers will overcome the challenges of transitioning clients to less intensive services with greater access to FCCS.
- By providing continuity of care following the graduation from FSP, FCCS programs will contribute to the reduction of hospitalization, incarceration, institutionalization, and out-of-home placement.
- Through its provision of safe and adequate housing, FCCS will help in the reduction of homelessness among the TAY who are suffering from SED or SPMI.
- TAY Administration will consult on an on-going basis with providers to help bring them into compliance with regards to Outcome Measure Application error reports.

Outcomes (as of 2/10/16)

Baselines are excluded when data does not meet reporting requirements. See Appendix III for a list of reasons data does not meet reporting standards

Percent "Yes" Responses at Termintation of Services Between 12 and 18 Months N=267

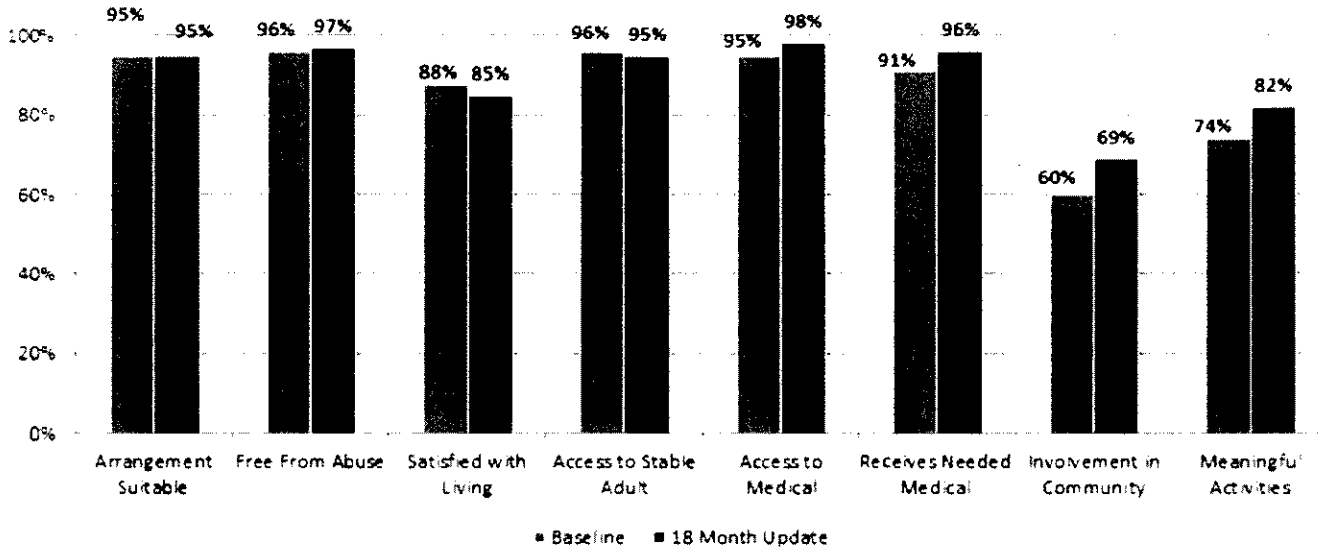


For those terminating between 12-18 months of services, TAY FCCS clients showed a positive change in the following areas:

15% increase with their involvement in the community

12% increase in their participation in meaningful activities

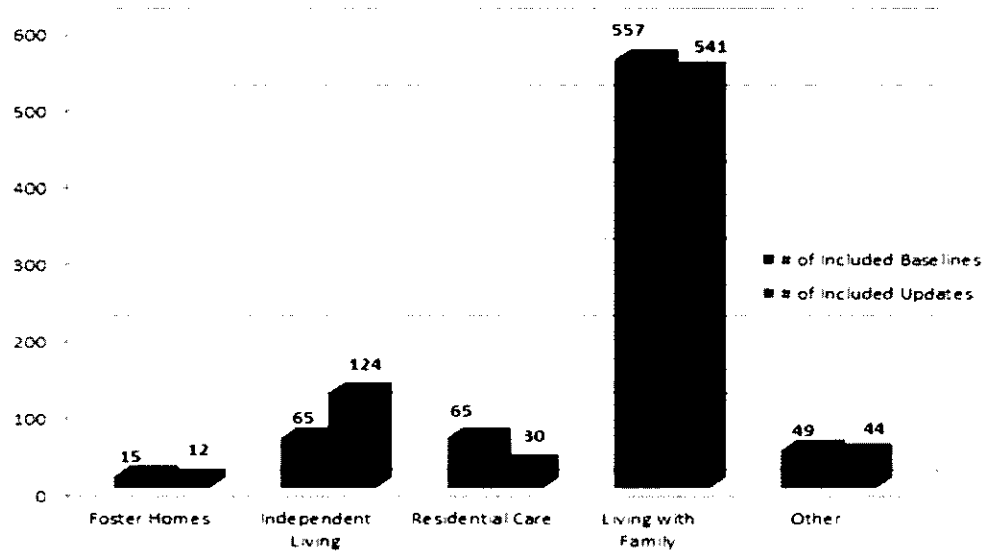
Percent "Yes" Responses at 18 Month Update
N=360



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

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

Residential Status at 18 Month Update
N=751



After 18 months of services:

- 91% increase in the number of clients living independently

Alternative Crisis Services: ACS-01

Client Contacts: 46,580

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

Achievements/Highlights in FY 2014-15

In October 2014, a new psychiatric Urgent Care Center (UCC) opened on the campus of Martin Luther King Community Hospital with Exodus Foundation as the operator. In FY 14-15, there were three UCCs operational: Exodus Recovery, Inc. operating the Eastside UCC; DMH operating the Olive View UCC; and Telecare Corporation operating the Mental Health UCC. These three UCCs served a total of 26,338 clients in FY 14-15.

Significant changes for FY 2016-17

With the implementation of Senate Bill (SB) 82, DMH is anticipating the opening of three new UCCs to be located in the Service Areas 1, 3, and 8. Each new UCC will be able to serve 12 adults (ages 18-54) and six adolescents (ages 12-17) and a total of up to 54 individuals a day.

Countywide Resource Management (CRM):

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

Residential and Bridging Program:

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

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

Achievements/Highlights in FY 2014-15

In FY14-15, CRM hired a total of six staff. Four CRM staff was hired to implement the Investment in Mental Health Wellness Act grant that will use MHSA to fund staff to fully implement three psychiatric Urgent Care Center (UCC) and 35 Crisis Residential Treatment Programs (CRTPs) proposed under the grant.

DMH developed Requests for Proposals for the UCC and CRTPs and collaborated with County Counsel and the Chief Executive Office, Real Estate Division to develop new County lease structures that would allow the county to fulfill the requirements of the grant. In addition, CRM hired two (2) staff to assist with the implementation of Laura's Law/Assisted Outpatient Treatment. In Los Angeles County, the Laura's Law Program is named Assisted Outpatient Treatment. DMH has contracted with 18 Full Service Partnership agencies and three (3) IMD Step-down programs to deliver the array of integrated mental health services required to individuals mandated for AOT under Laura's Law. Fully implemented, the AOT-LA program will provide an additional 300 FSP slots and 60 IMD Step-down beds.

In FY 14-15, CRM staff facilitated transition of over 16,000 clients between various levels of care. CRM also conducted assessments, treatment planning, placement at County psychiatric emergency rooms in order to facilitate linkage to intensive residential settings as swiftly as possible.

Significant changes for FY 2016-17

The CRM staff will continue to develop programs to provide enhanced coordination, linkage and integration of inpatient and residential services throughout the system thereby enhancing the goals of the MHSA by reducing re-hospitalization, incarceration, and the need for long-term institutional care, while increasing the potential for successful community living and recovery. CRM staff will develop additional resources for justice involved individuals; develop an alternative to state hospitals; and implements three new psychiatric Urgent Care Centers and 35 Crisis Residential Treatment Programs as part of the Investment in Mental Health Wellness Act.

Community Services and Supports Program Expansion

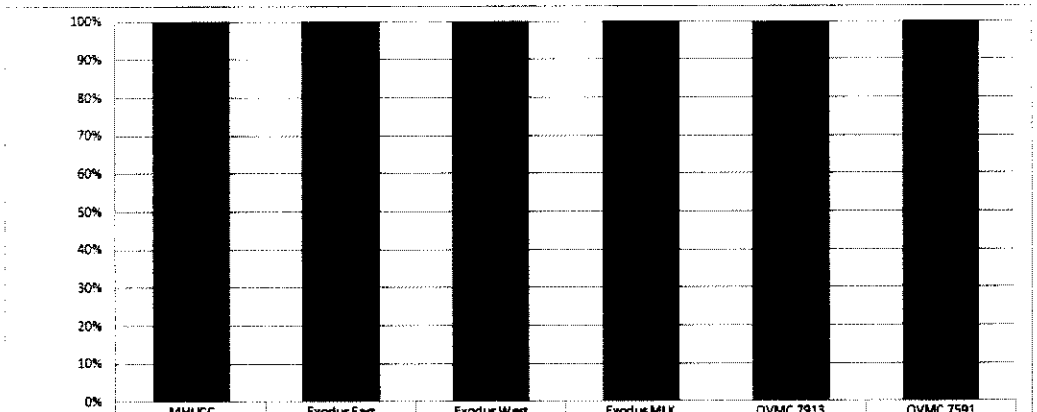
(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date (Estimated)
Service Component of SB82 California Health Facilities Financing Authority (CHFFA) Grant: Urgent Care Centers, Crisis Residential Program	Crisis Residential Program (CRP): The Request for Proposal was issued February 17, 2016. A proposer's conference is scheduled for March 9th and proposals are due on March 24th. Urgent Care Centers (UCC): Proposals were reviewed. Telecare Corporation was awarded the contract for Service Area 3.	CRP: September 2016 UCC: May 2016

Outcomes

July 1, 2015 through January 31, 2016

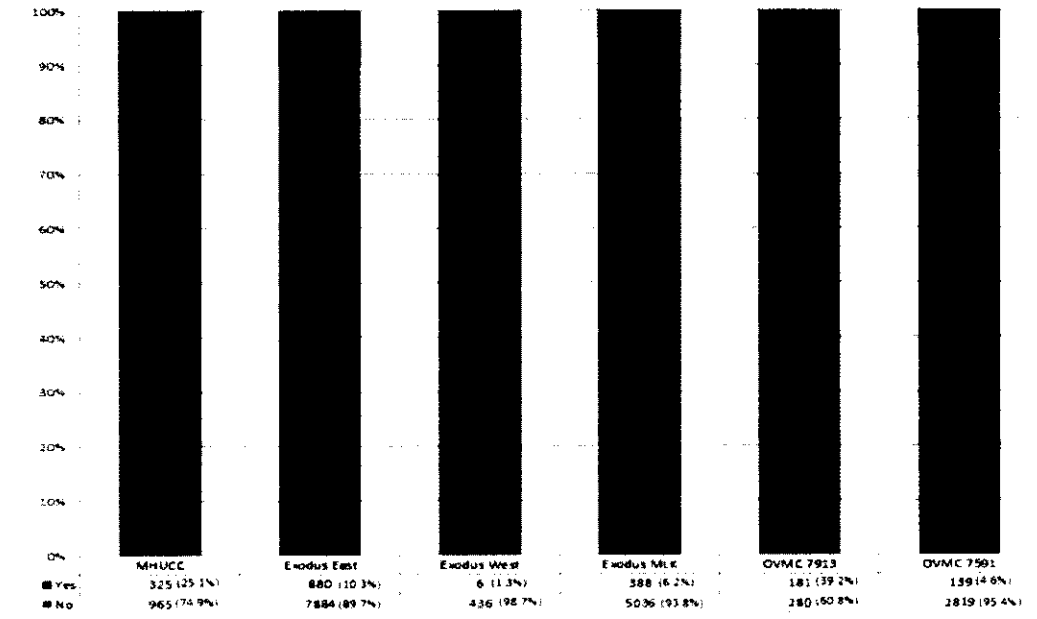
New Admissions at Urgent Care Centers (UCCs) by Age Category



	MHUCC	Exodus East	Exodus West	Exodus MLK	OVMC 7913	OVMC 7591
Unknown	0	0	0	0	1	1
Older Adult	54	588	17	284	14	143
Adult	1236	7966	419	5020	445	2799
TAY	0	319	4	749	1	15
Child	0	91	2	171	0	0

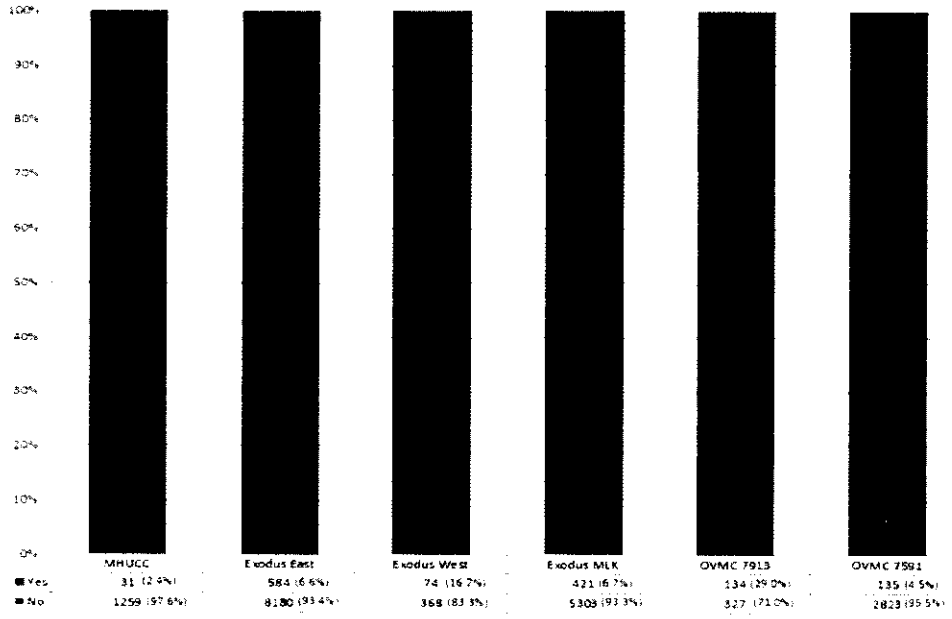
Note that OVMC has two components: The Crisis Stabilization Unit (7913) and the Outpatient UCC (7591). Data from the CSU are from Sept. 21, 2015 through January 31, 2016 only.

New Admissions at UCCs Who Were Homeless upon Admission



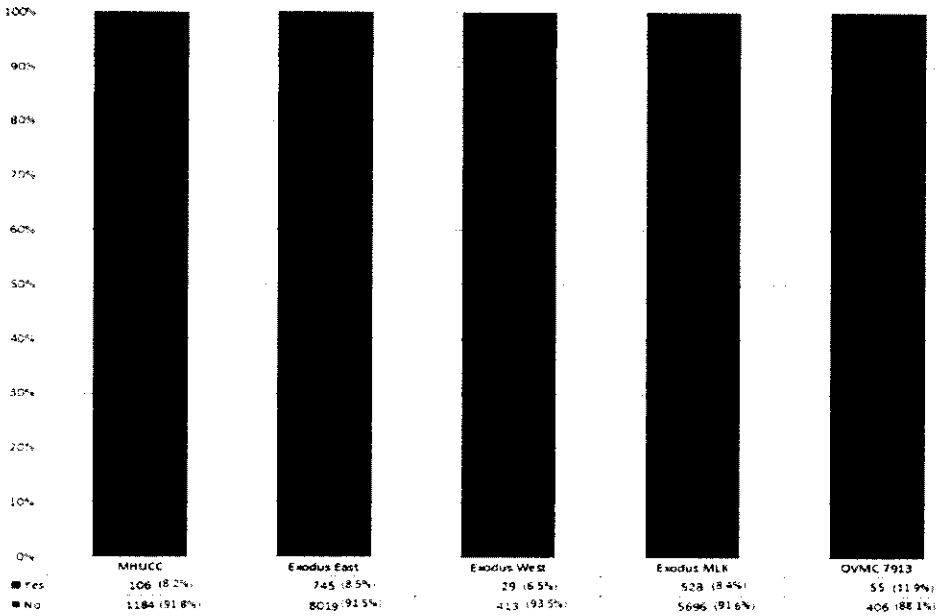
Note that OVMC has two components: The Crisis Stabilization Unit (7913)) and the Outpatient UCC (7951). Data from the CSU are from Sept. 21, 2015 through January 31, 2016 only.

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



Note that OVMC has two components: The Crisis Stabilization Unit (7913)) and the Outpatient UCC (7951). Data from the CSU are from Sept. 21, 2015 through January 31, 2016 only.

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



Note that data from the OVMC Crisis Stabilization Unit (CSU) are from Sept. 21, 2015 through January 31, 2016 only.

Service Area Navigator: SN-01

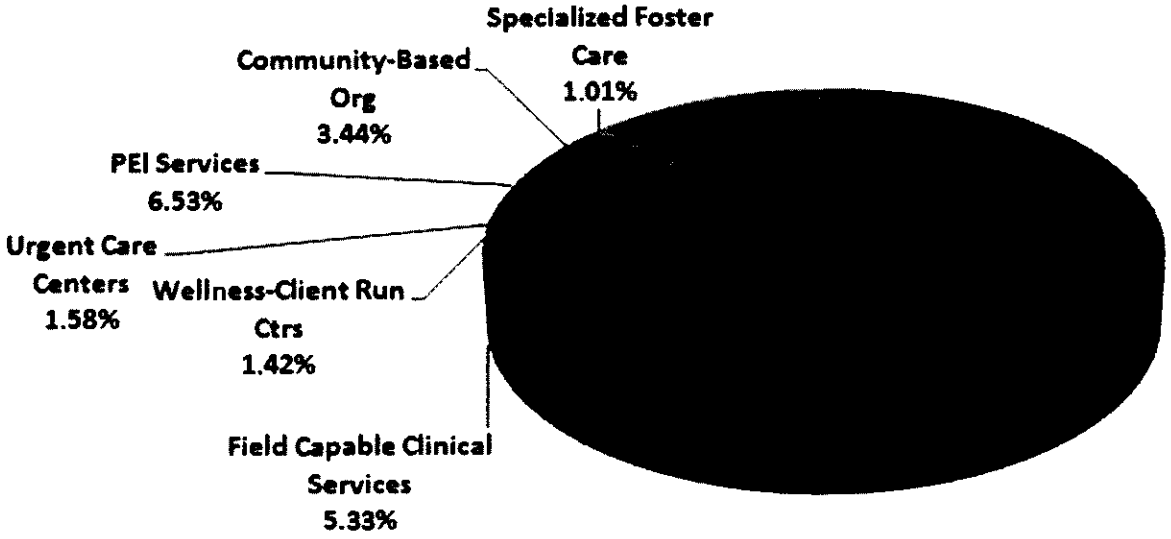
Client Contacts: 17,565

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

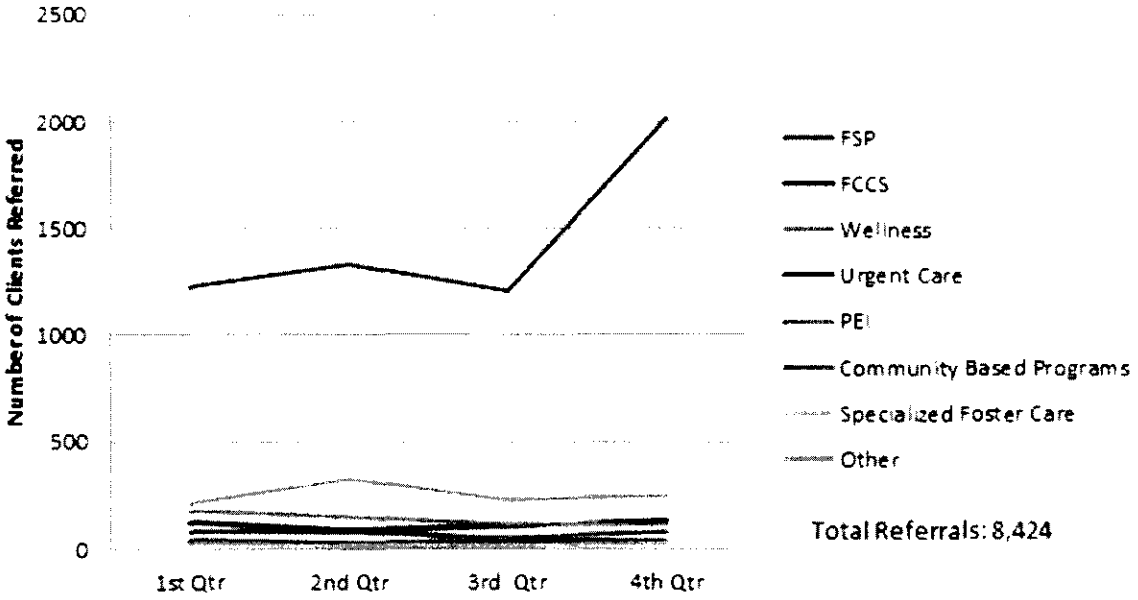
- Engaging in joint planning efforts with community partners, including community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith-based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services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

Percent of Referrals by Program Countywide FY 2014-15

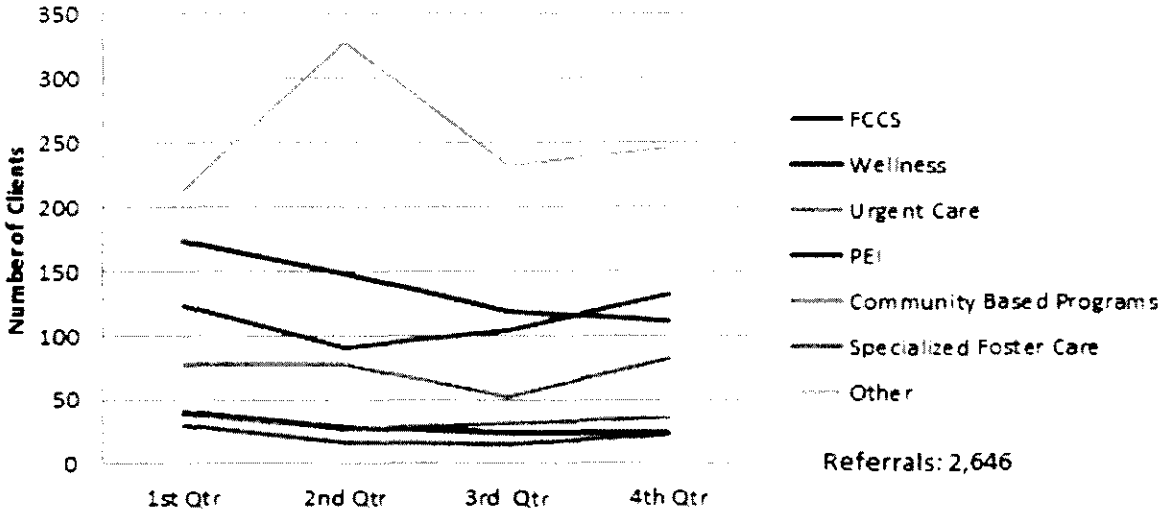
N= 8,424



Clients Referred to Services in FY 14-15

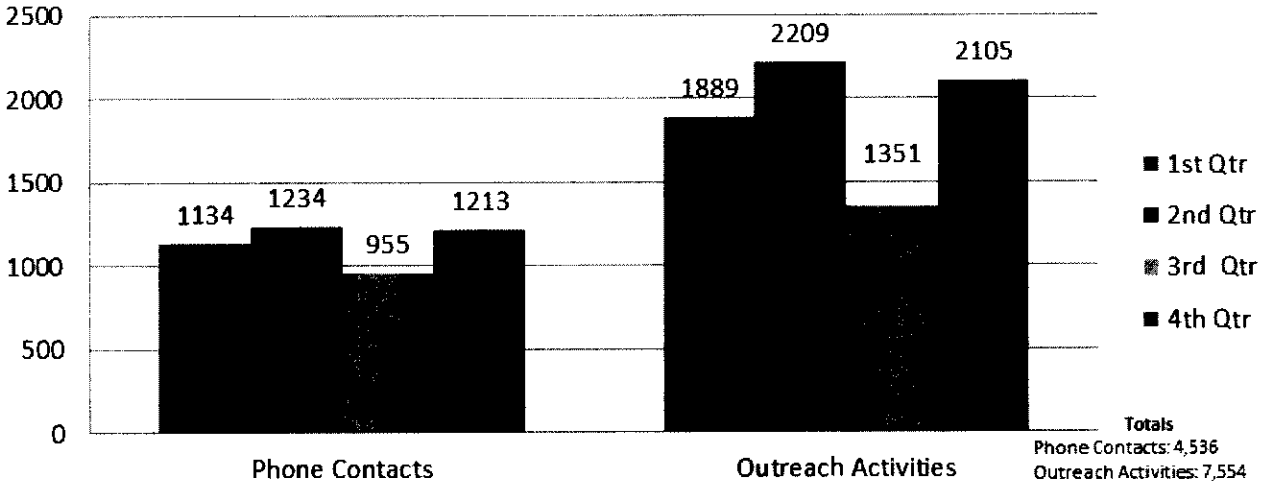


Clients Referred to Services other than FSP in FY 14-15

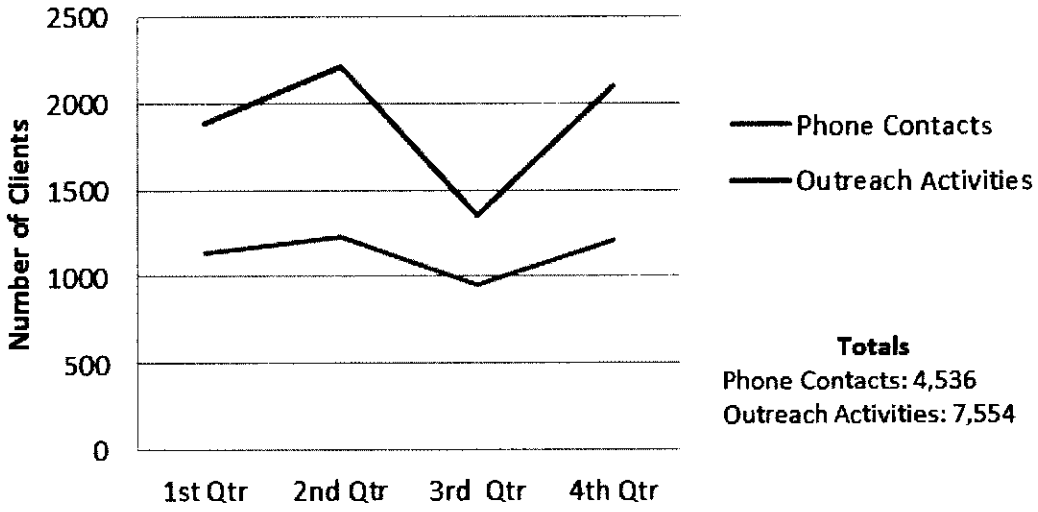


1st Quarter: July - September
2nd Quarter: October- December
3rd Quarter: January - March
4th Quarter: April - June

Phone Contacts and Outreach Activities in FY 14-15



Phone Contacts and Outreach Activities in FY 14-15



1st Quarter: July - September
2nd Quarter: October- December
3rd Quarter: January - March
4th Quarter: April - June

Planning Outreach & Engagement: POE-01

Client Contacts: 14,312

Underserved Cultural Communities (UsCC) *(formerly known as Under-Represented Ethnic Populations (UREP))*
Projects are aimed at serving unserved, underserved and inappropriately served populations with the goal of reducing racial/ethnic disparities.

Achievements/Highlights

African/African American (AAA) UsCC subcommittee

Ethiopian Community Mental Health Training and Education Project: The Ethiopian Community Mental Health Training and Education project was a joint effort of the County of Los Angeles Department of Mental Health and the African Communities Public Health Coalition to reduce the stigma of mental illness in the Ethiopian community to set a precedent of using culturally appropriate mental health education when working ethnic communities. This project educated over 200 community members of Ethiopian descent on basic mental health signs and symptoms. This project was initiated in 2011 and the implementation phase was between September 1, 2013 and June 30, 2014.

AAA Resource Mapping Project: Funds were allocated to develop a resource dictionary consisting of community resources, service providers, and agencies in South Los Angeles County where there is a large African/African American population. The third preprinting/updated version of this popular resource was released and all 6,000 printed copies were successfully distributed in SA 6 between November 2014 and March 2015.

AAA Culturally Relevant Brochures: Brochures will be developed that will describe common mental health conditions experienced in the AAA community. They will be used to educate and inform AAA communities of the benefits of utilizing mental health services and to provide referrals and contact information. The Brochures will be translated into two different African languages, Amharic and Swahili. This project was initiated in 2012 and the final implementation phase is scheduled to be completed by May 30, 2016.

AAA Community Mental Health Stigma Reduction Project: The focus of this project was to reduce the stigma of mental illness by funding agencies to provide outreach, engagement, training, education, non-traditional well activities, and to employed technological approaches specifically target three subpopulations of the AAA community. The targeted subpopulations include the LGBTQ community, the Somali community and the Pan-African Community. Over 60 community workshops, presentations, and outreach events were completed as a result of this project during the implementation process that took place between September 1, 2014 and April 1, 2015.

Sierra Leone Community Mental Health Training and Education: Sierra Leone community members will be trained as advocates and will facilitate community mental health awareness presentations to the larger community, as well as provide assistance to community members and help them cope with their losses and concerns related to the Ebola outbreak. This project was implemented on October 1, 2015 and is scheduled to be completed by May 30, 2016.

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

The American Indian/Alaska Native Mental Health Conference: The AI/AN Mental Health Conference, "Strengthening Native Voices to Build a Healthy Community," was held on November 4, 2014 and focused on identifying and building on AI/AN cultural and community resources and strengths to improve mental health outcomes. AI/AN researchers, clinicians, tribal chiefs, community leaders, veterans and youth presented an array of information related to these topics. Over 300 individuals attended this conference, which included community members. Status: completed

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

Asian Pacific Islander (API) UsCC subcommittee

API Consumer and Family Member Training and Employment Program: API consumers and family members from various API ethnic communities, service areas and age groups, were trained to become culturally competent Peer/Family Advocates and employed at mental health agencies that serve the API community. Three community presentations were conducted to identify individuals who were interested in becoming Peer Advocates. Once the potential Peer Advocates were identified, they participated in 25 two-hour mental health trainings to prepare for this role. Once trained as a Peer Advocate, they participated in an internship process and most of them successful gained employment at a DMH contracted legal entity. This project was completed on July 1, 2015.

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

Mental Health Media Campaign for the Russian and Armenian Community: A Public Service Announcement (PSA) focused on mental health, substance abuse and domestic violence awareness was developed and aired on different local Russian and Armenian TV stations. A total of 4 Russian and 8 Armenian PSAs were aired. As a result of this project, Los Angeles County Department of Mental Health ACCESS Hotline reported that there was an increase in the number of Armenian calls for August 2014 (65 calls), September 2014 (56 calls), and October 2014 (38 calls) compared to less than 10 calls per month between January 1, 2014 to July 31, 2014. This project was implemented on August 4, 2014 and was successfully completed on October 31, 2014.

Mental Health Radio Talk Shows for the Farsi-Speaking Community: Mental health radio talk shows were developed and aired on a local Farsi-speaking radio station and included mental health topics, such as common diagnoses, acculturation issues and parenting issues. A total of 22 mental health radio shows aired every Sunday from 2pm – 3pm on a local Farsi speaking radio station, KRIN 670 AM RADIOIRANIAN. This project was implemented on June 7, 2015 and was successfully completed on November 1, 2015. KRIN was able to assess the great success of the programs from the phone calls received by KIRN listeners, as well as the increase in calls and attendance in different programs that were offered through LACDMH participants. According to the radio station, the programs which included topics generally considered taboo within the community, such as, LGBTQ, domestic violence, chronic mental health illness within the family, and addiction, brought with them a greater response when aired. This clearly shows the need for discussion of these subjects as much as possible.

Latino UsCC subcommittee

Promotoras de Salud Research Project: This research project measured the effectiveness of the Promotoras Project Model (PPM) as an outreach and engagement strategy aimed at Latinos. The results of this study suggested the PPM helps reduce negative outcomes associated with mental disorders. It does so by improving access to mental health services, reducing the stigma associated with mental disorders and linking people to mental health resources. As a next step, the Latino UsCC subcommittee is in the process of completing the PEI application to place the PPM as a "Promising Practice" model when conducting mental health Outreach and education for the Latino community. This projected was completed on July 1, 2015.

Health Neighborhoods Mental Health Awareness Outreach Campaign: This project will include the dissemination of promotional items, which will include mental health information and resources to unserved Latino communities

Latino Media Outreach Campaign: The media outreach campaign consisted of Advertisements (Ads) and PSAs that aired on the local Spanish-speaking television and radio stations to increase awareness of mental health issues and community resources. The television and radio commercials aired on a daily basis between December 10, 2015 and January 3, 2016 on the local Spanish stations. The Ads aired on KMEX on television and KLVE-FM on the radio. The KMEX report shows that the original estimated numbered of Spanish-speaking adults over the age of 18 in the Los Angeles market to be reached was 14.4% and the final number reached was 17.9%. The KLVE-FM report shows 36.4% of Spanish-speaking adults over the age of 18 in the Los Angeles market were reached. This project was implemented on October 1, 2015 and was successfully completed by January 3, 2016.

Projects in Progress

African/African American (AAA) UsCC subcommittee

Black Male Mental Health Awareness Campaign: The campaign will outreach to black males ages 16 and older. Local Black males will be outreached and educated on mental health issues and available community resources. Community presentations and focus groups will be conducted using culturally relevant mental health outreach and engagement strategies. Status: development process

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

American Indian/Alaska Native Outreach and Engagement Media Campaign: Two television and radio advertisements (Ads) were developed and aired on the local television and radio stations to outreach and educate the AI/AN community regarding mental health issues and services. This project was implemented on October 1, 2015 and was successfully completed by January 3, 2016. The Ads aired on KABC-TV on television and KNX 10.70 on the radio. The KABC-TV report shows an achieved rating of 29.1, which means 29.1 of adults over the age of 18 in the Los Angeles market, were reached. The KNX-AM report shows a gross rating point (GRP) of 14.4, which means the radio spots reached approximately 14.4% of adults over the age of 18 in the Los Angeles market.

Asian Pacific Islander (API) UsCC subcommittee

API Family Member Mental Health Outreach, Education and Engagement Program: Linguistically and culturally appropriate mental health Outreach, Education and Engagement (OEE) events will target API families in the Korean, Chinese, Vietnamese, Samoan, Cambodian and South Asian communities. A total of 15 community presentations will be conducted and at least 300 community members will be outreached to. Status: in progress

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

Community Mental Health Education Project for the Arabic-speaking Community: Mental health community presentations will be made at schools, in partnership with faith-based organizations, to increase mental health awareness in the Arabic-speaking community. Materials will be made available via web-based sites. A total of 2 community presentations have been conducted and 4 more will be conducted at local mosques and community agencies. The project consultant reported that due to the recent terrorist attacks in San Bernardino County, the demand for mental health presentations within the community has significantly increased.

The Armenian Media Project: Mental health TV talk shows, conducted in Armenian, were developed to target the Armenian community to increase awareness of mental health issues. A total of 44 half-hour mental health TV talk shows have aired at the Armenian-Russian Television Network (ARTN-Shant), every Saturday and Sunday from 3:30 pm – 4 pm. The TV shows included the following mental health topics: Introduction to mental health, immigration and acculturation, loss and grief, older adults, divorce and its effects on children, bullying, depression, and parenting. This project was implemented on September 29, 2015 and is expected to be successfully completed on March 6, 2016. ARTN-Shant reports a great deal of positive feedback from the community regarding the shows and the mental health information provided.

Mental Health Awareness Project for Law Enforcement: Law enforcement personnel will be trained on mental health issues pertaining to the Arabic-speaking community. Community presentations will be held at various sheriffs and/or police departments to inform and educate law enforcement personnel about common mental health topics and issues pertaining to the Arabic speaking community, including the psychological effects of racial profiling. This project was implemented on January 4th, 2016 and is expected to be completed on June 30, 2016.

Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two-Spirit (LGBTQI2-S) UsCC subcommittee

The LGBTQ Survey: The survey aims to gather data pertaining to mental health clinicians' level of awareness and sensitivity when providing services for the LGBTQ population. This survey will be released by February 26, 2016.

Clinical Mental Health Trainings for LGBTQ Youth: Four 2-day clinical trainings will be provided to educate and improve the therapeutic skills of mental health clinicians who provide mental health services to LGBTQ youth. Thus far, two trainings have taken place in SA 2 and SA 4. This project is scheduled to be completed by April 30, 2016.

Homeless Outreach and Mobile Engagement Team (HOME)

Formerly known as HOET, HOME 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 services, substance abuse, mental health, benefits establishment services, transportation, assessment for inpatient psychiatric hospitalizations, and any other services required in order to assist the chronically homeless and mentally ill across gender, cultural and linguistic diversity.

Achievements/Highlights in FY 2014-15

HOME focused its outreach and engagement services in two Service Areas(SA) with the highest number of

homeless persons based on the 2015 Homeless Count. Previously, HOME provided services in the entire County. HOME has been involved with the Countywide Coordinated Entry System to increase its collaboration with other homeless outreach programs to more strategically utilize its limited staffing resources and to provide more focused and sustained outreach. Increased collaboration has allowed HOME to maximize its effectiveness through close coordination with new DMH outreach teams PATH-funded DMH Multi-Interdisciplinary Teams, SB 82 Mobile Triage Teams, Assisted Outpatient Team (Laura's Law). HOME is also closely collaborating with other outreach teams that focus on the general homeless population. These collaborations have included coordinated outreach with local cities, law enforcement to assist homeless along the riverbeds and, projects at urban hot spots. HOME also worked closely with psychiatric mobile crisis teams and Assisted Outpatient Treatment programs when mentally ill homeless required involuntary inpatient services. These collaborations allowed HOME to provide over 4500 services to homeless persons

Significant changes for FY 2016-17

HOME will continue to dedicate its outreach and engagement services in the two Service Areas of the county which have the highest number of homeless persons. Collaboration and coordination of outreach efforts will be further increased to work supportively with the Coordinated Entry System and agencies already active in SA 4 and 6. In addition to previously-mentioned collaborations, HOME will expand its work with other city and county entities including libraries, law enforcement, co-response teams and, fire departments.

Crossover Youth Multidisciplinary Team Program (MDT)

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

- Review available records of referred youth related to mental health, child welfare, and Probation history. Records will include, but will not be limited to: court files, police reports, current and past mental health reports, Individualized Education Plans (IEPs), psychiatric hospital discharge summaries, and DCFS court reports. Records will be reviewed for the purpose of providing information to the other MDT members during the meetings and for writing reports.

- Consult with case-carrying Children's Social Worker and the assigned Deputy Probation Officer, as well as attorneys, children's advocates, and others on the multi-disciplinary team.

- Conduct comprehensive mental health evaluations of referred youth (when permitted within the guidelines of the multi-disciplinary team) and prepare written reports of findings and recommendations that are then presented to the delinquency judicial officer to assist them with disposition.

- Participate in multi-disciplinary team meetings to discuss findings and recommendations and appear in juvenile delinquency court hearings as requested.

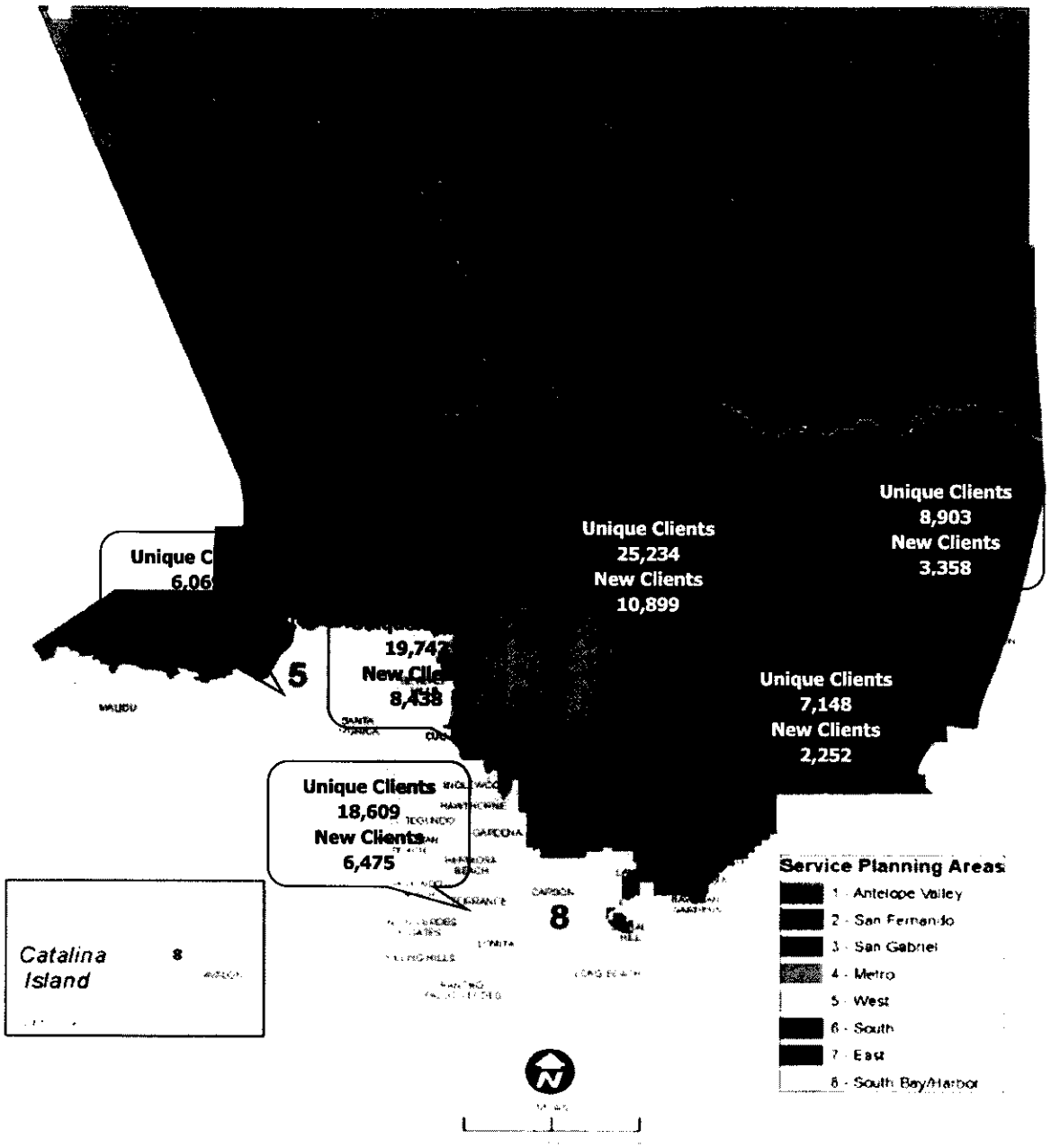
See Appendix V for a Summary of Findings for the Los Angeles County 241.1 Multidisciplinary Team.

Community Services and Supports Program Expansion

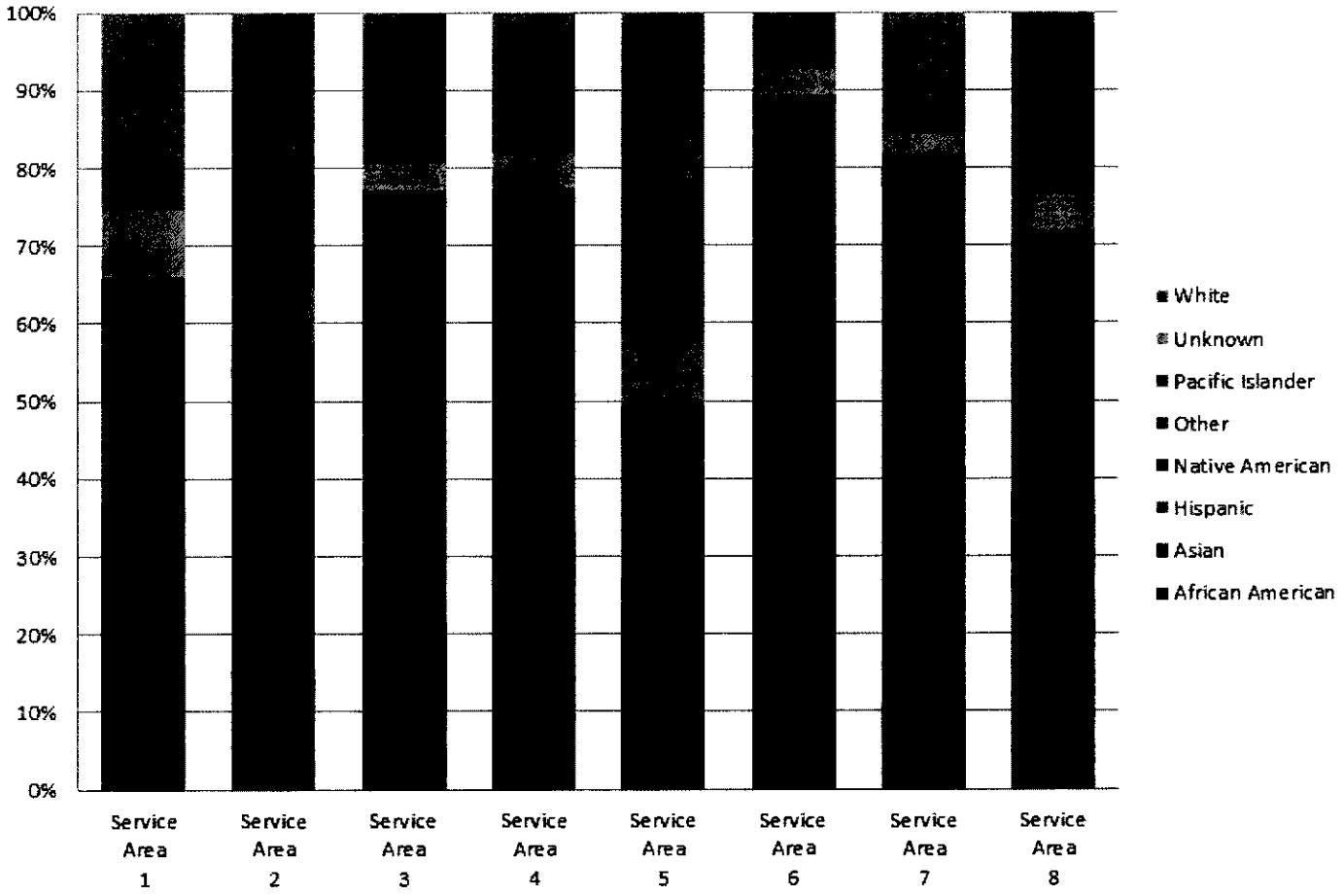
(See Appendix I for a complete proposal description)

Proposal	Status	Implementation Date (Estimated)
Increased capacity to outreach, engage and serve Under-Represented Ethnic Populations (UREP) communities	Implemented	October 2015
Los Angeles Lesbian Gay Bisexual Transgender Center's Recognize, Intervene, Support, and Empower (RISE)Project	Implemented	October 2015
Client Supportive Services Funds-SB82 Mobile Triage Team	Implemented	August 2015
Housing for Clients - SB82 Program	Implemented	August 2015
Health Neighborhood and Faith Outreach and Coordination	Waiting for board letter to be heard to request 8 positions, one for each Service Area.	May 2016

Los Angeles County Clients Served Through CSS by Service Areas Fiscal Year 2014-15



Ethnicity by Service Area



Service Area 1
African-American –36%
Hispanic – 27%
White – 25%
Other – 2%
Asian – 1%
Unknown – 9%
Native American - 1%
Pacific Islander - <0%

Service Area 2
White – 38%
Hispanic – 35%
African-American –11%
Asian – 4%
Other – 3%
Unknown – 8%
Native American - <0%
Pacific Islander - <0%

Service Area 3
Hispanic – 53%
White – 20%
Asian –12%
African-American –10%
Other –2%
Unknown –3%
Native American -1%
Pacific Islander -<0%

Service Area 4
Hispanic –41%
African-American –26%
White –18%
Asian –7%
Other –2%
Unknown – 5%
Native American -1%
Pacific Islander -<0%

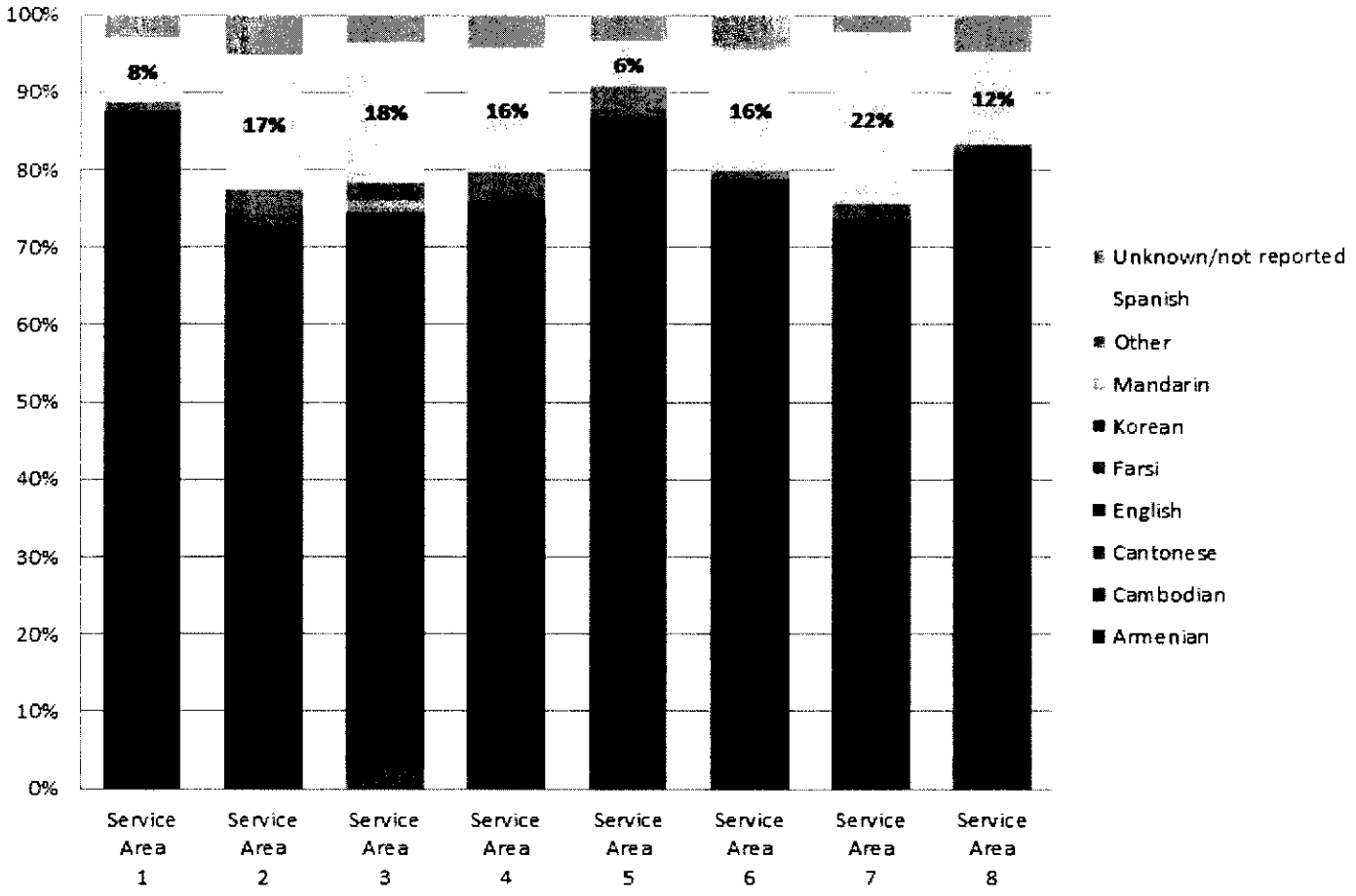
Service Area 5
White –42%
African-American –25%
Hispanic – 18%
Unknown – 9%
Other –4%
Asian –2%
Native American - 1%
Pacific Islander- <0%

Service Area 6
African-American – 52%
Hispanic –35%
White – 7%
Unknown – 4%
Other – 1%
Asian – 1%
Native American -0<%
Pacific Islander- 0<%

Service Area 7
Hispanic – 66%
White – 16%
African-American – 8%
Asian – 3%
Native American - 3%
Unknown – 3%
Other – 1%
Pacific Islander- <0%

Service Area 8
African-American – 30%
Hispanic – 31%
White – 23%
Asian – 9%
Unknown – 5%
Other – 2%
Native American - 0<%
Pacific Islander- 0<%

Primary Language by Service Area



Service Area 1
English - 88%
Spanish - 8%
Unknown/Not Reported - 3%
Other - 1%

Service Area 2
English - 69%
Spanish - 17%
Armenian - 3%
Farsi – 2%
Unknown/Not Reported - 5%
Other - 3%

Service Area 3
English - 71%
Spanish - 18%
Cantonese - 2%
Unknown/Not Reported - 3%
Other - 2%

Service Area 4
English - 73%
Spanish - 16%
Unknown/Not Reported - 4%
Other - 4%
Korean - 2%
Armenian - 1%

Service Area 5
English -87%
Spanish - 6%
Unknown/Not Reported - 3%
Farsi - 1%
Other - 3%

Service Area 6
English - 79%
Spanish - 16%
Unknown/Not Reported - 4%
Other - 1%

Service Area 7
English - 73%
Spanish - 22%
Unknown/Not Reported - 2%
Other - 2%
Cambodian - 1%

Service Area 8
English - 77%
Spanish - 12%
Cambodian - 3%
Unknown/Not Reported - 5%
Other - 1%
Vietnamese - 1%
Korean - 1%

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

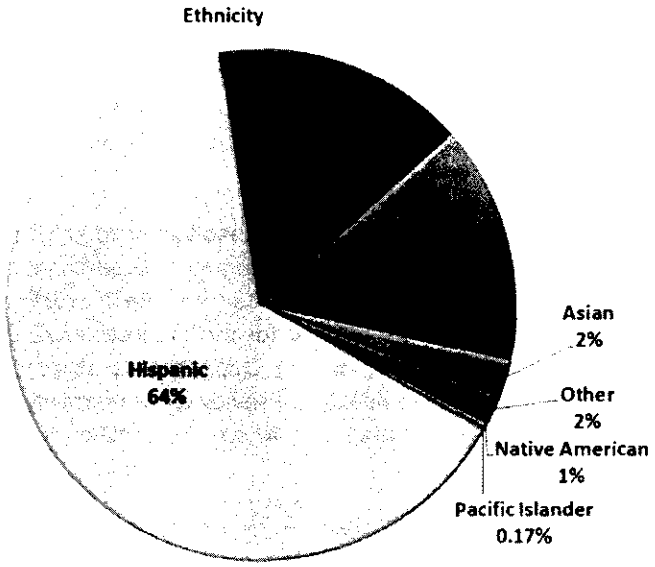
Each evidence-based, promising or community-defined evidence practice has a set of expectations established by the Department and informed by the practice developers that defines the training and/or certification necessary to deliver the practice, practice parameters and outcome measures associated with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

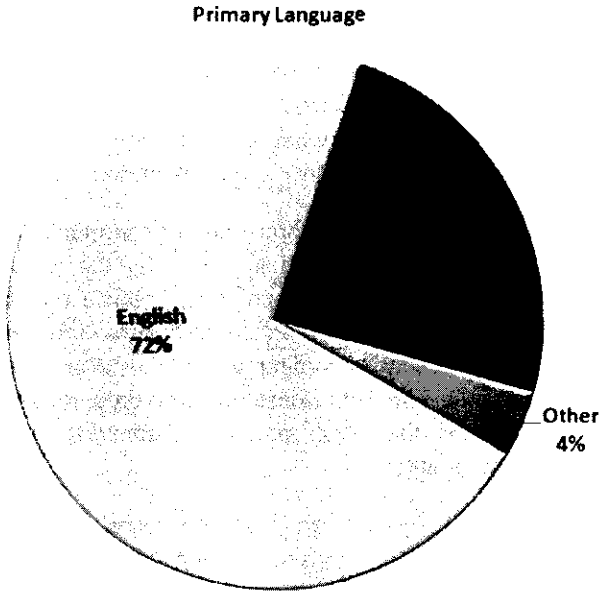
In order to submit an evidence-based, promising or community defined practice for consideration to be practiced in PEI programs, an application must be completed and submitted to the Department's PEI Evidence-Based Practice Committee, comprised of representatives of the 4 age groups, the MHSA Implementation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

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

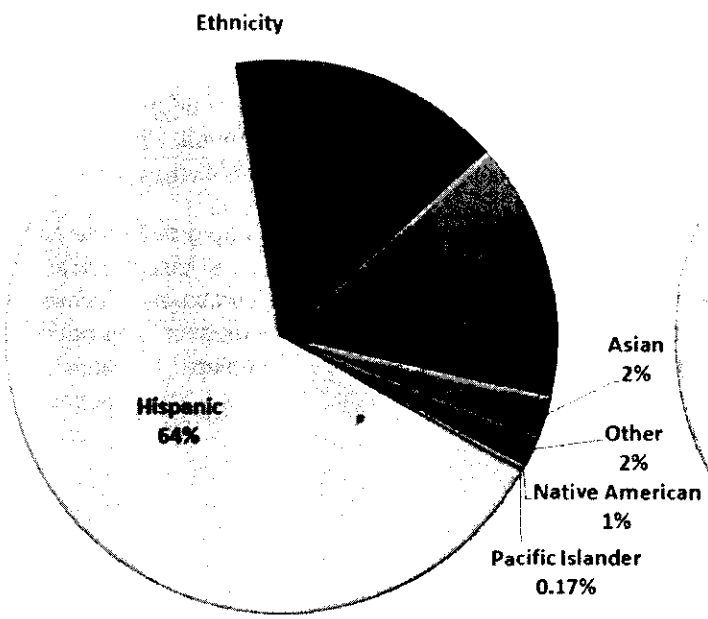
Outcome measures are selected through an initial review of measures in use for particular age groups related to particular foci of treatment. The results of the literature review are then presented to a joint provider-Department committee and a decision is made on which measures will be used to assess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

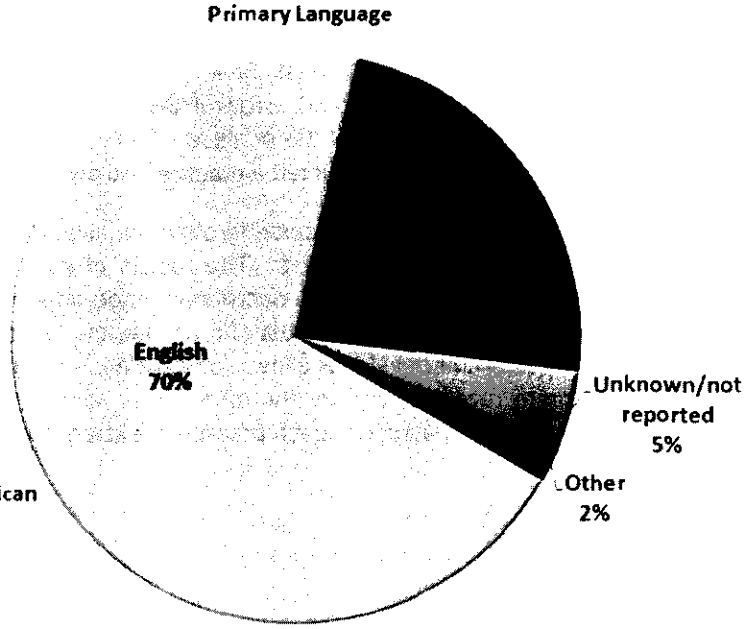
The number of unique clients receiving a direct mental health service through the PEI Plan: 55,094





The number of new clients receiving PEI services Countywide with no previous MHSA Service: 28,613





Evidenced Based Practices (EBPs): Number of Clients Served by EBP for Fiscal Year 2014-15

Top 10 EBPs Delivered in the County

Practice	*# of Clients*	*Average Cost per Client*
Managing and Adapting Practice	17,519	$ 4,060
Trauma Focused CBT	8,373	$ 8,198
Seeking Safety	8,198	$ 3,844
Individual Cognitive Behavioral Therapy	3,559	$ 1,773
Positive Parenting Program (Triple P)	2,714	$2,836
Child Parent Psychotherapy	2,179	$ 3,576
Interpersonal Psychotherapy for Depression	2,086	$ 2,646
Assertive Community Treatment	2,009	$ 7,881
Crisis Oriented Recovery Services	1,864	$ 1,062
School Threat Assessment Response	1,453	$ 2,061

Top 5 EBPs Delivered in the County by Age Group

Children	*# of Clients*
Managing and Adapting Practice	14,871
Trauma Focused CBT	7,244
Triple P Positive Parenting Program	2,642
Seeking Safety	2,320
Child Parent Psychotherapy	2,153

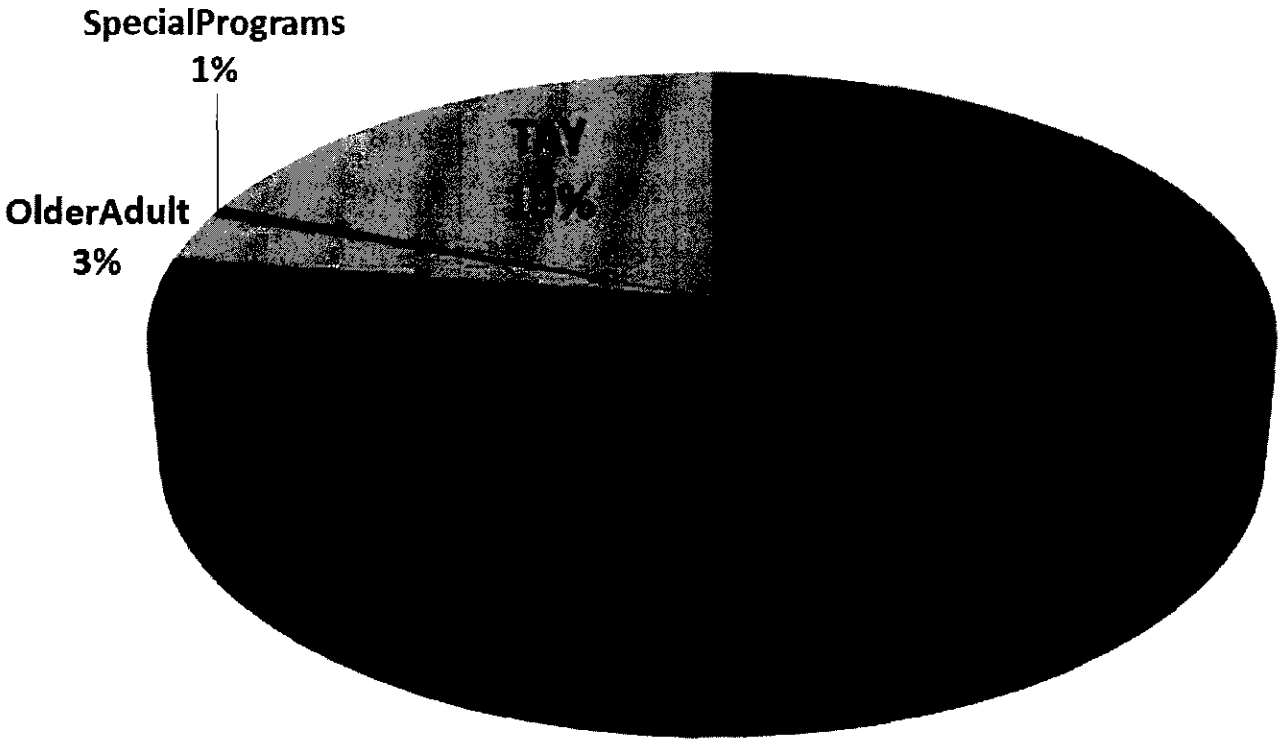
Adult	*# of Clients*
Individual Cognitive Behavioral Therapy	2,378
Seeking Safety	1,924
Assertive Community Treatment	1,556
Improving Mood-Promoting Access to Collaborative Treatment	849
Interpersonal Psychotherapy for Depression	581

Transitional Age Youth	*# of Clients*
Seeking Safety	3,916
Managing and Adapting Practice	2,996
Trauma Focused CBT	1,261
Individual Cognitive Behavioral Therapy	797
Interpersonal Psychotherapy for Depression	541

Older Adult	*# of Clients*
Interpersonal Psychotherapy for Depression	402
Seeking Safety	370
Individual Cognitive Behavioral Therapy	348
Assertive Community Treatment	260
Improving Mood-Promoting Access to Collaborative Treatment	219

Prevention and Early Intervention Age Group Breakdown[1]

N=56,228



[1] Clients may have received services in more than one age group.

Evidence-Based Practice (EBP); Promising Practice (PP); Community Defined Evidence Practice (CDE)

PEI Early Start-Suicide Prevention: ES-1

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

EBP/PP/CDEs Implemented:

Latina Youth Program:

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

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

For FY 2014-15, the program provided services to 214 students who had open cases. With regard to gender, 56% were female and 46% were male. During intake, 11% indicated a past suicide attempt as an issue they confronted within the past six months before participating in the LYP, and 33% indicated suicidal ideation. The program's staff provided crisis and urgent services as well as preventive activities such as outreach and education to 2,114 contacts, for a total of 1,830 contact hours.

A number of risk factors have been associated with higher risk for suicidality in adolescents. The program identified a number of risk factors, which were targeted for prevention, education and treatment activities, in addition to treatment of diagnosed mental health illnesses. The risk factors include: Presence of substance use or abuse, suicidal ideation and past suicide attempts. These risk factors have been perceived in the professional literature as most predictive of suicidal ideation. In addition, in past years, the program has also tracked other risk factors such as, running away from home, communication problems at home, poor school functioning, difficulty regulating emotions, involvement with the legal system, negative peer relations and issues related to sexual identity and poverty.

As stated previously, the Latina Youth Program was implemented to address the rising incidence of suicidality in Latina youth. Risk factors associated in the literature with research on suicide, were targeted for prevention and intervention. The program has been consistently successful at preventing suicide in the participants. As supported by the program experience over its fourteen years of operation, participants who endorsed suicide ideation as a significant problem at intake decreased in severity after participating in treatment, based on participant and parent report. This points to a decrease in thinking about committing suicide and in developing or carrying out a plan for suicide. During these 14 years we had one completed suicide on May 2014 despite the fact that the program targets those at higher risk for suicidality. A trend has been noted during recent evaluation periods, clinicians reported dealing with students who thought about or attempted suicide at a higher incidence rate than in previous years. Thus, although more students may be attempting suicide, the availability of easily accessible intervention, including hospitalization is helping keep most severe of cases safe. See Appendix VII for further details on Pacific Clinic's Latina Youth Program for FY 14/15.

24/7 Crisis Hotline: The 24/7 Suicide Prevention Crisis Line responded to a total of 66,231 calls, chats, and texts originating from Los Angeles County , including Spanish-language crisis hotline services to 3,744 callers. Korean and Vietnamese language services are also available on the Crisis Hotline. The majority of calls (49%) were concerning suicidal intent, with the remaining concerns being depression (37%) relationship/family issues (37%), past suicidal ideation/attempt (30%), and anxiety/stress (26%). Additionally, various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, lecture, medical, and safeTALK presentations. In Los Angeles County, 3,852 persons were reached through these outreach efforts. See attached report for further information on Didi Hirsch data for FY 14/15.

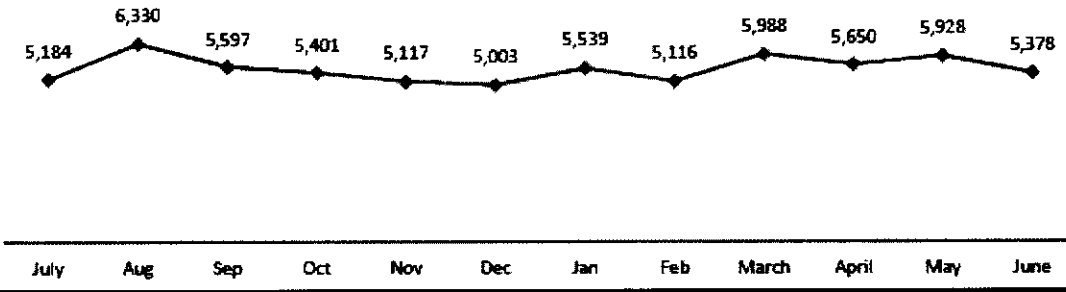
Outcomes

SUICIDE PREVENTION CENTER HOTLINE
SPC Overall Monthly Report

Didi Hirsch

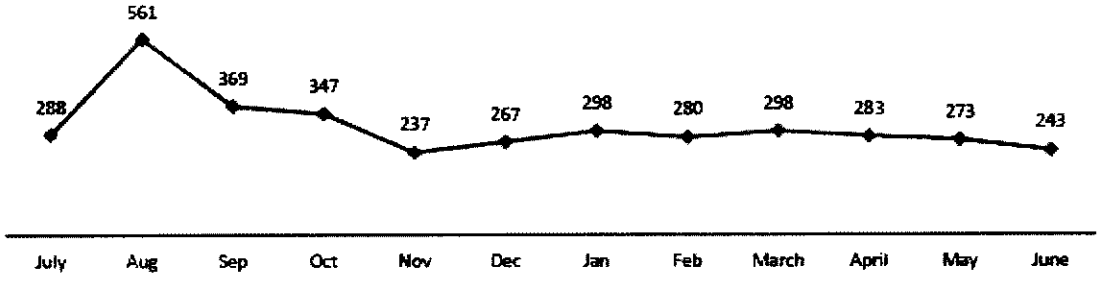
	Fiscal Year 14-15
TOTAL CALLS	61,231
TOTAL CHATS	4,898
TOTAL TEXTS	102
GRAND TOTALS	66,231

Monthly Chat, Text, and Call Volume



	Fiscal Year 14-15
Korean	39
Spanish	3,744
Vietnamese	21

Spanish Line Monthly Volume



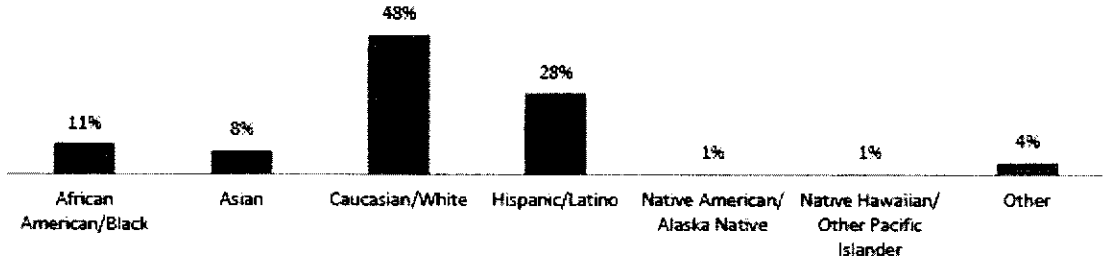
County	Fiscal Year 14-15	Percentage of State
Los Angeles	28,018	53%
Orange	8,047	15%
Riverside	3,008	6%
San Bernadino	3,000	6%
Santa Clara	2,573	5%
Ventura	1,663	3%

2014-2015 DEMOGRAPHICS

Gender

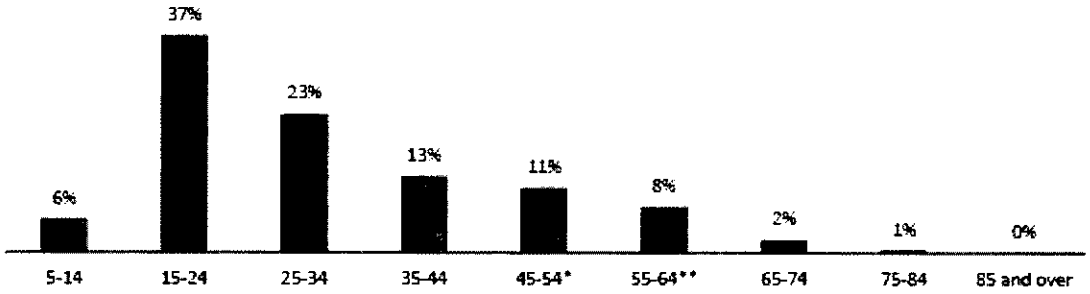
	Fiscal Year 14-15
Female	22,448
Male	18,047

Ethnicity



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

Age Groups



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

High Risk Categories

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

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

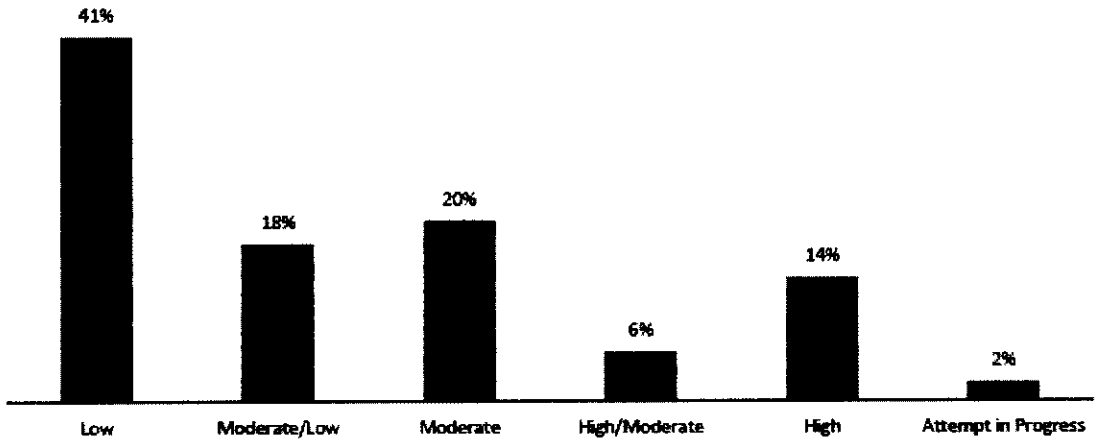
TOP 5 ISSUES DISCUSSED BY CALLERS (CALLERS MAY IDENTIFY MORE THAN ONE)

Caller Concern	Fiscal Year 14-15	Percentage
Suicidal Intent	16,865	49%
Depression	**12,669**	**37%**
Relationship/Family Issues	12,653	37%
Past Suicidal Ideation/Attempt	**10,317**	**30%**
Anxiety/Stress	8,988	26%

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

Rates of Suicide Risk Factors among Callers (callers may identify more than one)		
	Fiscal Year 14-15	Percentage
History of Psychiatric Diagnosis	14,147	50%
Prior Suicide Attempt	10,123	36%
Substance Abuse - Current or Prior	7,423	26%
Suicide Survivor	4,205	15%
Access to Gun	1,402	5%

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

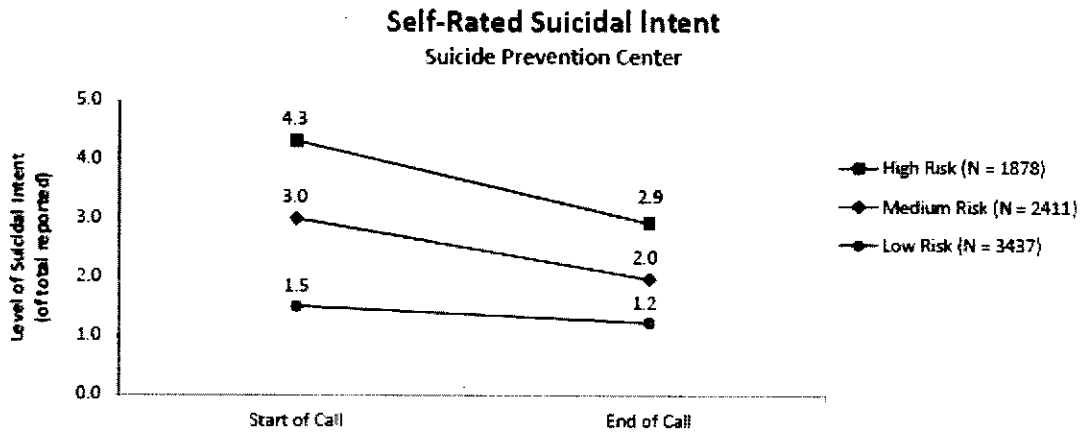


*Percentages are calculated out of the total number of callers with reported risk levels.

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

Self-rated Suicidal Intent

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



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

Emergency Rescue Type	Fiscal Year 14-15	Percentage
Third Party Rescue	1,084	46%
Self-Rescue	644	27%
SPC Initiated Rescue - Voluntary	249	10%
SPC Initiated Rescue - Involuntary	138	6%
Mandated Report	257	11%

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

Please note: There have been changes to our iCarol system and these numbers represent a best estimate since training is still underway on the additional follow up fields.

	Total YTD	Contacted	Linked	No Contact
Short-Term	223	94	40	129
Standard	1,743	867	369	876
Extended	124	59	42	65
Grand Total	**2,090**	**1,020**	**451**	**1,070**

Short-Term Follow-Up: Offered to callers at imminent risk who do not meet criteria for emergency rescue. The follow-up call or calls are made within 24 hours after the initial call.

Standard Follow-Up: Offered to moderate - high risk callers. The follow-up call or calls are made 1-7 days after the initial call.

Extended Follow-Up: Offered to callers who received standard follow-up and need continued assistance (e.g., developing a safety plan and/or connecting to resources). The follow up call or calls are made 1-8 weeks after the initial call.

Various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, Lecture, Medical, and safeTALK presentations.

Individuals reached through these efforts:

County	Fiscal Year 14-15
LA	3,852
Orange	4,121
Total	**7,973**

Partners in Suicide (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults:

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

PSP Team members participated in a total of 193 suicide prevention events during FY 2014-15, outreaching to more than 5,600 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners. Highlights included the provision of 14 Applied Suicide Intervention Skills Trainings (ASIST) to 368 participants, and attaining five new provisional ASIST trainers, for a total of 18 trainers (including adjunct trainers). PSP provided 82 Question, Persuade and Refer (QPR) Trainings throughout the county. Twelve staff members are qualified as QPR trainers, five of whom are members of the PSP team. Spanish-speaking QPR trainers trained 165 participants this fiscal year. Recognizing and Responding to Suicide Risk (RRSR) was provided via six trainings FY 2015-16, training a total of 223 participants. Four core PSP members completed the train-the-trainer program for Assessing and Managing Suicide Risk (AMSR). This training focuses on 24 core competencies required for clinicians to be successful in their work with suicidal clients. AMSR aims to build confidence and competence in assessing and managing suicide risk and reduce suicidal behaviors and completed suicides in the at-risk population. AMSR differs from RRSR in that the training is completed in one day. We are aiming to roll out AMSR trainings during FY 2015-16.

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

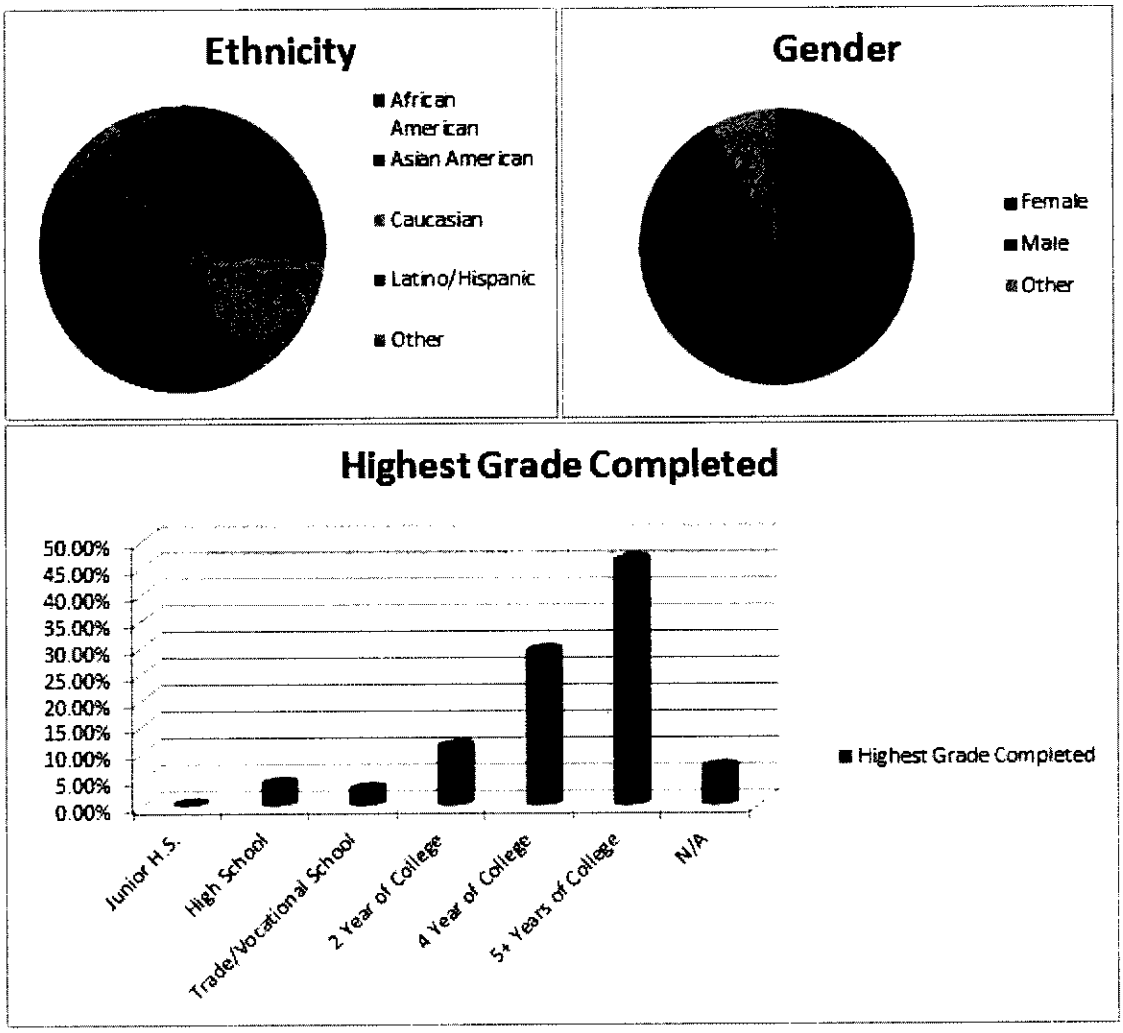
DMH in conjunction with Didi Hirsch launched the Fourth Annual Suicide Prevention Summit "Emerging Best Practices in Suicide Prevention" on September 9, 2014, which coincided with National Suicide Prevention Week. The PSP team collaborated with various agencies who presented a variety of best practice models. The models presented included Support Groups for Attempt Survivors, Older Adult Depression Screening, Suicide Prevention for Law Enforcement, Suicide Firearm Safety, Survivor Outreach team and Community Gatekeeper for LGBT Older Adults.

Outcomes

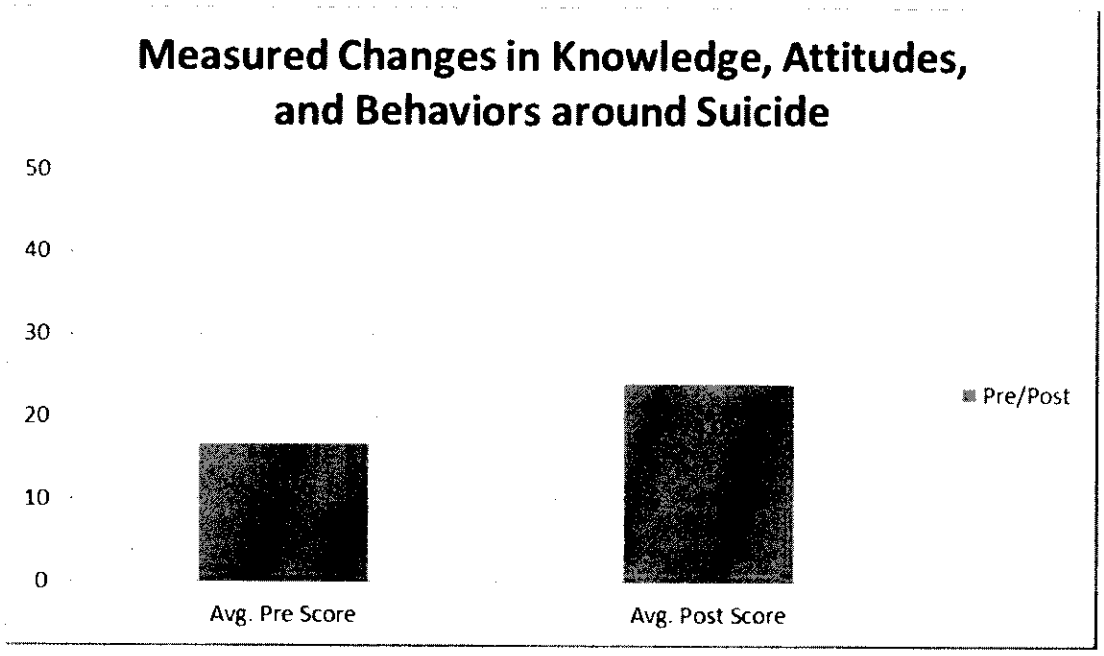
Los Angeles County Department of Mental Health has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. Surveys that directly measure changes regarding suicide show the following:

Total number of Survey Entries: 2,985
Average Age: 36

Demographics



Pre and Post Differences



The above chart illustrates that prior to suicide prevention training participants' level of understanding about suicide and suicide prevention was lower than at post. Overall, participants showed a 44% positive change from pre to post assessment; this leads us to believe that their knowledge about suicide and suicide prevention increased through training and education. 75% of suicide prevention participants reported having a higher level of education (4+ years of college) and therefore may have had more knowledge about the subject matter to begin with which in turn could have capped the amount of positive change we could have seen from pre to post measurement. Other interesting data elements regarding training participants included the following: 74% were women; 41% were Latino/Hispanic, 17% were Caucasian; and the average age was 36.

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

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

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

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

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

EBP/PP/CDEs Implemented:

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 Adult System of Care Anti-Stigma and Discrimination Team participated in 37 events during FY 2014-2015 and outreached to 959 Los Angeles County community members. These countywide events provided educational presentations to the faith community and PEI UREP populations. Community events were also held on college campuses (Cal State Long Beach, Cal State LA, Cal State Northridge, Long Beach City College).. There was also collaboration with various agencies including the jails and the Los Angeles County Sheriff Department.

Children's Stigma and Discrimination Reduction Project

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

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

During FY 2014-15, sixty six (66) trainings on ITC, EES, YMHFA, and Bullying were provided to parents, children and community members countywide.

Older Adults Mental Wellness

For the majority of FY 14/15, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of one Community Services Counselor and two Service Extenders. One of these promoted to Mental Health Advocate in April 2015 but still provides ASD assistance as needed. Occasionally, other Older Adult Systems of Care staff provides assistance, particularly if there is more than one presentation on a given day, or if there is a need for a specific language. Other than English, languages available for ASD presentations include Spanish, Farsi, Korean, Mandarin and Chinese.

The OA ASD Team participated in a total of 183 events during fiscal year 2014-2015, outreaching to more than 2,954 Los Angeles County residents. The majority of presentations take place in senior housing and senior centers; the remaining are in community centers, libraries, or civic organizations. The current menu of presentations includes "Depression and Anxiety," "Good Sleep," "Health, Wellness and Wholeness," "Hoarding," "Holiday Blues," "Substance Use," "Preserving your Memory through Brain Exercise," "Managing your Medication," "Psychological Resilience," "Senior Bullying," and "Life Transitions."

Highlights of OA ASD's accomplishments include:

- Provided over 180 presentations for seniors throughout the county
- Participated in 3 Health Fairs throughout the county
- Increased number of workshops in areas of SA 3, 5, 7
- Identified locations for Visually Impaired seniors
- Added presentations for Chinese seniors in Mandarin and Cantonese
- Added a Service Extender to provide assistance with presentations who was then promoted to Mental Health Advocate

Significant Changes for FY 2016-17:

- Additional workshop topic, e.g. Loneliness and its Effect on Older Adults
- Increase outreach and number of workshops in SA 1

Profiles of Hope Project

Profiles of Hope project is a set of 10-minute inspirational stories that spotlights high-profile individuals who candidly share how they overcame stigma and various obstacles to live successful and productive lives.

Fiscal year 2014-15 did not produce new Profiles of Hope videos; however, the following was accomplished:

- Completed a Request for Services (RFS) process, assisted in obtaining Board approval for and finalizing an agreement with a professional marketing firm. The purpose of this contract is for the vendor to assist DMH in production of new vignettes for the *Profiles of Hope* series and design a major marketing plan around the series. The contract was finalized and activities started in early July, 2015.
- Consulted with DMH staff to the Department's under-represented ethnic populations committees on production of a Public Service Announcement (PSA) in Spanish targeting the Latino population and one that is aimed at gaining attention of the Native American population.
- Continued to coordinate the Suicide Prevention campaign, "Know the Signs" for Los Angeles County targeting young African American men, young Latinas and older Caucasian males. Managed ad campaign that placed English and Spanish language posters on billboards, busses and trains, and 30 second trailer in local movie houses. During the campaign, Ms. Piche` participated in the Los Angeles City Council acknowledgement of lime green as the unifying color for mental health awareness. City Council also directed that City Hall be lighted in lime green. Coordinated suicide prevention outdoor campaign in LA County, The message encourages consumers to know the signs that lead to suicide, to find the words to talk about it, and to reach out to those who need help.
- Continued to monitor the growing number of "views" of PEI / anti-stigma videos on LACDMH's YouTube Channel.

Outcomes

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

Adult Surveys = 25

Mental Health First Aid (MHFA) is an interactive 8-hour evidence based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhance the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

Eighty percent of MHFA training participants either increased their knowledge of stigma or reported no change because they were already knowledgeable on the subject matter. Eighty percent of MHFA training participants also reported that they would advocate for someone living with mental illness. Other points of interest including the following:

- Prior to the training, 96% of participants' total scores were in either the Positive Attitudes category (12) or Very Positive Attitudes category (12). This suggests the vast majority of participants had positive beliefs about people with mental illness prior to being trained. At "post," every participant (i.e., 100%) was in either the Positive Attitudes category or Very Positive Attitudes category.
- Participants whose total score (32) was in the Neutral Attitudes category at "pre" shifted to the Positive Attitudes category at "post," with a score of (39).
- There were twelve participants with total scores in the Very Positive Attitudes category at "pre" treatment. At post, the number increased to nineteen (19) which is an improvement of 58%.
- The average total "pre" score fell within the Positive Attitudes range and the average total "post" score (46.31) fell in the Very Positive Attitudes range.

Child Surveys = 393

- 41% of participants expressed a greater willingness to talk to someone if feeling sad or depressed following training than before.
- 40% expressed a greater openness to speaking with a counselor or therapist after training than before.
- After training, 43% of participants indicated increased comfort in disclosing if they were receiving mental health services to others.
- Prior to training, 83% of participants acknowledged that they would be willing to assist another person in accessing mental health services. Of those participants, 49% increased their level of commitment to helping others access mental health services at the end of their training.

TAY Surveys = 40

- Prior to training, 100% of participants that initially were unwilling to disclose that they were receiving mental health services to others were willing to do so after completing their training.
- Prior to training, 40% of participants reported feeling comfortable with individuals that had a behavioral/mental health need. For those who did not feel comfortable prior to training, 54% reported feeling comfortable after the training.

Older Adult Surveys = 439

- 91% of SDR training participants would either agree or at least consider the possibility that their behavior and/or attitude could impact someone's ability in accessing mental health services. 59% of participants

checked off "Agree" and 32% checked off "Maybe" when asked to indicate how much they agree or disagree with the statement.

- Based on endorsed items, over 85% of respondents demonstrate a "positive attitude" related to the topic of stigma and discrimination.
- 95% of Spanish older adult surveys showed a "positive attitude" prior to receiving training.

School Based Services: PEI-1

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

EBP/PP/CDEs Implemented:

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

Family Education & Support Services: PEI-2

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

EBP/PP/CDEs Implemented:

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

**Program was added to the PEI Plan after 2009*

At Risk Family Services: PEI-3

The At Risk Family Services Project provides training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements. It builds skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement and provides support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

Trauma Recovery Services: PEI-4

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

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

Primary Care & Behavioral Health: PEI-5

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

EBP/PP/CDEs Implemented:

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

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

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

EBP/PP/CDEs Implemented:

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

Juvenile Justice Services: PEI-7

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

EBP/PP/CDEs Implemented:

1. Aggression Replacement Training
2. Cognitive Behavioral Intervention for Trauma in School
3. Functional Family Therapy
4. Group Cognitive Behavioral Therapy for Major Depression
5. Loving Intervention for Family Enrichment
6. Multidimensional Family Therapy
7. Multisystemic Therapy
8. Trauma Focused Cognitive Behavioral Therapy

Early Care & Support for Older Adults: PEI-8

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

EBP/PP/CDEs Implemented:

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

Program was added to the PEI Plan after 2009

Improving Access for Underserved Populations: PEI-9

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

EBP/PP/CDEs Implemented:

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

American Indian Project: PEI-10

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

EBP/PP/CDEs Implemented: American Indian Life Skills

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

PEI Practices Implemented

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

Prevention Programs Description

Six (6) programs were identified to prevent and minimize the impact of mental health issues for consumers and their families.

- Making Parenting a Pleasure (MPAP) is a promising practice, group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic backgrounds. Age group is parents of children (ages 0-8 years).
- Outreach and Education Pilot (OEP) for Underserved Populations focuses on assisting racial/ethnic minorities and underserved communities in Los Angeles County. OEP provides community-based outreach, educational workshops, case management, individual counseling, and group sessions delivered by and for targeted communities. Services can occur in culturally appropriate settings, which can range from community events to faith-based organizations, as well as other community-based organizations, primary care settings, community centers, and schools. Such activities are intended to help identify situations in which educational programs may lessen the impact or prevent more serious mental health issues from occurring. Serves all ages.
- Outreach and Education Pilot (OEP) for Transition Age Youth (TAY) (ages 16-25): at-risk of or involved with juvenile justice system; at-risk or on probation; at risk of substance abuse; and at-risk for School Failure. Services to TAY at-risk populations include community-based outreach, educational workshops, case management, individual counseling and group sessions, to TAY and their caregivers. Service delivery sites include juvenile probation settings, group homes, schools, community centers, community-based organizations, faith centers, and other non-traditional mental health settings.
- Positive Parenting Program (Triple P) is an evidence-based practice that is a multi-level parenting and family support strategy designed to prevent and treat behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills and confidence of parents. While acknowledging and respecting the diversity of family types and cultural backgrounds, the program builds on existing parenting strengths, and focuses on increasing parents' abilities to self-regulate and self-monitor their parenting skills. The Triple P system has interventions for individual families and small to large groups of parents. Interventions are available in a variety of delivery formats with varying levels of intensity including individual sessions, group sessions, seminars for large groups, self-help materials (self-help book and a self-directed online application), and mass media outreach and engagement materials. Age group is parents of children (ages 0-12 years).

Each prevention program provides one (1) or more types of services including: case management and/or individual services; workshops or seminars (one-time only services); and group sessions (multiple session services).

Cost

The average cost per client for community-based prevention programs for FY 2014-15 was $140 for case management services and $200 for group services. Averages based on 26,161 client case management and group contacts.

Community-Based Organizations Funded for Fiscal Year 2014-15

The agencies listed in the chart below were funded in FY 2014-15 and based on their performance and available one-time monies, were funded for an additional year.

Supervisorial District	Name	Prevention Program
JJ= Juvenile Justice; OEP = Outreach and Education Pilot; Triple P = Positive Parenting Program		
1	1. CASA of Los Angeles	OEP – TAY
	2. Catholic Charities of Los Angeles	OEP – Underserved Populations
	3. East Los Angeles Women's Center	OEP – Underserved Populations
	4. El Rancho Unified School District	Make Parenting a Pleasure
	5. Human Services Association	Triple P
	6. Little Tokyo Service Center Community Development Corp.	Make Parenting a Pleasure
	7. St. Barnabas Senior Center of Los Angeles	OEP – Underserved Populations
	8. Young Nak Outreach & Transformation	OEP – Underserved Populations
2	9. Avalon Carver Community Center	Make Parenting a Pleasure
	10. Child Alliance, Inc.	Make Parenting a Pleasure
	11. Crawford Ministries, Inc.	Make Parenting a Pleasure
	12. Helping Other People Excel	OEP – TAY
	13. His Sheltering Arms	Make Parenting a Pleasure
	14. Jeffrey Foundation	Make Parenting a Pleasure
	15. Korean American Family Service Center, Inc.	Triple P
	16. Lennox School District	Make Parenting a Pleasure
	17. Office of Samoan Affairs, Inc.	OEP – Underserved Populations
	18. Pathways LA	Triple P
	19. United Job Creation	OEP – TAY
	20. Westside Children's Center	Make Parenting a Pleasure
	21. World Mission University	OEP Underserved Populations
3	22. Coalition to Abolish Slavery & Trafficking	OEP Underserved Populations
	23. El Nido Family Centers	Make Parenting a Pleasure
	24.. Friends of the Family	Make Parenting a Pleasure
4	25. ABC Unified School District	OEP – Underserved Populations
	26. Cambodian Association of America	OEP – Underserved Populations
	27. Children and Families, Inc.	Make Parenting a Pleasure
	28. Refiners Fire Fellowship United Church of Christ	OEP – Underserved Populations
5	29. Paving the Way Foundation	OEP – TAY
	30.. Rancho San Antonio Boys Home, Inc.	OEP – TAY
	31.. YWCA San Gabriel Valley	OEP – Underserved Populations

PEI Outcomes

The table below lists practice and outcome information for PEI outcomes practices (Data as of 2/27/2015):

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Aggression Replacement Training (ART)	68.66%	3,130	41.5% (n=1,064)	58.5% (n=1,496)	YOQ Total Score (n=296)	24.14%	ECBI Intensity Scale (n=283)	9.84%
					YOQ-SR Total Score (n=438)	14.81%	ECBI Problem Scale (n=283)	21.43%
ART Skillstreaming		253	54.2% (n=84)	45.8% (n=71)	YOQ Total Score (n=19)	N<20	ECBI Intensity Scale (n=19)	N<20
					YOQ-SR Total Score (n=6)	N<20	ECBI Problem Scale (n=19)	N<20
Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)	84.82%	663	48% (n=305)	52.0% (n=331)	YOQ Total Score (n=180)	49.09%	PTSD-RI Child/ Adolescent Severity Score (n=165)	46.15%
					YOQ-SR Total Score (n=69)	48.00%	PTSD-RI Parent Severity Score (n=164)	50.00%
Brief Strategic Family Therapy (BSFT)	62.90%	146	61.1% (n=66)	38.9% (n=42)	YOQ Total Score (n=45)	47.92%	RBPC Anxiety-Withdrawal Raw Score (n=40)	66.67%
							RBPC Attention Problems-Immaturity Raw Score (n=40)	54.55%
							RBPC Conduct Disorder Raw Score (n=40)	46.15%
					YOQ-SR Total Score (n=24)	41.46%	RBPC Motor Tension Excess Raw Score (n=40)	50.00%
							RBPC Psychotic Behavior Raw Score (n=40)	0.00%
							RBPC Socialized Aggression Raw Score (n=40)	50.00%
Caring for Our Families (CFOF)	65.22%	725	68.3% (n=352)	31.7% (n=168)	YOQ Total Score (n=118)	25.00%	ECBI Problem Scale (n=49)	30.77%
							ECBI Intensity Scale (n=49)	21.19%

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Center for the Assessment & Prevention of Prodromal States (CAPPS)	54.20%	71	53.8% (n=28)	46.2% (n=24)	OQ Total Score (n=3)	N<20	SOPS Disorganized Symptoms (D) Total Score (n=11)	N<20
					YOQ Total Score (n=8)	N<20	SOPS General Symptoms (G)Total Score (n=11)	N<20
							SOPS Negative Symptoms (N) Total Score (n=11)	N<20
					YOQ-SR Total Score (n=9)	N<20	SOPS Positive Symptoms (P) Total Score (n=11)	N<20
							SOPS Total of All Scores (n=11)	N<20
Child-Parent Psychotherapy (CPP)	61.79%	3,244	49.2% (n=1,220)	50.8% (n=1,258)	YOQ Total Score (n=253)	56.00%	TYCYC PTS Total Score (n=392)	19.05%
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	92.92%	103	65.2% (n=58)	34.8% (n=31)	YOQ Total Score (n=31)	30.00%	PTSD-RI Child/ Adolescent Severity Score (n=32)	32.00%
					YOQ-SR Total Score (n=20)	21.62%	PTSD-RI Parent Severity Score (n=20)	23.53%
Crisis Oriented Recovery Services (CORS)	30.88%*	2,810	59.9% (n=1,147)	40.1% (n=767)	OQ Total Score (n=154)	20.55%	No specific outcome measure required for this practice	
					YOQ Total Score (n=568)	27.27%		
					YOQ-SR Total Score (n=254)	28.57%		
Dialectical Behavior Therapy (DBT)	27.75%	58	16.7% (n=2)	83.3% (n=10)	OQ Total Score (n=1)	N<20	DERS Total Score (n=1)	N<20
Depression Treatment Quality Improvement (DTQI)	89.13%	853	58.0% (n=474)	42.0% (n=343)	OQ Total Score (n=3)	N<20	PHQ-9 Total Score (n=247)	62.50%
					YOQ Total Score (n=231)	40.00%		
					YOQ-SR Total Score (n=223)	45.10%		

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Families Overcoming Under Stress (FOCUS)	39.92%	95	86.5% (n=77)	13.5% (n=12)	YOQ Total Score (n=36)	42.50%	FAD Affective Involvement (n=8)	N<20
							FAD Affective Responsiveness (n=8)	N<20
							FAD Behavioral Control (n=8)	N<20
					YOQ-SR Total Score (n=11)	N<20	FAD Communication (n=8)	N<20
							FAD General Functioning (n=8)	N<20
							FAD Problem Solving (n=8)	N<20
							FAD Roles (n=8)	N<20
Functional Family Therapy (FFT)	65.19%	1,475	65.7% (n=730)	34.3% (n=407)	YOQ Total Score (n=612)	29.92%	No specific outcome measure required for this practice	
					YOQ-SR Total Score (n=348)	29.17%		
Group Cognitive Behavioral Therapy for Major Depression (Group CBT)	85.69%	939	43.2% (n=287)	56.8% (n=378)	OQ Total Score (n=173)	22.39%	PHQ-9 Total Score (n=194)	42.86%
Incredible Years (IY)	72.38%	1,605	64.1% (n=962)	35.9% (n=539)	YOQ Total Score (n=669)	27.27%	ECBI Intensity Scale (n=369)	17.97%
							ECBI Problem Scale (n=369)	35.29%
Individual Cognitive Behavioral Therapy (Ind CBT)-Anxiety	54.09%	523	36.3% (n=95)	63.7% (n=167)	OQ Total Score (n=45)	38.16%	GAD-7 Total Score (n=46)	54.55%
Individual Cognitive Behavioral Therapy (Ind CBT)-Depression		1,630	37.9% (n=336)	62.1% (n=551)	OQ Total Score (n=172)	31.25%	PHQ-9 Total Score (n=186)	46.15%
Individual Cognitive Behavioral Therapy (Ind CBT)-Trauma		217	50.9% (n=56)	49.1% (n=54)	OQ Total Score (n=22)	42.27%	PTSD-RI Adult Severity Score (n=5)	N<20
					YOQ-SR Total Score (n=3)	N<20	PTSD-RI Child/ Adolescent Severity Score (n=9)	N<20

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Interpersonal Psychotherapy for Depression (IPT)	68.34%	3,329	52.9% (n=1,314)	47.1% (n=1,170)	OQ Total Score (n=447)	28.38%	PHQ-9 Total Score (n=730)	54.55%
					YOQ Total Score (n=177)	47.27%		
					YOQ-SR Total Score (n=266)	44.44%		
Loving Intervention Family Enrichment Program (LIFE)	100.00%	273	61.4% (n=151)	38.6% (n=95)	YOQ Total Score (n=88)	28.30%	ECBI Intensity Scale (n=63)	13.27%
					YOQ-SR Total Score (n=65)	16.98%	ECBI Problem Scale (n=63)	31.25%
[redacted]	44.62%**	18,396	42.7% (n=6,141)	57.3% (n=8,251)	YOQ Total Score (n=1,267)	40.74%	ECBI Intensity Scale (n=329)	23.85%
							ECBI Problem Scale (n=329)	43.75%
					YOQ-SR Total Score (n=395)	40.82%	PHQ-9 Total Score (n=309)	39.56%
							RCADS- Total Anxiety (n=287)	41.18%
							PTSD-RI Child/ Adolescent Severity Score (n=40)	46.67%
					OQ Total Score (n=3)	N<10	PTSD-RI Parent Severity Score (n=41)	40.91%
Mental Health Integration Program (MHIP) - Anxiety	112.20%	1,139	40.7% (n=421)	59.3% (n=614)	No General Measure Required for this Practice		GAD-7 Total Score (n=361)	47.66%
Mental Health Integration Program (MHIP) - Depression		4,031	33.7% (n=1,275)	64.3% (n=2,294)			PHQ-9 Total Score (n=1,073)	31.18%
Mental Health Integration Program (MHIP) - Trauma		294	30.2% (n=81)	69.8% (n=187)			PCL-C Total Score (n=52)	24.19%
Mindful Parenting (MP)	PEI OMA was updated to allow data entry for the practice as of 3/27/2015. To date there is not enough data entered to analyze.							

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Multidimensional Family Therapy (MDFT)	56.79%	49	92.0% (n=23)	8.0% (n=2)	YOQ Total Score (n=15)	N<20	RBPC Anxiety-Withdrawal Raw Score (n=9)	N<20
							RBPC Attention Problems-Immaturity Raw Score (n=9)	N<20
							RBPC Conduct Disorder Raw Score (n=9)	N<20
					YOQ-SR Total Score (n=17)	N<20	RBPC Motor Tension Excess Raw Score (n=9)	N<20
							RBPC Psychotic Behavior Raw Score (n=9)	N<20
							RBPC Socialized Aggression Raw Score (n=9)	N<20
Multisystemic Therapy (MST)	38.60%	117	73.9% (n=65)	26.1% (n=24)	YOQ Total Score (n=43)	51.61%	Specific outcome measure data for practice is not entered in PEI OMA	
					YOQ-SR Total Score (n=38)	36.17%		
Nurse-Family Partnership (NFP)	Outcome data is not reported in PEI OMA							
Promoting Alternate Thinking Strategies (PATHS)	49.21%	693	36.5% (n=159)	63.5% (n=277)	YOQ Total Score (n=33)	34.55%	ECBI Intensity Scale (n=33)	21.14%
					YOQ-SR Total Score (n=1)	N<20	ECBI Problem Scale (n=33)	37.50%
Parent-Child Interaction Therapy (PCIT)	60.40%	1,454	45.8% (n=470)	54.2% (n=556)	YOQ Total Score (n=212)	53.57%	ECBI Intensity Scale (n=331)	36.17%
							ECBI Problem Scale (n=331)	63.16%
Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)	77.78%	140	49.5% (n=54)	50.5% (n=55)	OQ Total Score (n=21)	29.58%	PHQ-9 Total Score (n=33)	54.55%
Prolonged Exposure Therapy for Post-Traumatic Stress Disorder (PE-PTSD)	34.45%	41	43.8% (n=7)	56.2% (n=9)	OQ Total Score (n=4)	N<20	PDS Symptom Severity Score (n=5)	N<20
Problem-Solving Therapy (PST)	55.27%	295	58.6% (n=140)	41.4% (n=99)	OQ Total Score (n=74)	29.85%	PHQ-9 Total Score (n=92)	40.00%

PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
Reflective Parenting Program (RPP)	59.72%	126	74.3% (n=81)	25.7% (n=28)	YOQ Total Score (n=42)	12.24%	ECBI Intensity Scale (n=34)	8.94%
					YOQ-SR Total Score (n=4)	N<20	ECBI Problem Scale (n=34)	7.14%
Seeking Safety (SS)	62.20%	14,144	40.8% (n=4,232)	59.2% (n=6,152)	OQ Total Score (n=513)	29.87%	PTSD-RI Adult Severity Score (n=323)	29.71%
					YOQ Total Score (n=667)	37.29%	PTSD-RI Parent Severity Score (n=319)	36.84%
					YOQ-SR Total Score (n=1,440)	32.69%	PTSD-RI Child/ Adolescent Severity Score (n=1,120)	28.57%
Strengthening Families (SF)	37.62%	234	88.6% (n=78)	11.4% (n=10)	YOQ Total Score (n=39)	33.93%	RBPC Anxiety-Withdrawal Raw Score (n=13)	N<20
							RBPC Attention Problems-Immaturity Raw Score (n=13)	N<20
							RBPC Conduct Disorder Raw Score (n=13)	N<20
					YOQ-SR Total Score (n=29)	26.92%	RBPC Motor Tension Excess Raw Score (n=13)	N<20
							RBPC Psychotic Behavior Raw Score (n=13)	N<20
							RBPC Socialized Aggression Raw Score (n=13)	N<20
[redacted]	39.71%**	10,399	57.6% (n=3,447)	42.4% (n=2,536)	YOQ Total Score (n=745)	48.98%	PTSD-RI Parent Severity Score (n=638)	43.45%
					YOQ-SR Total Score (n=289)	46.00%	PTSD-RI Child/ Adolescent Severity Score (n=687)	48.15%
	35.44%**	3072	57.9% (n=824)	42.1% (n=600)	YOQ Total Score (n=345)	42.62%	ECBI Intensity Scale (n=360)	28.26%
					YOQ-SR Total Score (n=27)	36.96%	ECBI Problem Scale (n=360)	44.44%

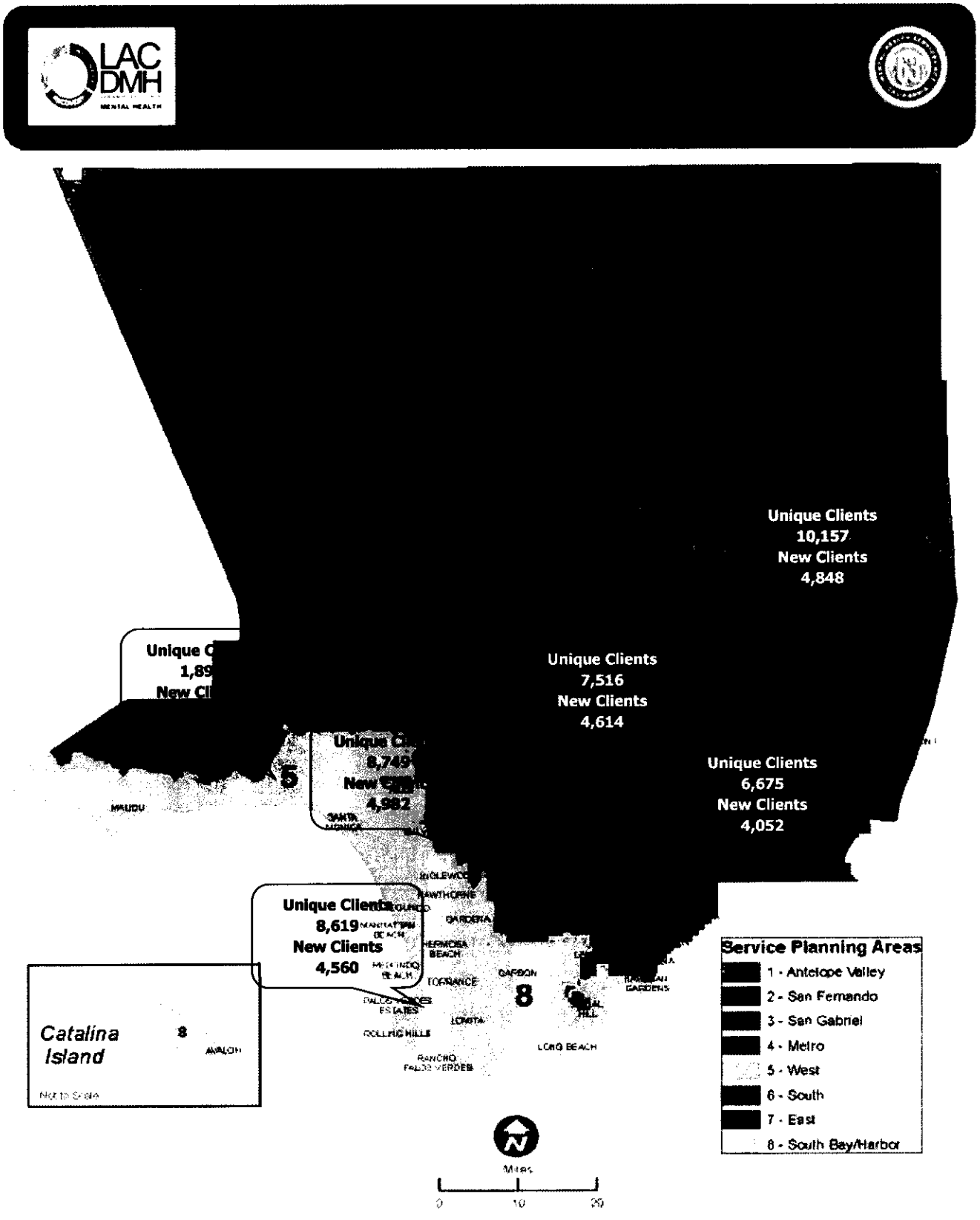
PEI Outcomes

Evidence-Based Practice	Outcomes, Starting July 2011 through June 30, 2015							
			Inactive Tx Cycles		Completed Practice			
	Compliance Rates	Treatment Cycles	Completed EBP Yes	Completed EBP No	General Outcome Measure	Percent Improvement Pre to Post Treatment	Specific Outcome Measure	Percent Improvement Pre to Post Treatment
UCLA Ties Transition Model (UCLA TTM)	84.76%	143	50.0% (n=52)	50.0% (n=52)	YOQ Total Score (n=3)	N<20	ECBI Intensity Scale (n=2)	N<20
							ECBI Problem Scale (n=2)	N<20

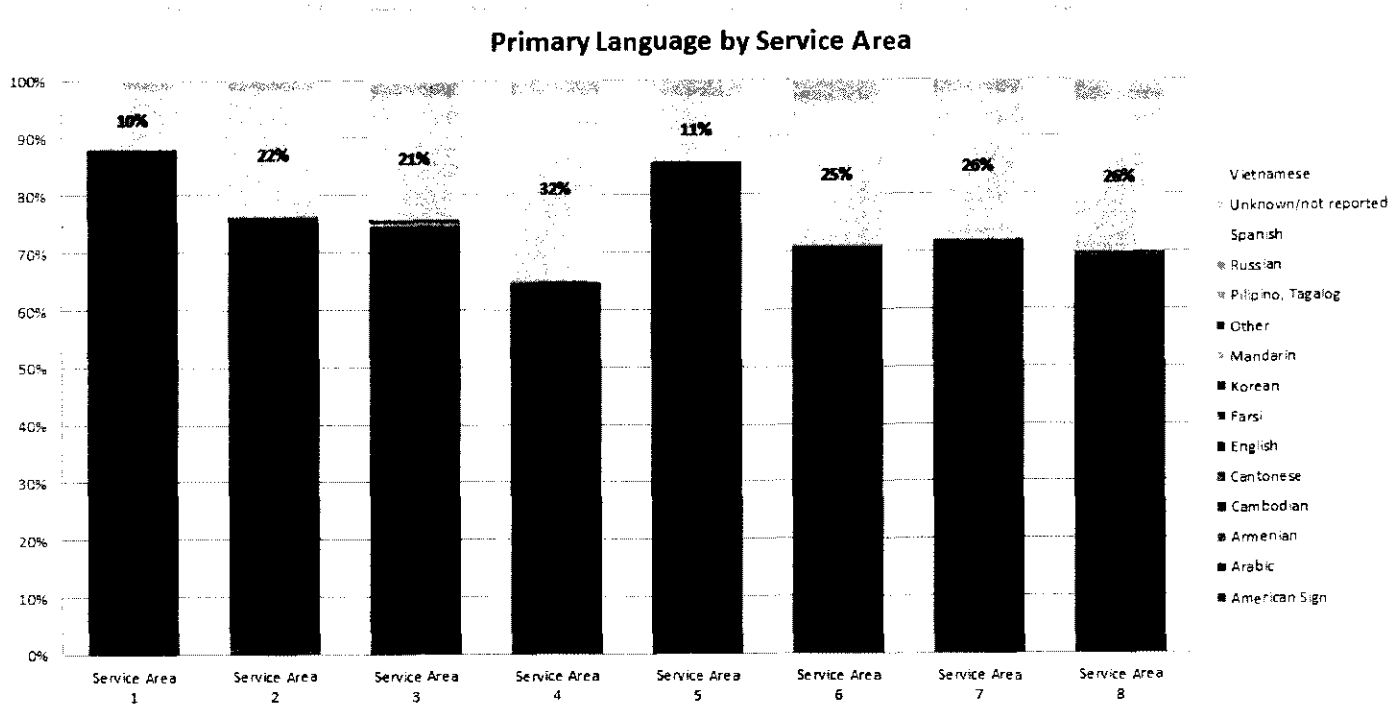
A general measure and focus of treatment specific measure is administered at the beginning of treatment and at the end of treatment, with pre- and post-treatment changes analyzed. If the treatment lasts greater than six months, both measures are given again at the six-month marker.

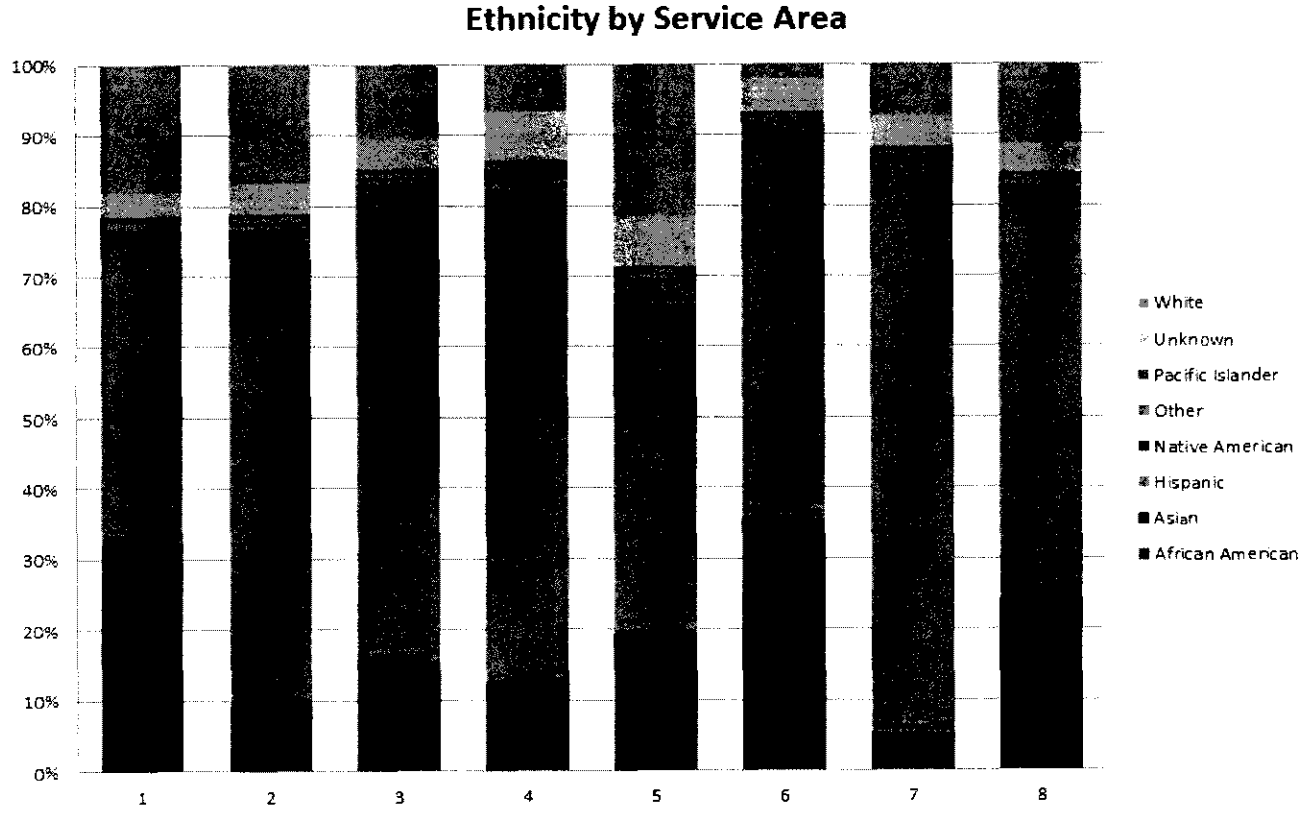
The MHSA Implementation and Outcomes Division provides regular training on the use of outcome measures for PEI and use of the PEI OMA web-based application in the form of in-person training as well as webinars and written guides. For more information on PEI outcome user support, use the following link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

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


Unique Clients
10,157
New Clients
4,848
Unique Clients
7,516
New Clients
4,614
Unique Clients
6,675
New Clients
4,052
Unique Clients
8,619
New Clients
4,560
Catalina Island
Service Planning Areas
1 - Antelope Valley
2 - San Fernando
3 - San Gabriel
4 - Metro
5 - West
6 - South
7 - East
8 - South Bay/Harbor
Miles
0
10
20

PEI Service Area Counts by Service Area





Innovation 1:

The Fiscal Year 2015-16 Annual Update contained the final results of the Integrated Clinic Model (ICM), the Integrated Mobile Health Team (IMHT) and the Integrated Services Management Model (ISM) for under-represented ethnic populations. The full report can be accessed via the following link http://file.lacounty.gov/dmh/cms1_226026.pdf . Innovation 1 promoted data-driven decision making at the program and system level through the development of an evaluation rubric that allowed the Department to identify a threshold level of success within each model and continue funding those providers through the Community Services and Supports Plan.

- 3 successful IMHT providers continued through the development of a specialized FSP program.
- 14 successful ICM and ISM providers continued through the development of a new work plan entitled Integrated Care Program.

The learning from these first three models has been presented over the course of the project at the California Institute for Behavioral Health Solutions (CiBHS)- County Behavioral Health Directors' Association (CBHDA) Policy Forums as well as at the 2014 and 2015 Los Angeles County Integrated Care conferences as well as at other conferences across the State. In addition, at the Department's February, 2016 System Leadership Team (SLT) meeting, successful integration strategies were presented for consideration system wide.

The final model associated with Innovation 1 was the Peer Run Model which tested out two entirely peer run strategies:

Peer Run Integrated Services Management Model (PRISM): A completely peer run alternative or supplement to public mental health services that focuses on empowering clients to improve their lives, increase and/or develop their skills, improve their social support system and lead productive lives.

Peer Run Respite Care Homes (PRRCH): A safe and supportive short term (less than 30 days) living environment for mental health clients experiencing a crisis operated entirely by individuals with lived experience of mental illness.

Below is a brief summary of the outcomes for PRISM and PRRCH. The full final outcome report with demographic and programmatic information can be accessed via the following link: http://file.lacounty.gov/dmh/cms1_239874.pdf

Consistent with the first 3 integrated care models and to ensure comparability across models and to national norms, **PRISM** programs collected the following key indicators of overall health:

- Physical health status improvement
- Mental health status improvement
- Substance use/abuse reduction
- Participant satisfaction
- Stigma reduction

In addition, staff linkages to other services were also collected based on the guest's goals.

To measure the participants' perspective of their behavioral and physical health and well-being, participants were asked to complete the Integrated Self-Assessment. The baseline Integrated Self-Assessment was

distributed within 30 days of enrollment, and follow-up assessments were given every three months. The Integrated Self-Assessment includes the Patient Reported Outcomes Measurement Information System (PROMIS) Global Health Scale, the Creating Healthy Outcomes: Integrated Self-Assessment Supplement (CHOIS), the Physical Health and Behavior Survey, the PROMIS-Derived Substance Use Scale, and the Internalized Stigma of Mental Illness Scale (ISMI). All measures were distributed semi-annually, except for the PROMIS Global Health Scale, which was distributed quarterly. Additionally, all participants were asked to complete a Feedback Survey developed for the peer programs semi-annually.

Due to the 30 day maximum stay, PRRCH guests were only able to complete one round of assessments, limiting the opportunity to measure the direct impact of the PRRCH model using longitudinal quantitative methods. To help compare PRRCH guests to those from other programs, all guests were asked to report on basic physical health indicators, including height, weight, and blood pressure. Each PRRCH location had scales and blood pressure cuffs available to guests so that they could assess and report on their health. Guests also completed the Feedback Survey prior to leaving the respite.

Staff from both the PRISM and PRRCH programs was asked to complete measures to provide an additional assessment of guest health and recovery. Staff was asked to complete the Illness Management and Recovery (IMR) Scale as well as the Milestones of Recovery Scale (MORS) quarterly to assess guest mental health and substance use recovery. Additionally, staff completed the Linkage Tracker. The form was designed to align with SAMHSA's Eight Dimensions of Wellness. It includes the emotional, physical, environmental, occupational, financial, intellectual, and spiritual aspects of a person's life. These Dimensions of Wellness may help people better manage their condition and experience recovery. This form is used to track participant goals, referrals and/or assistance provided to achieve the goals, and the success of each referral.

Assessments were completed and maintained in iHOMS described above. The system allows participants and peer staff to complete assessments electronically or to enter data from forms that were completed on paper.

Over the course of the project, both providers developed better ways to collect outcome data. Low sample sizes of matched data resulted in statistical analysis at the p<.10.

Peer Run Respite Care Homes (PRRCH)

	Project Return the Peer Support Network	[illegible]
Clients Served	310	296
Ethnicity	White: 44% African American: 30% Latino: 14% American Indian: 1% API: 2% Other/mixed: 3% Not reported: 6%	White: 28% African American: 33% Latino: 17% American Indian: 3% API: 4% Other/mixed: 15% Not reported: <1%
IMR Subscale Average Score at admission	**2.76**	**2.92**

The following are the feedback survey outcomes for each provider:

Project Return PRRCH Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Baseline Assessment (N=173 Guests)	0.0%	2.3%	97.7%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=173 Guests)	1.2%	5.2%	93.6%
People were available to talk with me as often as I felt it was necessary.			
Baseline Assessment (N=172 Guests)	1.2%	3.5%	95.3%
I feel safe when I am at this program.			
Baseline Assessment (N=171 Guests)	1.2%	2.3%	96.5%
As a result of this program I feel empowered to make positive changes in my life.			
Baseline Assessment (N=171 Guests)	1.2%	4.7%	94.2%
This program helps me reach my goals.			
Baseline Assessment (N=171 Guests)	1.8%	7.6%	90.6%
This program respects my cultural needs (race, religion, language, etc.).			
Baseline Assessment (N=170 Guests)	1.2%	5.3%	93.5%
My mental health, physical health, and substance use concerns are addressed.			
Baseline Assessment (N=170 Guests)	0.6%	8.8%	90.6%
My beliefs about health and well-being were respected in this program.			
Baseline Assessment (N=171 Guests)	0.0%	5.3%	94.7%
I have found referrals to resources that assisted me and/or my family.			
Baseline Assessment (N=172 Guests)	1.7%	16.9%	81.4%
I participated in the decision making about my recovery and wellness.			
Baseline Assessment (N=172 Guests)	1.7%	7.0%	91.3%
As a result of this program, I deal more effectively with daily problems.			
Baseline Assessment (N=172 Guests)	0.6%	12.2%	87.2%
Participating in this program has made me more effective in my relationships with family and friends.			
Baseline Assessment (N=170 Guests)	2.9%	27.6%	69.4%
After coming to this program, I am better able to work towards my life goals.			
Baseline Assessment (N=169 Guests)	1.2%	10.7%	88.2%
I feel comfortable talking about personal matters with peer staff.			
Baseline Assessment (N=171 Guests)	1.2%	8.8%	90.1%
I participate in activities with others in the community of my choice.			
Baseline Assessment (N=171 Guests)	2.3%	11.1%	86.5%

SHARE! PRRCH Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Baseline Assessment (N=192 Guests)	1.6%	2.1%	96.4%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=191 Guests)	5.8%	8.9%	85.3%
People were available to talk with me as often as I felt it was necessary.			
Baseline Assessment (N=188 Guests)	3.2%	5.3%	91.5%
I feel safe when I am at this program.			
Baseline Assessment (N=190 Guests)	3.2%	6.8%	90.0%
As a result of this program I feel empowered to make positive changes in my life.			
Baseline Assessment (N=191 Guests)	2.1%	6.8%	91.1%
This program helps me reach my goals.			
Baseline Assessment (N=192 Guests)	4.2%	9.9%	85.9%
This program respects my cultural needs (race, religion, language, etc.).			
Baseline Assessment (N=191 Guests)	1.0%	6.3%	92.7%
My mental health, physical health, and substance use concerns are addressed.			
Baseline Assessment (N=186 Guests)	2.2%	5.4%	92.5%
My beliefs about health and well-being were respected in this program.			
Baseline Assessment (N=190 Guests)	1.6%	5.8%	92.6%
I have found referrals to resources that assisted me and/or my family.			
Baseline Assessment (N=190 Guests)	8.9%	15.3%	75.8%
I participated in the decision making about my recovery and wellness.			
Baseline Assessment (N=187 Guests)	1.6%	3.2%	95.2%
As a result of this program, I deal more effectively with daily problems.			
Baseline Assessment (N=190 Guests)	2.6%	15.3%	82.1%
Participating in this program has made me more effective in my relationships with family and friends.			
Baseline Assessment (N=190 Guests)	4.7%	16.8%	78.4%
After coming to this program, I am better able to work towards my life goals.			
Baseline Assessment (N=186 Guests)	2.7%	11.3%	86.0%
I feel comfortable talking about personal matters with peer staff.			
Baseline Assessment (N=189 Guests)	5.3%	7.4%	87.3%
I participate in activities with others in the community of my choice.			
Baseline Assessment (N=188 Guests)	2.7%	13.3%	84.0%

Based on interviews of residents after a stay at the PRRCH programs, there are 2 areas where PRRCH programs had significant impact:

- Skill Development: Guests shared that respite was important in helping them build relationships coping and anger management skills. In learning these skills, guests learned and developed more accurate self-awareness from other respite guests and the peer staff.
- Managing Health Issues: Guests reported that their respite stay provided support so they could begin to treat or manage physical and mental health challenges. Motivation is a key to anyone's long term recovery. Many guests reported that they found the motivation they needed at the respite.

Lessons learned based on provider feedback:

- Peer staff noted that assisting guests with implementing the tools they acquired in the respite home and "taking that next step" in their recovery required more than 30 days.
- Many guests began their stay in the respite house after experiencing a significant loss related to violence, family disruption, abuse, or poverty.
- Guests that appeared to be lower functioning or unable to meet their basic needs and live independently, consideration for additional treatment methods such as mental health therapy, AA or recovery programs and/or medication were available. Peer support methods work effectively in conjunction or combination with other treatment modalities.
- Hiring and training of peer staff to learn how to effectively share their struggles and stories was a critical piece of peer support and building a relationship of "mutuality". This included mutual respect, trust and support based on a reciprocal peer relationship. Guests became hopeful and showed improvement in their mental, social and spiritual well-being when there was an ability to learn from peers who had transformed years of struggle with substance abuse and mental health issues.
- Guests often had little or no support systems once they returned to the community, which played a major role in their reentry into a respite home. Guests may have avoided psychiatric hospitalization, incarcerations, or drug and alcohol abuse if they had support during times of crisis.
- Outreach and engagement is vital in building relationships in the community and raising awareness about respite homes. Initially, people were made aware of respite homes based on referrals from other agencies. Now, due to the success of respite homes, most people are referred through word of mouth from previous guests.

Peer Run Integrated Services Management Model (PRISM)

Clients Served	168	364
Ethnicity	White: 35% African American: 31% Latino: 13% American Indian: 1% API: 4% Other/mixed: 5% Not reported: 11%	White: 25% African American: 35% Latino: 16% American Indian: 2% API: 6% Other/mixed: 13% Not reported: 3%
IMR Subscale Average Score at admission	**2.78**	**2.98**

- Six months after joining PRISM, 27.3% of Project Return participants reduced emergency room visits and 50% of participants maintained no hospital stays compared to baseline.
- Six months after joining PRISM, 26% percent of SHARE! Participants reduced their number of emergency room visits and 19.2% of participants reduced their number of hospital stays compared to baseline.
- Project Return participants 30.2% were homeless during the prior six months. No Project Return participants with matched assessments experienced chronic homelessness six months after enrolling in the program.
- 23.7% of participants showed a reduction in alcohol consumption and 17.9% showed an improvement in illegal drug use six months after enrollment.
- PRISM participants experienced significant improvement in several items on the Illness Management and Recovery scale, including time in structured roles and knowledge about symptoms, treatment and coping methods after enrolling in the program.

Lessons learned based on provider feedback:

- Outreach and engagement was based on building relationships in the community and raising awareness about the program. Authenticity was the key to building trust which increased the likelihood of developing a strong referral process.
- Working in collaboration with other agencies was very helpful to members to improve their overall care. Peer staff noted that peers, as part of the "team" became influential in the "treatment process." Peers were an important part of other peer lives. As one staff stated, "It doesn't work to be a fixer but try to be a supporter.
- Hiring and training of peer staff to learn how to effectively share their struggles and stories was a critical piece of peer support in building a relationship of "mutuality". This included mutual respect, trust and support based on a reciprocal peer relationship.

Lessons learned based on guest feedback:

- Guests shared that their stay at the respite house provided support and space so they could then begin to directly apply the skills they learned and some were able stayed connected to the staff as a continued support network to better manage their relationships and handle relapse
- Guests who stayed at the respite house stated: "The respite house were able to treat or manage their physical and mental health issues."
- The majority of guests agreed that the program helped them feel empowered to make positive changes in their life.
- Guests reported long lasting relationships with other guests once leaving the respite house.
- After leaving the respite house guests reported that they were able to make decisions on their own regarding their recovery and wellness.

The following are the feedback survey outcomes from Project Return and Share! PRISM Programs:

Project Return PRISM Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Six Month Assessment (N=12 People)	0.0%	33.3%	66.7%
If I had other choices, I would still come to this program.			
Baseline Assessment (N=12 People)	8.3%	25.0%	66.7%
People were available to talk with me as often as I felt it was necessary.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
I feel safe when I am at this program.			
Six Month Assessment (N=12 People)	0.0%	22.2%	77.8%
As a result of this program I feel empowered to make positive changes in my life.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
This program helps me reach my goals.			
Six Month Assessment (N=12 People)	0.0%	25.0%	75.0%
This program respects my cultural needs (race, religion, language, etc.).			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
My mental health, physical health, and substance use concerns are addressed.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
My beliefs about health and well-being were respected in this program.			
Six Month Assessment (N=12 People)	0.0%	8.3%	91.7%
I have found referrals to resources that assisted me and/or my family.			
Six Month Assessment (N=12 People)	0.0%	9.1%	90.9%
I participated in the decision making about my recovery and wellness.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
As a result of this program, I deal more effectively with daily problems.			
Six Month Assessment (N=12 People)	0.0%	41.7%	58.3%
Participating in this program has made me more effective in my relationships with family and friends.			
Six Month Assessment (N=12 People)	8.3%	41.7%	50.0%
After coming to this program, I am better able to work towards my life goals.			
Six Month Assessment (N=12 People)	0.0%	33.3%	66.7%
I feel comfortable talking about personal matters with peer staff.			
Six Month Assessment (N=12 People)	0.0%	0.0%	100.0%
I participate in activities with others in the community of my choice.			
Six Month Assessment (N=12 People)	8.3%	25.0%	66.7%

SHARE! PRISM Guest Feedback Survey			
	Disagree/Strongly Disagree	Neutral	Agree/Strongly Agree
I like coming to this program.			
Twelve Month Assessment (N=68)	0.0%	11.8%	88.2%
If I had other choices, I would still come to this program.			
Twelve Month Assessment (N=67)	4.5%	10.4%	85.1%
People were available to talk with me as often as I felt it was necessary.			
Twelve Month Assessment (N=67)	4.5%	4.5%	91.0%
I feel safe when I am at this program.			
Twelve Month Assessment (N=67)	1.5%	16.4%	82.1%
As a result of this program I feel empowered to make positive changes in my life.			
Twelve Month Assessment (N=67)	1.5%	10.4%	88.1%
This program helps me reach my goals.			
Twelve Month Assessment (N=67)	0.0%	11.9%	88.1%
This program respects my cultural needs (race, religion, language, etc.).			
Twelve Month Assessment (N=67)	1.5%	10.4%	88.1%
My mental health, physical health, and substance use concerns are addressed.			
Twelve Month Assessment (N=67)	4.5%	16.4%	79.1%
My beliefs about health and well-being were respected in this program.			
Twelve Month Assessment (N=66)	6.1%	15.2%	78.8%
I have found referrals to resources that assisted me and/or my family.			
Twelve Month Assessment (N=65)	3.1%	9.2%	87.7%
I participated in the decision making about my recovery and wellness.			
Twelve Month Assessment (N=66)	4.5%	13.6%	81.8%
As a result of this program, I deal more effectively with daily problems.			
Twelve Month Assessment (N=67)	4.5%	10.4%	85.1%
Participating in this program has made me more effective in my relationships with family and friends.			
Twelve Month Assessment (N=66)	4.5%	18.2%	77.3%
After coming to this program, I am better able to work towards my life goals.			
Twelve Month Assessment (N=66)	3.0%	10.4%	86.6%
I feel comfortable talking about personal matters with peer staff.			
Twelve Month Assessment (N=66)	1.5%	11.9%	86.6%
I participate in activities with others in the community of my choice.			
Twelve Month Assessment (N=66)	4.5%	25.8%	69.7%

Innovation 2:

After Mental Health Services Act Oversight and Accountability Commission approval of the Department's Innovation 2 Health Neighborhood plan on May 28, 2015, the Department has been drafting the solicitation Request for Services for lead agencies to propose specific community partnerships to build capacity in 10 geographically-defined areas of Los Angeles County to build community capacity to identify and address individuals experiencing trauma or who have trauma risk factors. Implementation of the four year project is projected to begin in the first quarter of Fiscal Year 2016-17. The solicitation for the evaluation of Innovation 2 is expected to have a similar projected time frame.

Over 20 community presentations have been made on Innovation 2 to promote the project and to engage interested agencies to submit documentation that will allow them to bid on the solicitation once it is released.

Workforce Education and Training

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

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

1 *75 staff trained through the Recover Oriented Practice (formerly known as Public Mental Health Workforce Immersion)*
During FY 2014-15, 75 individual staff members of the public mental health workforce attended the Public Mental Health Workforce Immersion into MHSA.

2 *104 Stipends were awarded to 2nd Year MSW and MFT Student* These stipends were awarded in exchange for a one year commitment to work in a hard-to-fill area of the County. Priority is given to individuals representing un- or under- served populations and/or speaking a threshold language.

3 *33 individuals completed the Health Navigator Skill Development Program*
100% of participants self-identified as representing underserved communities, and 54% spoke a threshold language.

4 *135 individuals received ongoing career advisement in order to further their careers in the public mental health system*
All 135 participants in this program are currently employed in the public mental health system.

5 *18 mental health consumers completed the Core Peer Advocate Training*
These individuals with lived experience are interested in working as mental health peer advocates.

6 *201 staff members participated in the interpreter training program*
Interpreters and clinicians trained to effectively use interpreters.
**Not unique number as some individuals participated in more than one training component*

7 *428 faculty and students attended MHSA presentations or MHSA mini-immersion training*
These individuals were trained on MHSA core tenets which support efforts to recruit future clinicians to public mental health service.

8 *70 participants completed the Intensive MH Recovery Specialist Training Program*
These participants were trained to work in the public mental health system as mental health rehabilitation specialists.

9 *151 supervisors completed the Recovery Oriented Supervision Training*
These supervisors are currently employed in the mental health system and are trained to effectively implement recovery oriented supervision.

10 *Licensure Examination Preparation*
During FY 2014-15, 253 MSWs, MFT Interns, and Psychologists were registered in the Licensure Examination Preparation Program.

1-Workforce Education and Training (WET) Coordination

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

2 -WET County of Los Angeles Oversight Committee

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

3 -Transformation Academy without Walls

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

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

During FY 2014-15, this program was delivered from July 1st, 2014 through December 31st, 2014. Subsequently, 75 individual staff members of the public mental health workforce attended this training.

Licensure Preparation Program (LPP)

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

The number of participants for each specific exam is as follows:

MSW - Part I	83	53	50	35	15
MSW - Part II	42	20	22	22	4
MFT - Part I	65	35	34	27	6
MFT - Part II	42	26	24	22	2
Psych - Part I	15	8	6	6	1
Psych - Part II	6	4	4	3	2

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

Health Navigator Skill Development Program

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

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

5 - Recovery Oriented Supervision Trainings

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

During FY 2014-15, 151 supervisors completed the program. 620% of these participants represented individuals from un- or under- served populations and 43% spoke a second language.

The ROSTCP program will cease on June 30, 2016.

6 - Interpreter Training Program

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

FY 2014-15 Outcomes:

Interpreter Training in Mental Health Setting (21 Hours)	72
Advance Training (7 hours)	22
Training MH Providers in Working with Interpreters (4 Hours)	25
Improving Spanish MH Clinical Terminology Part I (7 hours)	52
Improving Spanish MH Clinical Terminology Part II (7 hours)	30

7 - Training for Community Partners

Faith Based Roundtable Project

This project continues to bring together clergy and mental health staff to address the mental health issues of the individuals and communities they mutually serve. It has provided an opportunity for faith-based clergy to understand the essence of mental health services focused on recovery as well as for mental health personnel to understand and integrate spirituality in the recovery process. As of FY 2014-15, all eight service areas now participate in these Roundtable sessions. The program continued to fund a consultant in order to assist in facilitating the roundtable discussions, and provide guidance and structure when needed.

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

8 - Intensive Mental Health Recovery Specialist Training Program

Mental Health Rehabilitation Specialist Training will prepare consumers and family members with a Bachelor's degree, advanced degree, equivalent certification, to work in the field of mental health as psycho-social rehabilitation specialists. This 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.

During FY 2014-15, two contractors delivered this training and were completed by 70 individuals interested in employment in the public mental health system. Of these participants, 81% represented individuals from un- or under- served populations, and 54% spoke a threshold language.

This program ceased on December 31, 2014 and re-solicited with an updated curriculum which currently being implemented.

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

Peer Advocate Training prepares individuals interested in work as mental health peer advocates in the public mental health system. During FY 2014-15, certificated training consisted of the core peer advocate training.

During FY 2014-15, a total of 18 individuals completed the peer advocate training. Of these participants, 89% represented individuals from un- or under- served populations, 28% spoke a threshold language, and 39% have secured employment in the public mental health system.

This program ceased on December 31, 2014. Future training is projected to begin FY 2015-16.

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

This training program is intended to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: the work of family support for mental health; supporting the employment of parents and caregivers of children and youth consumers in our public mental health system; and/or promoting resilience and sustained wellness through an emphasis on increasing the availability of a workforce oriented to self-help, personal wellness and resilience techniques that are grounded in parent advocate/parent partner empowerment.
This program will be put out for solicitation with training anticipated to begin FY 2016-17.

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

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

Training Component	Train-The-Trainer Participants	New Speakers Trained	Presentation Participants
Adult Consumers Advocacy Speakes		34	144
Family Advocacy Speakers		10	21
Family Support and Advocacy Training	4	40	714
Family Support and Advocacy Training In Spanish		7	160
Family Advocacy Lobby Outreach Program		20	96
Family Advocate and Recovery Training Program			500
Family Advocate Wellness and Diversity Training Program			285
Family Advocate Wellness and Spirituality Training Program			200
Family Advocate and Provider Training Program			100
Parent/Caregiver Advocate Provider Training Program			150
Parent/Caregiver Advocate Wellness and Recovery Training Program			491
Child/Adolescent Consumer Advocacy Speakers Bureau		40	29
Parent Advocacy Speakers' Bureau		15	32
Parent Support and Advocacy Training Bureau	3	10	288
Parent Support and Advocacy Training Bureau in Spanish		8	60
Parent and Teachers Joint Advocacy Program		32	255
TOTALs	**7**	**216**	**3,525**

12 - Mental Health Career Advisors

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

During FY 2014-15, 135 individuals received an aggregate total of 529 career advisement sessions.

13- High School through University Mental Health Pathway

The County of Los Angeles, thru one contractor, is working on promoting mental health careers to a high school and the junior high school from where the student body originates. These outreach efforts are currently delivered in areas of the county where ethnically diverse populations reside.

During FY 2014-15, the first phase of this pilot program, a curriculum was developed and outreach was completed to two schools in the Antelope Valley/Palmdale area of the County. Implementation of this mental health recovery focused curriculum is projected to be partially implemented during the 2016-17 academic year.

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 students on the core tenets of MHSA; consultative services with faculty on recovery oriented curriculum enhancement; and MHSA mini immersion training opportunities where students and faculty learn first about the benefits of MHSA and the recovery process.

During FY 2014-15, a total of 428 faculty and students received curriculum consultation, attended the MHSA presentations or MHSA mini-immersion.

This program ceased on December 31, 2014.

16 - Recovery Oriented Internship Development (Recovery Oriented and Integrated Care Internship Training Program)

This program consists of training targeted to supervising field instructors employed in the public mental health system (PMHS) and their student interns. The purpose of this program is to 1) promote recovery oriented and integrated care principles and 2) establish standards for student training critical for the preparation of the future PMHS workforce. Field instructors will have an opportunity to increase their exposure, knowledge and expertise in recovery oriented and integrated care principles; and augment student interns' classroom instruction through training and supervised direct service experience.

During FY 2014-15, participants included 14 supervisors and 40 interns; of the supervisors, 50% represented an underserved community and 36% spoke a threshold language; of the interns, they self-identified as 45% and 30% respectively.

The following 8 mental health programs participated during FY 2014-15:

- Antelope Valley Mental Health Center
- West Valley Mental Health Center
- Northeast Mental Health Center
- Coastal Asian Pacific MHC
- Antelope Valley Enrichment Services
- Exodus Recovery
- Telecare Inc.
- MHALA Village and Wellness Center

19 - Public Mental Health Workforce Financial Incentive Program

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

Tuition Reimbursement Program

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

Loan Forgiveness Program

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

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

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

LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to service the traditionally unserved and underserved populations of the County.
During FY 2014/2015 this program was available to 52 MFT, 52 MSW, and 4 Nurse Practitioners students. During this award cycle, all but 4 NP stipends were awarded. 74% of all recipients identified from populations recognized as un- or under- served. During the same cycle, 73% spoke a threshold language.

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

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

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

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

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

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

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

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

UCLA Faculty Consultation Services (Edelman Mental Health Clinic)

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

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

Clinical Scholars Program (West Central Mental Health Clinic)

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

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

Geropsych Fellowship Services

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

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

Contract Provider Technology Project (CPTP)

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	3/19/2008	*Project End Date:*	6/30/2018
Project Objectives:	The primary objective is to provide a means for non-governmental agency Short-Doyle Contract Providers within the LAC-DMH provider network to obtain the funding necessary to fully participate in the County's Integrated Information Systems Infrastructure and address their technological needs consistent with the MHSA Capital Facilities and Technological Needs Guidelines.		
Phase:	Implementation		
Accomplishments:	• Completed review of IT Project Proposal submissions from Legal Entity Contract Providers • CPTT Workgroup Meetings 11/6/2014 and 5/5/2014 • As of June 30, 2015, 118 Technological Needs Funding Agreements for each contract provider has been fully executed.		

Integrated Behavioral Health Information System (IBHIS)

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	4/1/2009	*Project End Date:*	6/30/2017
Project Objectives:	To acquire Commercial-Off-the-Shelf (COTS) and proven software with the necessary clinical functionality to support the delivery of quality mental health services consistent with the Mental Health Services Act and integrated with administrative and financial functionality.		
Phase:	Implementation Phase/Production Roll-Out		
Accomplishments:	• Completed the migration of 121 Directly Operated programs into IBHIS. • DMH has implemented software known as JAWS for visually impaired employees as part of DMH Americans with Disabilities Act (ADA) compliance. The solution is in production use with one user and others are considering it. • Began working with Probation and Sheriff to use Care Connect to integrate IBHIS data. • Completed 20 system modifications intended to improve the efficiency of the claiming process in IBHIS. This is a necessary predecessor to bringing on legal entities at volume.		

Personal Health Record Awareness & Education

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	1/13/2015	*Project End Date:*	TBD

Project Objectives:

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

Phase:

Phase I: Construction Phase (Software Deployment)

Accomplishments:

- Project Kick-off, Project Charter, and Planning Documents completed
- Project Team and resources identified and committed
- Netsmart Vendor Consultant is now on board
- Requirements and Design work started
- Business Workflow Sessions started
- Demo system provided by the vendor to allow project team to navigate through some of the functionality
- Training and Communication Material development started
- Started work on DMH Terms and Conditions of Use and Privacy Statement
- Start Web Development for Client Information site and secure Login Page
- Started work on standing up the new Test environment

Consumer/Family Access to Computer Resources

Project Status:	On Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	1/19/2010	*Project End Date:*	6/30/2018

Project Objectives:

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

Phase: Expansion Phase

Accomplishments:

- Completed 83 computer installations and 51 ergonomic stand-sit carts
- Completed first annual survey
- Sent to all site contacts
- Reviewed responses and evaluated in preparation to revisit each site
- Completed 50% of the planned revisits to existing sites
- Corrected unreported issues
- Retrained staff and volunteers on library card processing and computer tutoring
- Evaluated adds/moves and changes for existing sites
- Identified and introduced basic, intermediate and advanced free online computer training opportunities
- Obtained ability to process library cards for minors at DMH sites
- Completed 50% of several phases of project expansion
- Identified 50% of the potential new sites
- Identified expansion needs for existing sites
- Completed 50% of staff and volunteer training on library card processing and computer tutoring

Data Warehouse Re-Design

Project Status:	Behind Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	July 2013	*Project End Date:*	To be determined
Project Objectives:	Redesign the current data warehouse to support the data requirements of the Department of Mental Health's new Integrated Behavioral Health Information System (IBHIS) as well as new data collected from MHSA programs such as Prevention & Early Intervention (PEI), Workforce Education and Training, and Innovation. The redesigned data warehouse will include the full scope of MHSA program and service data including clinical, outcomes, financial, and administrative data.		
Phase:	Construction Phase (Software Deployment)		
Accomplishments:	• Conceptual Data Model developed • Business Intelligence Roadmap Document developed • High Level Extract, Transform and Load (ETL) approach defined and documented • High Level Business Rules identified • Logical Data Model developed • Physical Data Model developed		

Telepsychiatry Implementation

Project Status:	On Schedule	*Budget Status:*	Within Approved Budget
Project Start Date:	7/1/2010	*Project End Date:*	6/30/2018
Project Objectives:	To address service disparities among remote and underserved populations by implementing networked videoconferencing at multiple service locations to allow provision of direct Telepsychiatry treatment services to clients by psychiatrists and specialty tele-consultation between Psychiatrists and primary care providers.		
Phase:	Implementation Phase		
Accomplishments:	Completed construction and took occupancy of the permanent TeleMental Health Hub (in the same site as Harbor UCLA Wellness Center the 2nd week of April, 2015.		

Below are the capital facilities projects in progress. During the implementation phase of the projects, costs associated with land and materials have increased from the original estimates. Upon completion of the projects above, remaining funds will be reassessed.

Downtown Mental Health Center

Project Description: Purchased 25,000 sq.ft. building for $3.5 Million and refurbish and retro fit entire building. . The refurbishment and retro fit of the entire building is finished and was open for business in December 2015. Building will house 70 staff and service approximately 220 clients per day and provides direct services to clients in the surrounding vicinity.

Supervisorial District: 2
Cost: ***$15,900,000***

Arcadia Mental Health Center

Project Description: Building of the new 12,000 sq. ft. clinic in existing parking lot of old clinic was finished September 2015. The Arcadia Mental Health Center provides crisis evaluation and assessment, case management, psycho-social rehabilitation services, referrals, and individual and group therapy for approximately 2,400 clients annually.

Supervisorial District: 5
Cost: ***$13,500,000***

San Fernando Courthouse

Project Description: Potential site to relocate West Valley MHC and West Valley FCCS programs. Department of Public Works has an architecture firm working on the different concepts at this time. The building will be approximately 17K square feet of renovated space or new construction.

Supervisorial District: 3
Cost: ***$4,900,000***

Exodus Recovery

Project Description: Refurbishment of Ted Watkins Building for Martin Luther King Psychiatric Urgent Care Center was completed and opened November 2015. The Unit will provide intensive outpatient mental health services and will have Mental Health Lanterman-Petris-Short (LPS) designated staff.

Supervisorial District: 2
Cost: ***$1,300,000***

Fiscal Year 2016-17 through Fiscal Year 2018-19 Three-Year Mental Health Services Expenditure Plan

Funding Summary

County: Los Angeles

Date: 3/17/16

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	357,969,964	153,822,772	47,140,336	26,478,174	11,000,000	
2. Estimated New FY2016/17 Funding	383,001,629	95,750,407	25,197,476			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	740,971,593	249,573,179	72,337,812	26,478,174	11,000,000	
B. Estimated FY2016/17 MHSA Expenditures	479,597,340	88,149,431	23,008,720	13,239,087	10,700,000	
C. Estimated FY2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	261,374,253	161,423,748	49,329,092	13,239,087	300,000	
2. Estimated New FY2017/18 Funding	397,786,738	99,446,685	26,170,180			
3. Transfer in FY2017/18[a/]	0					
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	659,160,991	260,870,433	75,499,272	13,239,087	300,000	
D. Estimated FY2017/18 Expenditures	470,649,819	88,149,431	23,008,720	13,239,087	300,000	
E. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	188,511,172	172,721,002	52,490,552	0	0	
2. Estimated New FY2018/19 Funding	399,849,272	99,962,318	26,305,873			
3. Transfer in FY2018/19[a/]	0					
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	588,360,444	272,683,320	78,796,425	0	0	
F. Estimated FY2018/19 Expenditures	470,649,819	88,149,431	23,008,720	0	0	
G. Estimated FY2018/19 Unspent Fund Balance	117,710,624	184,533,889	55,787,705	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	160,725,402
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2016	160,725,402
5. Contributions to the Local Prudent Reserve in FY 2016/17	0
6. Distributions from the Local Prudent Reserve in FY 2016/17	0
7. Estimated Local Prudent Reserve Balance on June 30, 2017	160,725,402
8. Contributions to the Local Prudent Reserve in FY 2017/18	0
9. Distributions from the Local Prudent Reserve in FY 2017/18	0
10. Estimated Local Prudent Reserve Balance on June 30, 2018	160,725,402

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

Community Services and Supports (CSS) Component Worksheet

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	115,945,420	69,751,586	25,220,787	0	20,973,047	0
2. Family Support Services	4,246,877	4,246,877	0	0	0	0
3. Children-Field-Capable Clinical Services	88,168,810	12,531,257	46,155,116	0	29,482,437	0
4. TAY Full Service Partnerships	35,876,362	16,549,461	12,534,902	0	6,791,999	0
5. Drop-in Centers	408,000	408,000	0	0	0	0
6. TAY Housing Services	697,915	697,915	0	0	0	0
7. TAY Supportive Employment Services	375,000	375,000	0	0	0	0
8. Probation Camp Services	1,184,713	1,184,713	0	0	0	0
9. TAY-Field-Capable Clinical Services	4,675,013	1,194,428	2,178,609	0	1,301,521	455
10. Adult Full Service Partnerships	96,047,741	64,795,804	31,191,471	0	60,466	0
11. Wellness/Client Run Centers	11,391,283	6,469,012	4,446,964	0	91,367	383,940
12. IMD Step Down Facilities	6,074,499	3,655,299	2,419,200	0	0	0
13. Adult Housing Services-25M onetime	2,260,634	2,260,634	0	0	0	0
14. Adult Supportive Employment Model Pilot	666,998	454,856	212,142	0	0	0
15. Adult Promotores	248,435	248,435	0	0	0	0
16. Jail transition & Linkage Services	462,579	447,479	10,074	0	337	4,689
17. Adult-Field-Capable Clinical Services	18,797,388	10,070,576	8,722,414	0	1,305	3,093
18. Integrated Care Program	3,098,246	1,857,744	1,122,047	0	118,465	0
19. Older Adult Full Service Partnerships	10,114,886	6,148,454	3,966,432	0	0	0
20. Transformation Design Team	0	0	0	0	0	0
21. Older Adult Field-Capable Clinical Services	9,044,713	6,103,711	2,775,463	0	0	165,539
22. OA Training	42,772	42,772	0	0	0	0
23. OA Service Extenders	34,425	34,425	0	0	0	0
24. Service Area Navigator Teams	5,667,937	5,633,647	25,777	0	8,166	347
25. Planning, Outreach, Engagement	4,497,734	4,462,939	34,795	0	0	0
26. Alternative Crisis Services	18,653,976	10,590,558	8,008,446	0	43,541	3,431
Non-FSP Programs						
27. Children's Full Service Partnerships	0	0	0	0	0	0
28. Family Support Services	0	0	0	0	0	0
29. Children-Field-Capable Clinical Services	118,264,895	16,808,753	61,909,988	0	39,546,154	0
30. TAY Full Service Partnerships	0	0	0	0	0	0
31. Drop-in Centers	1,632,000	1,632,000	0	0	0	0
32. TAY Housing Services	1,628,467	1,628,467	0	0	0	0
33. TAY Supportive Employment Services	125,000	125,000	0	0	0	0
34. Probation Camp Services	3,554,139	3,554,139	0	0	0	0
35. TAY-Field-Capable Clinical Services	6,270,811	1,602,142	2,922,269	0	1,745,791	610
36. Adult Full Service Partnerships	0	0	0	0	0	0
37. Wellness/Client Run Centers	85,678,025	48,655,014	33,447,254	0	687,203	2,887,753
38. IMD Step Down Facilities	6,580,707	3,959,907	2,620,799	0	0	0
39. Adult Housing Services-25M onetime	9,042,538	9,042,538	0	0	0	0
40. Adult Supportive Employment Model Pilot	222,333	151,619	70,714	0	0	0
41. Adult Promotores	579,681	579,681	0	0	0	0
42. Jail transition & Linkage Services	7,247,068	7,010,512	157,822	0	5,279	73,455
43. Adult-Field-Capable Clinical Services	25,213,803	13,508,128	11,699,776	0	1,750	4,149
44 Integrated Care Program	17,556,725	10,527,214	6,358,268	0	671,243	0
45. Older Adult Full Service Partnerships	0	0	0	0	0	0
46. Transformation Design Team	478,358	470,358	0	0	0	0
47. Older Adult Field-Capable Clinical Services	12,132,091	8,187,189	3,722,857	0	0	222,045
48. OA Training	171,086	171,086	0	0	0	0
49. OA Service Extenders	195,075	195,075	0	0	0	0
50. Service Area Navigator Teams	3,778,625	3,755,765	17,184	0	5,444	232
51. Planning, Outreach, Engagement	11,011,695	10,926,507	85,188	0	0	0
52. Alternative Crisis Services	96,470,525	55,825,394	40,302,017	0	329,955	13,160
CSS Administration	33,677,204	32,598,471				1,078,733
CSS MHSA Housing Program Assigned Funds	18,450,000	18,450,000				
Total CSS Program Estimated Expenditures	898,643,206	479,597,340	312,338,775	0	101,865,460	4,841,631
FSP Programs as Percent of Total	91.5%					

CSS Component Worksheet (continued)

		Fiscal Year 2017/18					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1	Children's Full Service Partnerships	115,945,420	69,751,586	25,220,787	0	20,973,047	0
2	Family Support Services	4,246,877	4,246,877	0	0	0	0
3.	Children-Field-Capable Clinical Services	88,168,810	12,531,257	46,155,116	0	29,482,437	0
4	TAY Full Service Partnerships	35,876,362	16,549,461	12,534,902	0	6,791,999	0
5.	Drop-in Centers	408,000	408,000	0	0	0	0
6.	TAY Housing Services	697,915	697,915	0	0	0	0
7.	TAY Supportive Employment Services	375,000	375,000	0	0	0	0
8.	Probation Camp Services	1,184,713	1,184,713	0	0	0	0
9.	TAY-Field-Capable Clinical Services	4,675,013	1,194,428	2,178,609	0	1,301,521	455
10.	Adult Full Service Partnerships	96,047,741	64,795,804	31,191,471	0	60,466	0
11.	Wellness/Client Run Centers	11,391,283	6,469,012	4,446,964	0	91,367	383,940
12.	IMD Step Down Facilities	6,074,498	3,655,299	2,419,200	0	0	0
13.	Adult Housing Services-25M onetime	800,634	800,634	0	0	0	0
14.	Adult Supportive Employment Model Pilot	666,998	454,856	212,142	0	0	0
15.	Adult Promotores	248,435	248,435	0	0	0	0
16	Jail transition & Linkage Services	462,579	447,479	10,074	0	337	4,689
17	Adult-Field-Capable Clinical Services	18,797,387	10,070,576	8,722,414	0	1,305	3,093
18.	Integrated Care Program	3,098,246	1,857,744	1,122,047	0	118,455	0
19	Older Adult Full Service Partnerships	10,114,886	6,148,454	3,966,432	0	0	0
20	Transformation Design Team	0	0	0	0	0	0
21	Older Adult Field-Capable Clinical Services	9,044,713	6,103,711	2,775,463	0	0	165,539
22.	OA Training	42,772	42,772	0	0	0	0
23.	OA Service Extenders	34,425	34,425	0	0	0	0
24.	Service Area Navigator Teams	5,667,937	5,633,647	25,777	0	8,166	347
25.	Planning, Outreach, Engagement	4,497,734	4,462,939	34,795	0	0	0
26	Alternative Crisis Services	18,653,976	10,598,557	8,008,446	0	43,541	3,431
Non-FSP Programs							
27.	Children's Full Service Partnerships	0	0	0	0	0	0
28.	Family Support Services	0	0	0	0	0	0
29.	Children-Field-Capable Clinical Services	148,360,979	21,086,250	77,664,859	0	49,609,870	0
30.	TAY Full Service Partnerships	0	0	0	0	0	0
31	Drop-in Centers	1,632,000	1,632,000	0	0	0	0
32.	TAY Housing Services	1,628,467	1,628,467	0	0	0	0
33.	TAY Supportive Employment Services	125,000	125,000	0	0	0	0
34.	Probation Camp Services	3,554,139	3,554,139	0	0	0	0
35	TAY-Field-Capable Clinical Services	7,866,609	2,009,855	3,665,929	0	2,190,060	765
36.	Adult Full Service Partnerships	0	0	0	0	0	0
37.	Wellness/Client Run Centers	93,466,936	53,079,070	36,487,913	0	749,676	3,150,276
38.	IMD Step Down Facilities	6,580,707	3,959,907	2,620,799	0	0	0
39.	Adult Housing Services-25M onetime	3,202,538	3,202,538	0	0	0	0
40.	Adult Supportive Employment Model Pilot	222,333	151,619	70,714	0	0	0
41.	Adult Promotores	579,681	579,681	0	0	0	0
42.	Jail transition & Linkage Services	7,247,068	7,010,512	157,822	0	5,279	73,455
43.	Adult-Field-Capable Clinical Services	39,763,704	21,303,141	18,451,260	0	2,760	6,543
44.	Integrated Care Program	17,556,725	10,527,214	6,358,268	0	671,243	0
45	Older Adult Full Service Partnerships	0	0	0	0	0	0
46	Transformation Design Team	478,358	478,358	0	0	0	0
47	Older Adult Field-Capable Clinical Services	10,871,050	7,336,191	3,335,893	0	0	198,966
48.	OA Training	171,086	171,086	0	0	0	D
49.	OA Service Extenders	195,075	195,075	0	0	0	0
50.	Service Area Navigator Teams	3,778,625	3,755,765	17,184	0	5,444	232
51.	Planning, Outreach, Engagement	11,011,695	10,926,507	85,188	0	0	0
52.	Alternative Crisis Services	96,470,525	55,825,394	40,302,017	0	329,955	13,160
CSS Administration		33,677,204	32,598,471				1,078,733
CSS MHSA Housing Program Assigned Funds		750,000	750,000				
Total CSS Program Estimated Expenditures		926,412,857	470,649,819	338,242,486	0	112,436,928	5,083,624
FSP Programs as Percent of Total		92.9%					

CSS Component Worksheet (continued)

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's Full Service Partnerships	115,945,420	69,751,586	25,220,787	0	20,973,047	0
2. Family Support Services	4,246,877	4,246,877	0	0	0	0
3. Children-Field-Capable Clinical Services	88,168,810	12,531,257	46,155,116	0	29,482,437	0
4. TAY Full Service Partnerships	35,876,362	16,549,461	12,534,902	0	6,791,999	0
5. Drop-in Centers	408,000	408,000	0	0	0	0
6. TAY Housing Services	697,915	697,915	0	0	0	0
7. TAY Supportive Employment Services	375,000	375,000	0	0	0	0
8. Probation Camp Services	1,184,713	1,184,713	0	0	0	0
9. TAY-Field-Capable Clinical Services	4,675,013	1,194,428	2,178,609	0	1,301,521	455
10. Adult Full Service Partnerships	96,047,741	64,795,804	31,191,471	0	60,466	0
11. Wellness/Client Run Centers	11,391,283	6,469,012	4,446,964	0	91,367	383,940
12. IMD Step Down Facilities	6,074,498	3,655,299	2,419,200	0	0	0
13. Adult Housing Services-25M onetime	800,634	800,634	0	0	0	0
14. Adult Supportive Employment Model Pilot	666,999	454,856	212,142	0	0	0
15. Adult Promotores	248,435	248,435	0	0	0	0
16. Jail transition & Linkage Services	462,579	447,479	10,074	0	337	4,689
17. Adult-Field-Capable Clinical Services	18,797,387	10,070,576	8,722,414	0	1,305	3,093
18. Integrated Care Program	3,098,246	1,857,744	1,122,047	0	118,465	0
19. Older Adult Full Service Partnerships	10,114,886	6,148,454	3,966,432	0	0	0
20. Transformation Design Team	0	0	0	0	0	0
21. Older Adult Field-Capable Clinical Services	9,044,713	6,103,711	2,775,463	0	0	165,539
22. OA Training	42,772	42,772	0	0	0	0
23. OA Service Extenders	34,425	34,425	0	0	0	0
24. Service Area Navigator Teams	5,667,937	5,633,647	25,777	0	8,166	347
25. Planning, Outreach, Engagement	4,497,734	4,462,939	34,795	0	0	0
26. Alternative Crisis Services	18,653,976	10,598,557	8,008,446	0	43,541	3,431
Non-FSP Programs						
27. Children's Full Service Partnerships	0	0	0	0	0	0
28. Family Support Services	0	0	0	0	0	0
29. Children-Field-Capable Clinical Services	148,360,979	21,086,250	77,664,859	0	49,609,870	0
30. TAY Full Service Partnerships	0	0	0	0	0	0
31. Drop-in Centers	1,632,000	1,632,000	0	0	0	0
32. TAY Housing Services	1,628,467	1,628,467	0	0	0	0
33. TAY Supportive Employment Services	125,000	125,000	0	0	0	0
34. Probation Camp Services	3,554,139	3,554,139	0	0	0	0
35. TAY-Field-Capable Clinical Services	7,866,609	2,009,855	3,665,929	0	2,190,060	765
36. Adult Full Service Partnerships	0	0	0	0	0	0
37. Wellness/Client Run Centers	93,466,936	53,079,070	36,487,913	0	749,676	3,150,276
38. IMD Step Down Facilities	6,580,707	3,959,907	2,620,799	0	0	0
39. Adult Housing Services-25M onetime	3,202,538	3,202,538	0	0	0	0
40. Adult Supportive Employment Model Pilot	222,133	151,619	70,714	0	0	0
41. Adult Promotores	579,681	579,681	0	0	0	0
42. Jail transition & Linkage Services	7,247,068	7,010,512	157,822	0	5,279	73,455
43. Adult-Field-Capable Clinical Services	39,763,704	21,303,141	18,451,260	0	2,760	6,543
44. Integrated Care Program	17,556,725	10,527,214	6,358,268	0	671,243	0
45. Older Adult Full Service Partnerships	0	0	0	0	0	0
46. Transformation Design Team	478,358	478,358	0	0	0	0
47. Older Adult Field-Capable Clinical Services	10,871,050	7,336,191	3,335,893	0	0	198,966
48. OA Training	171,086	171,086	0	0	0	0
49. OA Service Extenders	195,075	195,075	0	0	0	0
50. Service Area Navigator Teams	3,778,625	3,755,765	17,184	0	5,444	232
51. Planning, Outreach, Engagement	11,011,695	10,926,507	85,188	0	0	0
52. Alternative Crisis Services	96,470,525	55,825,394	40,302,017	0	329,955	13,160
CSS Administration	33,677,204	32,598,471				1,078,733
CSS MHSA Housing Program Assigned Funds	750,000	750,000				
Total CSS Program Estimated Expenditures	926,412,857	470,649,819	338,242,486	0	112,436,928	5,083,624
FSP Programs as Percent of Total	92.9%					

Budget

PEI Component Worksheet (continued)

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	760,768	239,141	313,278		208,349	
2. PEI Early Start-School Mental Health Initiative	10,100,893	3,175,132	4,159,467		2,766,294	
3. PEI Early Start-Stigma Discrimination	459,939	144,578	189,399		125,962	
4. School-based Services	0	0	0		0	
5. Family Education and Support Services	4,366,321	1,372,517	1,798,016		1,195,788	
6. At-risk Family Services	0	0	0		0	
7. Trauma Recovery Services	0	0	0		0	
8. Primary Care & Behavioral Health	0	0	0		0	
9. Early Care & Support for TAY	517,725	162,743	213,195		141,787	
10. Juvenile Justice Services	0	0	0		0	
11. Early Care & Support for Older Adults	0	0	0		0	
12. Improving Access for Underserved Populations	0	0	0		0	
13. American Indian Project	53,386	12,649	16,571		11,020	13,146
PEI Programs - Early Intervention		0	0		0	
14. PEI Early Start-Suicide Prevention	0	0	0		0	
15. PEI Early Start-School Mental Health Initiative	0	0	0		0	
16. PEI Early Start-Stigma Discrimination	0	0	0		0	
17. School-based Services	19,632,979	6,171,465	8,084,703		5,376,811	
18. Family Education and Support Services	21,586,945	6,785,678	8,889,331		5,911,936	
19. At-risk Family Services	31,036,697	8,274,732	13,670,359		9,091,606	
20. Trauma Recovery Services	68,530,538	18,271,011	30,184,819		20,074,708	
21. Primary Care & Behavioral Health	16,874,087	5,304,230	6,948,614		4,621,243	
22. Early Care & Support for TAY	44,084,740	11,753,487	19,417,473		12,913,780	
23. Juvenile Justice Services	22,219,241	6,984,435	9,149,705		6,085,101	
24. Early Care & Support for Older Adults	4,881,417	1,534,433	2,010,128		1,336,856	
25. Improving Access for Underserved Populations	12,340,150	3,879,024	5,081,575		3,379,551	
26. American Indian Project	1,922,521	604,328	791,679		526,514	
PEI Administration	13,479,848	13,479,848				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	272,848,195	88,149,431	110,918,312	0	73,767,306	13,146

PEI Component Worksheet (continued)

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	760,768	239,141	313,278		208,349	
2. PEI Early Start-School Mental Health Initiative	10,100,893	3,175,132	4,159,467		2,766,294	
3. PEI Early Start-Stigma Discrimination	459,939	144,578	189,399		125,962	
4. School-based Services	0	0	0		0	
5. Family Education and Support Services	4,366,321	1,372,517	1,798,016		1,195,788	
6. At-risk Family Services	0	0	0		0	
7. Trauma Recovery Services	0	0	0		0	
8. Primary Care & Behavioral Health	0	0	0		0	
9. Early Care & Support for TAY	517,725	162,743	213,195		141,787	
10. Juvenile Justice Services	0	0	0		0	
11. Early Care & Support for Older Adults	0	0	0		0	
12. Improving Access for Underserved Populations	0	0	0		0	
13. American Indian Project	53,386	12,649	16,571		11,020	13,146
PEI Programs - Early Intervention		0	0		0	
14. PEI Early Start-Suicide Prevention	0	0	0		0	
15. PEI Early Start-School Mental Health Initiative	0	0	0		0	
16. PEI Early Start-Stigma Discrimination	0	0	0		0	
17. School-based Services	19,632,979	6,171,465	8,084,703		5,376,811	
18. Family Education and Support Services	21,586,945	6,785,678	8,889,331		5,911,936	
19. At-risk Family Services	31,036,697	8,274,732	13,670,359		9,091,606	
20. Trauma Recovery Services	68,530,538	18,271,011	30,184,819		20,074,708	
21. Primary Care & Behavioral Health	16,874,087	5,304,230	6,948,614		4,621,243	
22. Early Care & Support for TAY	44,084,740	11,753,487	19,417,473		12,913,780	
23. Juvenile Justice Services	22,219,241	6,984,435	9,149,705		6,085,101	
24. Early Care & Support for Older Adults	4,881,417	1,534,433	2,010,128		1,336,856	
25. Improving Access for Underserved Populations	12,340,150	3,879,024	5,081,575		3,379,551	
26. American Indian Project	1,922,521	604,328	791,679		526,514	
PEI Administration	13,479,848	13,479,848				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	272,848,195	88,149,431	110,918,312	0	73,767,306	13,146

Budget

PEI Component Worksheet (continued)

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. PEI Early Start-Suicide Prevention	760,768	239,141	313,278		208,349	
2. PEI Early Start-School Mental Health Initiative	10,100,893	3,175,132	4,159,467		2,766,294	
3. PEI Early Start-Stigma Discrimination	459,939	144,578	189,399		125,962	
4. School-based Services	0	0	0		0	
5. Family Education and Support Services	4,366,321	1,372,517	1,798,016		1,195,788	
6. At-risk Family Services	0	0	0		0	
7. Trauma Recovery Services	0	0	0		0	
8. Primary Care & Behavioral Health	0	0	0		0	
9. Early Care & Support for TAY	517,725	162,743	213,195		141,787	
10. Juvenile Justice Services	0	0	0		0	
11. Early Care & Support for Older Adults	0	0	0		0	
12. Improving Access for Underserved Populations	0	0	0		0	
13. American Indian Project	53,386	12,649	16,571		11,020	13,146
PEI Programs - Early Intervention		0	0		0	
14. PEI Early Start-Suicide Prevention	0	0	0		0	
15. PEI Early Start-School Mental Health Initiative	0	0	0		0	
16. PEI Early Start-Stigma Discrimination	0	0	0		0	
17. School-based Services	19,632,979	6,171,465	8,084,703		5,376,811	
18. Family Education and Support Services	21,586,945	6,785,678	8,889,331		5,911,936	
19. At-risk Family Services	31,036,697	8,274,732	13,670,359		9,091,606	
20. Trauma Recovery Services	68,530,538	18,271,011	30,184,819		20,074,708	
21. Primary Care & Behavioral Health	16,874,087	5,304,230	6,948,614		4,621,243	
22. Early Care & Support for TAY	44,084,740	11,753,487	19,417,473		12,913,780	
23. Juvenile Justice Services	22,219,241	6,984,435	9,149,705		6,085,101	
24. Early Care & Support for Older Adults	4,881,417	1,534,433	2,010,128		1,336,856	
25. Improving Access for Underserved Populations	12,340,150	3,879,024	5,081,575		3,379,551	
26. American Indian Project	1,922,521	604,328	791,679		526,514	
PEI Administration	13,479,848	13,479,848				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	272,848,195	88,149,431	110,918,312	0	73,767,306	13,146

Innovation Component Worksheet

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Evaluation	1,000,000	1,000,000	0		0	
2. Innovation #2	20,000,000	20,000,000	0		0	
INN Administration	2,008,720	2,008,720				
Total INN Program Estimated Expenditures	23,008,720	23,008,720	0	0	0	0

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

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

Budget

Workforce, Education and Training (WET) Component Worksheet

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	1,006,357	1,006,357				
2. Mental Health Career Pathway	4,190,258	4,190,258				
3. Residency and Internship	200,239	200,239				
4. Financial Incentive	6,671,038	6,671,038				
WET Administration	1,171,195	1,171,195				
Total WET Program Estimated Expenditures	13,239,087	13,239,087	0	0	0	0

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	1,006,357	1,006,357				
2. Mental Health Career Pathway	4,190,258	4,190,258				
3. Residency and Internship	200,239	200,239				
4. Financial Incentive	6,671,038	6,671,038				
WET Administration	1,171,195	1,171,195				
Total WET Program Estimated Expenditures	13,239,087	13,239,087	0	0	0	0

Capital Facilities/Technological Needs (CFTN) Component Worksheet

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Downtown Parking Space	8,200,000	8,200,000				
2.	0	0				
3.	0	0				
4.	0	0				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Contract Provider Technology Needs Project	2,500,000	2,500,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	10,700,000	10,700,000	0	0	0	0

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0	0				
2.	0	0				
3.	0					
4.	0					
5.	0					
6	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Contract Provider Technology Needs Project	300,000	300,000				
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	300,000	300,000	0	0	0	0

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Fiscal Year 2014-15 MHSA Services by Component

Community Services and Supports Plan

Stakeholder Recommended Changes from Previously Approved Plan

The Department's Executive Management Team identified a trend of under-spending within the CSS Plan and asked the SLT for an age group allocation methodology for $30 million in each of the next 3 Fiscal Years. After reserving $10 million for Board of Supervisor expansion program priorities, the SLT approved the following age group percent distribution of net CSS dollars:

Child: 13% TAY: 13% Adult: 61% Older Adult: 13%

This would result in an additional $2.6 million allocation for child, TAY and Older Adults and $12.2 million for adults for each of the Fiscal Years 2014-15, 2015-16, 2016-17.

After reviewing 51 proposals, the SLT recommended to the Department and to the Mental Health Commission the following program expansions and new programs.

Board Priorities with Stakeholder support from SLT

1. Implementation of Laura's Law/Assisted Outpatient Treatment via the expansion of adult FSP services, Service Area Navigation Teams and Alternative Crisis Services:

MHSA Component and Work Plan: Adult, Assisted Outpatient Treatment Program is an expansion of the following Adult CSS programs:

- Service Area Navigation Teams – 500 evaluations per year
- Full Service Partnership – Adult, 300 additional slots
- Alternative Crisis Services – capacity to serve 60 additional clients

What is being expanded? Assembly Bill 1421 established the Assisted Outpatient Treatment (AOT) Demonstration Project Act of 2002, known as Laura's Law. Laura's Law addresses the needs of mentally ill adults by providing a process to allow court-ordered outpatient treatment. The legislation established an option for counties to provide a way for courts, probation, and the mental health systems to address the needs of individuals who are unable to benefit from mental health treatment programs in the community without supervision. The unique programmatic component of Laura's Law is the AOT Team. These teams screen requests, conduct extensive outreach and engagement, develop petitions and manage the court processes to connect AOT enrollees with service providers primarily those who are Full Service Partnership Providers (FSP). Extensive outreach and engagement must be completed by this team in order to adequately assess for the law's detailed criteria. Successful implementation is predicated upon extensive inter-agency collaboration and provision of significant resources from the courts, County Counsel, Public Defender, the District Attorney's office, and local law enforcement. Laura's Law enrollees require higher levels of care, which may include on-site mental health and supportive services to

transition to stable community placement and prepare for more independent community living. The Enriched Residential Services program will provide such services at selected Adult Residential Facilities.

Estimated MHSA Budget Service Area Navigation, MHSA $726,658
FSP, MHSA $ 1,919,880
IMD Step-Down, MHSA $ 1,226,400

Estimated Medi-Cal Budget Service Area Navigation, MHSA $1,089,988
FSP, MHSA $2,879,820
IMD Step-Down, MHSA $1,839,600

2 IMD Step Down Programs This program expansion will help decompress LA County hospital psychiatric emergency services

MHSA Component and Work Plan Adult, Alternative Crisis Services - Institutions for Mental Disease (IMD)

What is being expanded? The IMD Step-Down program will be expanded to increase by 22 additional beds. IMD Step-Down Facilities are designed to provide supportive on-site mental health services at selected Adult Residential Facilities, and, in some instances, assisted living, congregate housing, or other independent living situations. The program accommodates persons being discharged from acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care who are appropriate for this service. The program targets those individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living.

Estimated MHSA Budget $1.2 Million

3 Service component of SB82 California Health Facilities Financing Authority (CHFFA) Grant

MHSA Component and Work Plan Adult, Alternative Crisis Services - Urgent Care Centers and Crisis Residential Programs. Investment in Mental Health Wellness Act of 2013 (SB82) California Health Facilities Financing Authority (CHFFA) Grant.

What is being expanded? Alternate Crisis Services provide a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration.

- Urgent Care Centers (UCC) provide intensive crisis services to individuals who otherwise would be brought to emergency rooms.
- Crisis Residential Programs stabilize symptoms through medication intervention and develop social rehabilitation skills to facilitate community reintegration.

DMH has requested funds from the SB82 CHFFA grant to develop four UCCs to be located on the campus of Harbor-UCLA Medical Center, South-East Los Angeles, the Antelope Valley and the San Gabriel area to serve 72 individuals at any given time and 35 new Crisis Residential Programs to increase capacity by 560 beds countywide.

The new UCCs are intended to decompress the County Hospital emergency rooms and acute inpatient services. Two of the four new UCCs are intended to serve as points of entry for the proposed Pre-Booking Diversion Pilot Programs and the Assisted Outpatient Treatment Programs for the AV and LB Police Departments. The new Crisis Residential Programs will increase capacity countywide.

Estimated MHSA Budget	$3 Million	
Estimated Medi-Cal Budget	Medicaid Expansion	$1,020,000
	Medi-cal (Gross)	$990,000
	Total	**$2,010,000**

Child

Existing Programs

Child Full Service Partnership (C-01)
No changes to existing plan.

Family Support Services (C-02)
No changes to existing plan.

Child Field Capable Clinical Services (C-05)
Expanded to serve an additional 330 clients per FY ($1.13 mil for each of FY's 14/15, 15/16, 16/17).

Housing Trust Fund (listed under Adult in the CSS Plan but multi-age group): Continue funding at $250,000 for FY's 15/16 and 16/17

MHSA Housing Program: $200,000 for FY's 15/16 and 16/17 to build permanent housing.

New Programs

1 Family Wellness/Resource Centers

Program Description. Family Wellness/Resource Centers (FWRC) are designed to act as a welcoming and family-friendly center within the community where families with children in need of mental health services can go to obtain information and resources to navigate the mental health, physical health and educational systems and participate in self-help meetings and workshops. FWRCs include a resource library and computer stations for families within the community and offers peer counseling, parent support groups and educational classes. FWRCs are located within established community organizations (e.g. Integrated School Health Centers, parks and recreational centers, children's mental health clinics, health clinics, etc.) and work in partnership with other community non-profit and government agencies. Parent Partners/Parent Advocates are integral to FWRCs

Target Population. FWRC offers resources and self-help groups/workshops to families with children in need of mental health services.

Program Goals:

a) To provide resources, training and support to families within the community caring for children with mental health problems

b) To provide family-focused information which empower families to make informed choices and decisions
c) To enhance collaboration between parents/caregivers and community partners (e.g. mental health agencies/clinics, schools, health clinics, etc.)

Expected Program Outcomes:

a) Increase timely access to services
b) Increase community awareness of mental health services

Estimated Budget by FY: MHSA: $750,000 for FY 2015/16 and 16/17
Medi-Cal: $0

2 Family Crisis Services: Respite Care Program

Program Description: Respite Care Services are positive, supportive services intended to help relieve families from the stress and family strain that result from providing constant care for a child with Severe Emotional Disturbance (SED), while at the same time addressing minor behavior issues, implementing existing behavioral support plans, and assisting with daily living needs. Approximately 168 clients will be served each FY.

Target Population: Respite Care will be available to parents/caregivers that are providing in-home care for a child or youth, aged 0-15, with SED and receiving mental health services (e.g. FCCS or FSP) and meet the following conditions:

a) Parents/caregivers are under significant stress as a result of the responsibility of providing constant care to the client enrolled in Child FSP
b) Continued caretaking without respite care may result in out-of-home placement; and
c) All other available formal and informal sources of support have been exhausted.

Program Goals: Respite care is intended to provide short-term relief to caregivers that provide in-home care for a SED child to prevent out-of-home placements and preserve the family.

Expected Program Outcomes: Anticipated outcomes of the Family Crisis Services/Respite Care Program include:

a) Increase family stability and well-being
b) Reduce incidence of out-of-home placement

Estimated Budget by FY: MHSA: $500,000 for FY 2015/16 and 16/17
Medi-Cal: $0

3 Self-help Support Groups for Children

Program Description: This funding will be used to establish self-help support groups for four evidence-based self-help programs: 1) Rainbows for children (4-15) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for at risk children 0-5 to establish healthy parental attachment; 3) Alateen for children (13-15) who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of Children(10-15) with ADD, mental health and other behavioral issues.

Target Population: Children and parents needing support for the issues described above.

Program Goals: Improved outcomes for 0-5 at risk children; Having children realize that they are not to blame and are not alone in facing issues in their lives: Teens who cannot be distinguished from teens coming from functional families when compared in their 20's. Parents engaged with the mental health system and better coordination of services, as well as better outcomes for children with mental health and other behavioral issues.

Intended Program Outcomes: Eighty percent of ages 0-5 at-risk children will have excellent attachment; 80 percent of participants in Rainbows will improve communication in their families and peer relationships. After a year Rainbow participants will improve school attendance and academic performance: 60 percent of Alateen attenders will experience less negative moods and significantly more positive moods and higher self-esteem: 70 percent of Because I Love You participants will express more competence in being parents of children with mental health issues.

Estimated Budget (MHSA only) FY 15/16, $75,000
FY 16/17, $75,000

4. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters (Promoters) /Community Health Workers (CHWs) as a directly operated, cross-cutting program across age groups, within each Service Area. Community Mental Health Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Community Mental Health Promoters/Community Health Workers generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals:
General: Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities
Specifics: Roll Out is planned over a 3-year period.

a) Year 1

1. Roll out of Promoters/Health Navigator Teams in each Service Area following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
2. Translate all prepared and available presentations from Spanish to English.
3. Train in-house trainers with the help of Training Consultant to assure sustainability

b) Year 2

1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA
2. Develop Strategies to adapt program to other languages and cultural groups.

c) Year 3: Roll out expanded program, including translated and culturally adapted trainings to other cultural and linguistic groups within the SA, according to the needs of the different regions

Intended Program Outcomes

a) Decrease stigma and fear associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations
c) Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups
d) Coordinate services between health/mental health service providers for community members seeking their assistance

Estimated Budget by FY

FY 14/15: $250,000
FY 15/16: $250,000
FY 16/17: $250,000

Transition Age Youth

Existing Programs

TAY Full Service Partnership (T-01).
Expand the number of slots by18. For fiscal years 14/15, 15/16 and 16/17 add $141,000

TAY Drop-In Centers (T-02)
Three additional centers. FY 14/15 serve additional 400 clients with $250,000. FY 15/16 and 16/17, serve an additional 1,200 clients with $750,000

TAY Housing Services (T-03)
No changes to program.

TAY Probation Camp services (T-04)
No changes to program.

TAY Field Capable Clinical Services (T-05)
Expand capacity to serve an additional 36 clients at $88,000 for FY's 14/15, 15/16 and 16/17.

Housing Trust Fund: FY 14/15: $46,950, FY 15/16: $610,000, FY 16/17 $610,000.

MHSA Housing Program: For fiscal years 14/15, 15/16 and 16/17 add $550,000

New Programs

1. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters (Promoters) /Community Health Workers (CHWs) as a directly operated, cross-cutting program across age groups, within each Service Area. Mental Health Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Community Mental Health Promoters/Community Health Workers generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals

General: Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities

Specifics: Roll Out is planned over a 3-year period.

a) Year 1
    1. Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
    2. Translate all prepared and available presentations from Spanish to English.
    3. Train in-house trainers with the help of Training Consultant to assure sustainability.
b) Year 2
    1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA.
    2. Develop Strategies to adapt program to other languages and cultural groups
c) Year 3: Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.

Intended Program Outcomes

a) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations

c) Increase community awareness of mental health services particularly for linguistically and culturally underserved groups
d) Coordinate services between health/mental health service providers for community members seeking their assistance

Estimated Budget by FY FY 14/15: $228,000
FY 15/16: $228,000
FY 16/17: $228,697

2 Self-Help Support Groups for TAY

Program Description: Using four evidence-based self-help programs: 1) Rainbows for TAY (15-18) who have experienced trauma, death, divorce, violence, removal from home and other losses; 2) La Leche League for pregnant TAY support for attachment parenting and breastfeeding; 3) Alateen for teens who have parents with mental health, substance abuse or other dysfunction in their families; 4) Because I Love You for parents of TAY (15-30) with ADD, mental health and other behavioral issues.

Estimated Budget by FY: FY 15/16: $45,000, FY 16/17: $45,000

3 TAY Supportive Employment

Program Description: Employment is an important aspect of an individual's recovery. It provides a sense of identity and structure. Utilizing evidence based supportive employment services (such as the Individual Placement and Support model), TAY Supportive Employment will assist TAY, receiving mental health services and residing in permanent supportive housing (and other housing situations), to obtain and maintain gainful employment to achieve self-sufficiency. TAY Supportive Employment will incorporate effective strategies that are driven by the individual's choice and include principles that integrate with mental health treatment.

The proposed funding will be utilized to train current TAY mental health providers in implementing supportive employment services within their existing mental health delivery system.

Target Population: TAY (18-25 years old)

Program Goals: Provide supportive employment services to TAY to increase their self-sufficiency by obtaining and maintaining gainful employment and maintaining stable housing.

Intended Program Outcomes: Seventy-five percent of the TAY enrolled in the program will achieve employment success, as defined by maintaining their employment for a period of 6 months. Ninety percent of the TAY enrolled in the program will maintain their housing situation.

Estimated Budget by FY: FY 14/15: $125,000 (30 clients to be served)
FY 15/16: $500,000 (125 clients to be served)
FY 16/17: $500,000 (125 clients to be served)

4 Integration of Co-Occurring Mental Health and Substance Abuse Disorders (COD) Treatment Practices Training and Technical Assistance

Program Description: Both the COD Integration Training Project and the Annual Integrated Care Conference provide essential support for the effective implementation of full service partnerships by

continuing to develop, expand and support fully integrated age appropriate Co-Occurring Disorder models of integrated treatment to serve Children and their caregivers, Transitional Age Youth (TAY), Adult, and Older Adult consumers affected by Co-occurring disorders.

COD was included in the original CSS plan for children only and ended in 2008. This will add COD training back into the CSS Plan.

Target Population Behavioral health service providers.

Program Goals To build and improve a system of care utilizing age appropriate strategies that seamlessly and effectively addresses and integrates the treatment of co-occurring disorders that often significantly exacerbate the effects of mental illness.

Intended Program Outcomes.

a) Provide didactic training, consultation and education that enhances Knowledge, Skills and Ability in the provision of integrated services to clinical staff, physicians, nurse practitioners and paraprofessional staff from DMH, contract agencies, and community partners, that provide direct Full Service Partnership treatment services to Children, Transitional Age Youth (TAY), Adult, Jail Mental Health, AB 109 populations, and selected community partners in the context of the development of Health Neighborhoods.

b) Provide ongoing consultation in person and via DMH Tele-Mental Health System to trained staff to enhance screening, assessment, treatment, care coordination and care management practices in the provision of COD services.

c) Develop programs for on-line seminars, workshops and forums to educate and train on, issues faced by these diverse populations.

d) One and one-half day Annual Conference on Integrated Care for 1,000+ attendees.

Estimated Budget by FY FY 15/16: $36,391
FY 16/17: $36,391

Adult

Existing Programs

Adult Full Service Partnership (A-01)

Slots will be expanded in the following ways:

a) Twenty-five slots will be added in FY 14/15.
b) One hundred slots will be added for FY 15/16. Seventy-five additional slots to be added to providers who demonstrated success with their Innovation program, which ends June 30, 2015. Psychiatric capacity expanded by four psychiatrists across the directly operated FSP system.
c) One hundred slots will be added for FY 16/17. Seventy-five additional slots to be added to providers who demonstrated success with their Innovation program, which ends June 30, 2015. Psychiatric capacity expanded by four psychiatrists across the directly operated FSP system.

Assisted Outpatient Program described under Board priorities #1 above.

Wellness/Client Run Centers (A-02)

Services are being expanded in the following ways

a) Adjunct services for clients in Wellness Centers who are not in need of intensive services as part of this model will include medication management, non-intensive case management, and peer support. Staffing for the Wellness adjunct program to minimally include a Psychiatric Nurse and Peer Case Manager. Estimated to serve an additional 29,000 clients in FY's 14/15, 15/16 and 16/17.

b) Expand staffing to implement Supported Employment, an Evidenced-based Practice which assists clients to obtain and maintain employment. 150 clients to be served in FY 14/15 and 300 clients in FY's 15/16 and 16/17.

c) Adding one Housing Specialist per program to ensure field capable housing support for Wellness Services to support individuals in maintaining their housing and to create service capacity for clients with a Section 8 Voucher which requires a service match to maintain. The Wellness program definition will also need to be clarified to ensure field services are available "as needed" to support housing stability. 1,500 clients to be served in each of FY's 14/15, 15/16 and 16/17.

d) Adding a total of 35 peer staff to directly operated Wellness Centers and to contract Client Run Centers to serve an additional 1,750 clients.

e) Expand Client Run Centers to ensure availability in every service area. Increase support to pilot "Life Coaches" in Peer Run Centers. Expand Peer Run Center staff to ensure services are available in multiple languages and meet cultural needs. In FY 14/15 an additional 500 clients would be served while in FY's 15/16 and 16/17 an additional 2,000 clients would be served.

IMD Step-Down Facilities (A-03)

Expansions listed under Board priorities above.

Adult Housing Services (A-04)

a) **MHSA Housing Program**
   1. An investment in capital development and operating subsidies to expand the number of affordable, permanent supportive housing units for DMH clients. Funding goes through CalFHA.
   2. FY 14/15: $2.5 million

b) **Housing Trust Fund**
   1. Extending the current 5 year contracts which are ending for some agencies. The funding will also allow us to expand supportive services to more permanent supportive housing programs.
   2. FY 14/15: $158,500
   3. FY 15/16: $980,000
   4. FY 16/17: $1.6 mil.

Jail Transition and Linkage (A-05)

No changes to previously approved work plan.

Adult Field Capable Clinical Services (A-06)

Additional capacity will be created in the following ways.

a) FY 14/15: Increase clients served by 50.

b) FY 15/16: Increase clients served by 200. Providers who demonstrated success with their innovation program, ending in June 30, 2015 will have their contracts amended to serve collectively an additional 132 clients.

c) FY 16/17: Increase clients served by 200. Providers who demonstrated success with their innovation program, ending in June 30, 2015 will have their contracts amended to serve collectively an additional 132 clients.

New Programs

1. Community Mental Health Promoters/Community Health Workers

Program Description: This proposal seeks to add Community Mental Health Promoters/Community Health Workers as a directly operated, cross-cutting program across age groups, within each Service Area. *Mental Health* Promoters/Community Health Workers are trained and stipend community members who are trusted members of and/or have an unusually close understanding of the community served. Mental Health Promoters / Community Health Workers (CHWs) generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve. These social attributes and trusting relationships enable CHWs to serve as educators, stigma busters, and as a liaison, link, or intermediary between health, mental health and social services and the community to facilitate access to and enrollment in services and improve the quality and cultural competence of services. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino and Asian Pacific Islander communities.

Target Population: Minority ethnic and cultural underserved individuals and families who traditionally do not seek mental health services or do not understand the symptoms of mental health as a result of cultural beliefs and/or the stigma associated with seeking mental health services. A special emphasis is on linguistic capacity to serve linguistically isolated populations.

Program Goals

General. Promoters/CHWs can enhance a community's understanding of mental health symptoms, syndromes, and available treatments. They can assist with provider-client communication; preventive care; follow-up, and referral; and navigation of the mental health/health and educational systems for all age groups. Promoters/CHWs build individual and community capacity by increasing mental health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy among communities such as Hispanic/Latino communities

Specifics: Roll Out is planned over a 3-year period.

a) Year 1
    1. Roll out of Promoters/Health Navigator Teams in each Service Area, following an established and tested model, including initial training, coaching and presentations for a small core group of participants.
    2. Translate all prepared and available presentations from Spanish to English.
    3. Train in-house trainers with the help of Training Consultant to assure sustainability.
b) Year 2
    1. Complete roll out and training of all selected Promoters. Increase participants as needed by SA.
    2. Develop Strategies to adapt program to other languages and cultural groups.
c) Year 3: Roll out expanded program, including translated and culturally adapted trainings, to other cultural and linguistic groups within the SA, according to the needs of the different regions.

Intended Program Outcomes:

a) Decrease stigma and fear, associated with either being diagnosed with a mental illness or seeking mental health services.
b) Improve timely access to mental health services for underserved populations

c) Increase community awareness of mental health services, particularly for linguistically and culturally underserved groups
d) Coordinate services between health/mental health service providers for community members seeking their assistance.

Estimated Budget by FY: FY 14/15: $350,000
FY 15/16: $350,000
FY 16/17: $350,000

2. Integration of Co-Occurring Mental Health and Substance Abuse Disorders (COD) Treatment Practices Training and Technical Assistance:

Estimated Budget by FY: FY 15/16: $170,000
FY 16/17: $170,000

Issues Requiring Action or Further Discussion

During the planning process, a concern was expressed that adult MHSA programs where peer staffing was mandated as part of the program are not being staffed accordingly. The Department agreed to review peer staffing discrepancies and hold providers (contracted and directly operated) to the expectations documented in FSP guidelines, Wellness Center RFS requirements and contractual language.

Older Adult

Existing Programs

Older Adult Full Service Partnership (OA-01)
Expand slots by 122 over the three fiscal years.

Transformation Design Team (OA-02)
No changes to previously approved work plan.

Field Capable Clinical Services (OA-03)
Increase capacity by 456 clients over the three fiscal years.

Service Extenders (OA-04)
No changes to previously approved work plan.

Older Adults Training (OA-05)
No changes to previously approved work plan.

Housing Trust Fund (A-04)
$250,000 per Fiscal Year for older adult housing development.

Services Cutting Across Age Groups

Existing Programs

System Navigators (SN-01)
See Assisted Outpatient Treatment program under Board priorities above for service expansions.

Alternative Crisis Services (ACS-01)
See programs listed under Board priorities above for service expansions.

Planning, Outreach & Engagement (POE-01)
Strategies to enhance existing outreach and engagement services include:

a) Identifying specific outreach and engagement strategies to engage TAY into services, including the use of social media and technology.
b) Outreach and engage TAY who are victims of commercial/sexual exploitation.
c) Focus TAY outreach efforts in high schools, alternative schools, community colleges, universities and trade/vocational schools.
d) Focus outreach and engagement efforts at unserved and under-served ethnic communities, using the UREP recommendations.
e) Outreach and engage the TAY LBGTQ community with early signs of mental illness.
f) Incorporate learning from the Integrated Services Management Model Innovation programs to the outreach and engagement process, including the utilization of effective non-traditional approaches.

Prevention and Early Intervention

Stakeholder Recommended Changes from Previously Approved Plan

No changes will be made to the current PEI Plan.

Potential Changes Requiring Additional Stakeholder Discussion and Input:

a) An interest was expressed to categorize early intervention services at the level of the PEI Program rather than at the more granular level of the early intervention Evidence-Based Practice, Promising Practice or Community-Defined Evidence practice. Each program would still consist of one of more of these practices but would be augmented with other services, such as employment support or short-term targeted case management that would aid in the transition back to a pre-morbid or higher level of functioning.
b) The Department will examine its Prevention programs in the next planning cycle to prioritize those most at risk of developing a mental illness and the programs and services that align with early intervention and, to some degree, CSS programs.
c) The Department will review the results of the PEI Statewide Projects that have created local impact in Los Angeles County to determine whether those efforts should continue.
d) Focus and build capacity to target TAY and Older Adult for stigma and discrimination reduction and Suicide Prevention trainings, presentations, and services. Utilize Mental Health First Aid; Question, Persuade, Refer; Applied Suicide Intervention Skills Training.
e) Identify and integrate best practices related to stigma reduction in schools settings targeting TAY.
f) Provide training to reduce staff stigma. The proposal, entitled "From the inside out: Turning the Tide of Stigma and Discrimination" would train staff, consumers, family members and other

friendly community members to counter stigmatizing and discriminatory language and behavior in the community with direct, respectful and assertive messages

g) A DHS psychiatrist is funded for the provision of psychiatric services, including consultation and directive services to clients receiving mental health services through the DMH/DHS Collaboration Program. Clients will receive integrated physical and mental health services provided through a primary care provider and treatment team.

Workforce Education and Training

Stakeholder Recommended Changes from Previously Approved Plan

No recommended changes from previously approved plan.

Potential Changes Requiring Additional Stakeholder Discussion and Input

Expand WET Project 8 to include a TAY-focused peer certification process to prepare TAY aged individuals to work as peer advocates within the mental health system. Individuals trained would be able to provide peer services in outreaching to TAY and for TAY accessing mental health services.

Capital Facilities and Technological Needs:

Stakeholder Recommended Changes from Previously Approved Plan

The allocated amount for Capital Facilities (CF) and Information Technology (IT) is $131,007,000. Stakeholders determined 70% ($91,704,900) of funds above would support IT Projects, with the remainder to support CF Projects.

Change: Move $3 million from CF Projects to IT to support the continued deployment of the Integrated Behavioral Health Information System (IBHIS), changing the initial ratio of TN to CF funds from 70%/30% to 72% TN, 28% CF. The recommended change was approved by the SLT.

Innovation

The Integrated Mobile Health Team, Integrated Clinic Model and Integrated Services Management Model all are scheduled to conclude on June 30, 2015. The Integrated Peer Run Model will conclude on June 30, 2016.

The Department is beginning the process of identifying potential new Innovation projects that would begin sometime during FY 2015-16.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU – MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Proposal for use of Unallocated Funds
MHSA Community Services and Supports (CSS) Plan

This proposal was approved by the Department's System Leadership Team at its June 17, 2015 meeting.

ONE-TIME INVESTMENTS:

MHSA Housing Program (A-04) **$17.5 million + $200,000**

- This funding will be transferred to the California Housing Finance Agency who administers this statewide program and will be used to continue the development of permanent, supportive, affordable housing for individuals living with serious mental illness, who are homeless, and their families. This program serves all populations including families, Transition Age Youth, Adults and Older Adults.

- $200,000 was allocated to the Housing Trust Fund in the 3 year plan for FY 14-15 but was not used due to implementation delays. Per a recommendation from the Department's MHSA Housing Advisory Committee, the funding will be transferred to the California Housing Finance Agency who administers this statewide program and will be used for the development of permanent, supportive, affordable housing for individuals living with serious mental illness, who are homeless, and their families. This program serves all populations including families, Transition Age Youth, Adults and Older Adults.

MHSA Housing Trust Fund (A-04) **$7.5 million**

This funding will be used to provide supportive services and/or other housing supports to those individuals living with serious mental illness, who are/were homeless, and their families and have or are in the process of transitioning into permanent housing.

Los Angeles Lesbian Gay Bisexual Transgender Center's Recognize, Intervene, Support, and Empower (RISE) Project (POE-01) **$350,000**

The Lesbian-Gay-Bisexual-Transgender-Questioning (LGBTQ) population is a non-ethnic, cultural underserved population in Los Angeles. The extent of service gaps, especially within the public mental health system is significant. Individuals within this population are more often tracked solely through their ethnic, language, and age groupings. Risk and vulnerability for mental health, co-morbid, and co-occurring issues are higher in LGBTQ populations especially in response to high levels of stigma and discrimination; their higher occurrence of depression and anxiety are known risk factors for attempted and completed suicides. LGBTQ children and youth are more often subjected to intense bullying and other harsh behaviors from their peers and classmates, and sometimes rejection from their families. Within the Los Angeles County dependency system, a recent study revealed that nearly 20-percent of children/youth ages 12 - 21 in out-of-home placement self-identified as LGBTQ. Reducing the number of youth, including LGBTQ youth in long-term foster care, is a priority focus of the L.A. County dependency system. Long-term foster care is statistically significant for less optimal self-

sufficiency outcomes with respect to emotional well-being homelessness, educational attainment, employment, etc. The DMH will fulfill its obligation to outreach and engage the unique mental health needs of DCFS LGBTQ children and youth in out-of-home placement and family caregiving settings through the MHSA Planning-Outreach-Engagement (POE) plan. DMH will help fund the Los Angeles LGBT Center's R.I.S.E. (Recognize, Intervene, Support, and Empower) Project. This project will provide outreach, engagement, linkage, and psychosocial strategies to youth, families, caregivers, and service workers with the goal of improving family acceptance, functioning, and improving the self-sufficiency trajectory for this population.

Pilot Employment Program – Wellness Centers (A-02) **$250,000 each year for 2 years**
This funding will be used to provide employment services to DMH clients in two directly operated wellness centers. The funding will be allocated through a solicitation to an agency with an expertise in providing employment services with the goal of increasing the number of DMH clients that achieve their employment recovery goals

Assisted Outpatient Treatment (AOT) Evaluation (A-01) **$300,000**
This funding will go to evaluate the effectiveness of the Department's AOT program. The evaluation will focus on:

- Effectiveness: Assess the effectiveness of AOT to determine and contrast promising practices for effective outreach to and outcomes of and between AOT eligible subgroups (including but not limited to):
    1. Clients referred to AOT-LA who do not receive AOT outreach services.
    2. Clients referred to AOT-LA who meet AOT eligibility criteria and who voluntarily accept services.
    3. Clients referred to AOT-LA who meet AOT eligibility criteria who refuse voluntary services and for whom a court order is not sought.
    4. Clients referred to AOT-LA who meet AOT eligibility criteria and who sign a Settlement Agreement with the Court.
    5. Clients referred to AOT-LA who meet AOT eligibility criteria and who are court ordered to receive AOT services.
- Community Improvement: Assess the extent the program contributes to improving the local community.
- Stakeholder Satisfaction: Assess the satisfaction levels of stakeholder groups, including clients and providers.
- Cost: Assess the cost effectiveness of treatment (voluntary or mandated).

ONGOING INVESTMENTS:

Katie A. – FCCS expansion for Intensive Care Coordination (ICC) and Intensive In-Home Behavioral Services (IHBS) (C-05) **$3.3 million**
As a result of the State of California Katie A. settlement agreement, Los Angeles County was mandated to address the needs of "Katie A. Subclass" members. Defined as DCFS involved children most in need of specialty mental health services, subclass members are entitled to receive Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS). Child Welfare Division will incorporate ICC and IHBS into the expansion of Intensive Field Capable

Clinical Services programs to DMH contract providers across all Service Areas to specifically address the needs of Katie A. Subclass members in order to comply with the settlement agreement. Both services are consistent with FCCS.

Katie A. – Intensive Care Coordination Services for FSP (C-01) **$1.6 million**
Children's Full Service Partnership (FSP) will incorporate ICC and the CFT process for the Katie A. Subclass members receiving services in the program to assist with the Department of Mental Health (DMH) compliance of the Katie A settlement agreement. Adding ICC to Child FSP will make the program more consistent with Wraparound that provides a very similar service at a cost of $6,000 more per slot than Child FSP.

Historically, Katie A. Subclass members fill approximately 33% (587) of Child FSP slots. The Department of Mental Health proposed augmenting 30% of each provider's current Child FSP slot allocation to bring ICC services in FSP for Katie A. Subclass members. This method of distribution ensures each provider will be accountable for providing a standardized service delivery system to the Katie A. Subclass while simultaneously meeting the needs of its FSP clientele.

Health Neighborhood and Faith Outreach and Coordination (POE-1) **$900,000**
This will fund the positions necessary to coordinate faith outreach and Health Neighborhood development in each of the Service Areas. To meet the objectives of the County's *Strategic Initiative 4: Healthy Neighborhood Projects*, the Department of Mental Health is developing the capacity of high-need/underserved communities for improving mental wellness and resiliency, reducing juvenile and adult delinquency and addressing homelessness. This aligns with LACDMH's Strategic Plan *Goal 3: Enhance the community's social and emotional well-being through collaborative partnerships*. This program intends to develop, streamline, integrate and focus the ability of the Los Angeles County Department of Mental Health (LACDMH) to improve health literacy, neighborhood resources and community's capacity for collective action to address issues of wellness, resiliency, justice involvement and homelessness. The program will implement a logic model for community partnership development and activation focused on high-need/underserved communities where justice involvement and homelessness are prevalent. The program will use local faith communities as loci for engaging grassroots and organizational actors for collective action. It will leverage existing outreach and engagement efforts focused on faith communities such as the Service Area clergy meetings, Faith Based Advocacy Council meetings, DMH Clergy Roundtable Program and the Clergy Academy Program. Given the resource limitations and the local focus of partnership development, at least one local "community wellness and resiliency liaison" is needed per Service Area. The liaison will work closely with the Department's Community & Government Relations Division for outreach, engagement and education focused on faith communities.

Client Supportive Services Funds – SB 82 Mobile Triage Team (POE-1) **$800,000**
This funding will be used to support the outreach and engagement of individuals who are homeless, veterans and/or older adults in crisis as identified by the SB 82 DMH Mobile Triage

Teams. The funding will provide basic necessities such as food, water, toiletries and blankets and other items such as transportation and birth certificates. The SB 82 funding precluded funding for non-service expenditures.

Housing for Clients – SB 82 Program (POE-1) **$300,000**
This funding will be used to provide temporary shelter to individuals/families in crisis, as identified by SB 82 DMH Mobile Triage Teams. The funding will be used for temporary shelter while a long term treatment plan is being developed and implemented. The SB 82 funding precluded funding for non-service expenditures.

Expansion of FCCS Capacity (C-05, T-05, A-06, OA-3) **$3.6 Million**
Expand capacity and broaden service continuity by adding FCCS services to all current FSP programs without an FCCS component for each age group. This would include Assisted Outpatient Treatment (AOT) contactors with FSP slots.

FCCS Service Expansion in Skid Row (A-06) **$1.5 million**
Expand FCCS capacity specifically to the Downtown LA Skid Row area, focusing on mentally ill adults who are homeless or at risk of homelessness.

Increased capacity to outreach, engage and serve Under-Represented Ethnic Populations (UREP) communities (A-06 Adult FCCS and POE-01) **$1.3 million**
Post Innovation – 1, expand current FCCS and outreach and engagement capacity to the Samoan community and to meet critical language needs of Armenian and Farsi speaking consumers.

Service Redirection from PEI to FCCS (C-05, T-05, A-06, OA-3) **$28.4 million**
System of care capacity was reduced during years where CGF/realignment was reduced. While agencies received Prevention and Early Intervention funding, an unmet remains related to serving clients with serious mental illness or serious emotional disturbance that don't meet FSP criteria. This action creates system capacity to address this unmet need.

Forensic FSP (F-FSP) Services (A-01) **$3 million**
This would expand FSP capacity to serve individuals with criminal justice histories who are at risk of re-incarceration, institutionalization, homelessness, or psychiatric in-patient services. F-FSP services support individuals as they reintegrate into the community and transition to lower levels of care. Participants engage in the development of their recovery and wellness focused treatment plan with their provider. Services are evidenced based and designed to meet the special needs of the forensic population. The treatment team is available 24/7 to provide phone and in-person crisis services to the client.

Men's Jail Integration Program (A-05) **$2.5 million**
The Department of Mental Health Adult System of Care (ASOC) will establish a Men's Community Reintegration/Re-entry Services and Education Center (MCRSEC) to serve men

with co-occurring mental health and substance use disorders being released from the Men's Central Jail (MCJ) or Twin Towers Correctional Facility (TTCF). MCRSEC will provide innovation models of care for men struggling with histories of persistent mental illness and substance abuse, repeated arrests and incarcerations, physical health disorders, homelessness, unemployment, financial instability and domestic and community violence. MCRSEC will also serve and an education and training center for a variety of integrated care providers.

Law Enforcement Team (New Work Plan Proposed - LE-01) **$5.7 million**

The DMH Emergency Outreach Bureau (EOB) plans to expand its Mental Health - Law Enforcement Teams (MH-LET) that provide field based crisis intervention services to children, adolescents, TAY and adults throughout Los Angeles County. The expansion will fund mental health staff to create 42 new teams with law enforcement agencies that have expressed an interest in establishing a partnership with DMH. This funding will cover the cost of the mental health staff. Law enforcement agencies will fund their officers.

The teams are based on a co-response model: one licensed mental health clinician is partnered with a law enforcement officer to respond to 911 calls or patrol car requests for assistance involving persons suspected of having a mental illness. Teams provide crisis intervention including assessment for WIC 5150, de-escalate potentially violent interactions between clients, family members and police, make appropriate referrals to community agencies, and/or facilitate hospitalization. The teams/programs serve to decrease the need for inpatient psychiatric hospitalization by providing immediate field based services. Additionally, clinical staff will provide training to law enforcement officers on mental health and strategies when engaging persons with mental illness.

Expansion of Mobile Interdisciplinary Teams (MITs) (A-06) **$600,000**

This funding will provide additional staff for the Multidisciplinary Integrated Teams currently funded by DMH/County Homeless Prevention Initiative in key areas of the County reflecting high incidence of homelessness, as follows: one (1) additional team in Skid Row, one (1) additional staff in Service Areas 2 and 8, and two (2) additional staff in Service Area 6 will increase capacity to engage, link individuals that are homeless to mental health programs and support clients in accessing and retaining housing.

TAY Drop-In Center expansion (T-02) **$250,000**

Drop-In Centers provide temporary safety and basic supports for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are living on the streets or in unstable living situations. Drop-In Centers provide "low-demand, high tolerance" environments in which TAY can make new friends, participate in social activities, access computers, books, music, and games. As the youth is ready, staff persons can connect them to the services and supports, including linkages to ongoing mental health and co-occurring services, they need in order to work toward stability and recovery. The initial MHSA CSS plan for Drop-In Centers was approved in 2009 and DMH contracted with two agencies to provide

MHSA CSS One-Time and Ongoing Funding Proposal
Page 6

Drop-In Center services in different Service Areas. MHSA funding provides the opportunity for the agencies to leverage their existing non-MHSA funded Drop-In Centers to operate and provide services and supports during extended hours during the week and on the weekends. With the growth and availability of additional MHSA funding during the past years, DMH is now able to fund a Drop-In Center in all eight Service Areas. This will allow DMH to engage the TAY population in services and supports to promote their wellness and recovery throughout the County

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

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

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

DEFINITION: Disenrollment can apply to either an interruption or a discontinuation of service. An interruption of service is defined as a temporary situation in which the client is expected to return to services within twelve (12) months or less from the date of last contact. A discontinuation of service is defined as a long-term situation in which the client is not expected to return to services for more than twelve (12) months from the date of last contact. The reasons for disenrollment are as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   If Countywide Programs staff does not authorize client for disenrollment they will complete and send Full Service Partnership Disenrollment /Transfer Request Supplemental Form to FSP program and Impact Unit. FSP program must continue services.

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

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

4. If FSP agency does not agree with the decision of the Impact Unit or Countywide Programs Administration, then agency may file an appeal (see III.B. Procedure for Filing Appeals Related to FSP Client Enrollment, Disenrollment or Transfer).

A client transferring from one FSP program to another FSP program is not considered a disenrollment (see V.C. Transfer of Clients Between Full Service Partnership Programs).

FORMS:

- Full Service Partnership Disenrollment Request Form
- Full Service Partnership Disenrollment/Transfer Request Supplemental Form

REFERENCES:

- http://dmhoma.pbwiki.com (Los Angeles County DMH Outcome Measures Application (OMA) Wiki website)

Full Service Partnership Outcomes Measures Application
Living Arrangement Exception Reasons and Corrections

FSP OMA Living Arrangement Exception Reasons and Corrections (Revised 1/29/10)

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Client has Multiple Baselines/Multiple Baseline within 365 days	Only one baseline should be done for a client unless the client has been disenrolled from FSP for 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC	Multiple agencies may need to coordinate the correction process. Each agency will have to follow steps outline by MHSA Implementation Unit	Investigate the problem and determine whether there truly is a duplicate baseline. Once you determine there is a duplicate baseline, you need to identify which baseline you wish to keep and delete the duplicate baseline and any assessments (KEC and 3M's) associated with the duplicate baseline. Often multiple agencies need to coordinate the data correction process when client's data resides in multiple agencies	Submit a Data Change/Request form to delete duplicate baseline. OMA team will investigate which baseline to keep and any KEC's or 3M's that needed to be re-entered due to the assessments associated with the baseline that needed to be deleted
Partnership Date on Baseline is Prior to 7/1/2005	July 1, 2005 is the earliest possible start date for FSP in Los Angeles County. The July 1, 2005 start date only pertains to a few directly operated programs; most programs started after December 1, 2006	When making a change to the partnership date, one must always go back and make sure the baseline information is correctly representing the revised 12 month period.	Partnership dates cannot predate CW authorization date. Discuss with Countywide Age group Authorization unit when necessary. Need to make the partnership date change and change living arrangement date range to match. Changes to the partnership date may change the 3M due dates	Changes to partnership date and living arrangement ranges can be changed directly in the OMA by the provider. If changing of the partnership date affects the 3M(s) due dates, information on the 3M needs to change to reflect accurate time frame of the 3M assessment(s)
Baseline Disenrolled over 365 Days	If a client is re-enrolling into FSP after having left the program for more than 365 days from the date of disenrollment indicated on a KEC, a new baseline is needed	A client is enrolled in FSP on 7/1/06 and disenrolls on 8/30/06 according to the KEC. The client returns to FSP on 9/2/07, and the agency does a reestablishment KEC when a new baseline should have been done.	Need to confirm a second baseline is needed for the client	Delete the KEC that was created for re-establishment and instead create a new baseline for the client
Partnership Date in Admininfo is null/ blank	The report considers the partnership date as the start of the FSP services. Without the date, the report cannot make the comparison of pre-partnership days and changes that took place after the FSP started	None	Determine when the client was enrolled in the program. This needs to be the first date of service billed in the IS for the program. For FSP, this date cannot predate the countywide authorization date.	Provider needs to input the partnership date and ensure correct date range for the living arrangement and baseline info

FSP Baseline Exception Reasons

Exception Reason	Explanation of the Exception	Example/ Comment	Type of Correction Needed	Corrective Action
Maximum "Date To" on Baseline LA Not Equal to Partnership Date - 1	Baseline living arrangement date range must include 365 consecutive, non overlapping days. The last "Date To" date must be the day before the partnership date. The earliest "Date From" date must be 365 days before the partnership date. **Remember that 2008 was a leap year which means there was an extra day in Feb. You need to account for this extra day if your partnership date falls on or between 3/1/08 - 2/28/09.**	If Partnership date= 7/15/09. Date from and to range = 7/15/08 to 7/14/09. Minimum "date from" = 7/15/08 Maximum "date to" = 7/14/09	The most recent "date to" (end date) needs to be one day before the partnership date. Consult the living arrangements example (attached) if needed	Need to list all the days within the correct date range by the provider. Changes can be made directly in the OMA
Minimum "Date From" on Baseline LA Not Equal To Partnership Date - 365			The earliest date from (start date) needs to be 365 days before the partnership date. Consult the living arrangements example (attached) if needed	
Has "Date To" on Baseline LA Greater Than or Equal To Partnership Date			The pre-partnership living arrangements cannot extend into the partnership. The information by definition is based on the 12 months prior to enrollment.	
		Partnership date for leap year =1/15/09. Wrong Date Range= 1/15/08 to 1/1409. This yields 366 days. Correct Date Range= 1/16/08 to 1/14/09, which will yield 365 days	Take into account of the extra day due to a leap year. Need to adjust the range (Move the start date a day later). Affects partnership dates from 3/1/08-2/28/09 inclusive	
Does Not have a total of 365 Days of Pre-Partnership Living Arrangements	365 days of pre-partnership living arrangements on baseline are required. Validation exists now in OMA to prevent this from occurring. Exclusion due to this reason pertain to very early OMAs that predate the validation.	None	Need to examine the correct date range for the client and ensure all data is captured	Provider is able to make the changes in the OMA
Residential Type selected Can Not be Checked on Tonight Column	IMD, "Mental Health Rehabilitation Center" (MHRC), Prison, Jail, Community Treatment Facility (CTF)", "California Youth Authority/DOJJ", "Probation Camp/ Ranch", "lives in a group home (L12), "Lives in a group home (L14), "State Psychiatric Hospital", "Juvenile Hall", "Skilled Nursing Facility (Psychatric)", can not be checked as a residential type in the "tonight" column on baseline. Clients can not be enrolled into FSP until they are discharged from the aforementioned placements. These residential types can be checked in the "Yesterday" column in the baseline LA with other residential types endorsed in the tonight column.	Remember the "tonight" column signifies where the program housed the client on the first day they enrolled in FSP. For example if a client is picked up from jail or a hospital and then housed in an emergency shelter the same night, emergency shelter should be checked in the tonight column.	Mark the appropriate residential setting where the client was housed upon enrollment. If the client was moved around on that first day, pick where the client was at 11:59 as the residential type to record in the "tonight" column.	Provider can make the change by logging onto OMA and checking the appropriate box for a residential type other an those listed in the explanation. Remember that only one living arrangement can be checked to be saved
Tonight Column Checked for More than one Baseline Living Arrangement	You can only record one residential type in the "tonight column". If the client stayed in multiple locations on the first day of partnership, choose where the client was at 11:59 p.m. The client cannot be in more than one place at 11:59 on the night of partnership.	See above for information on residential types that cannot be selected in the "tonight column"	Select the correct living arrangement type at the start of the partnership	Provider is able to make the changes in the OMA by ensuring one box and only one box is checked
Tonight Column Not Checked for any living arrangement	A check in the "tonight" column represents the first residential type the client stays in on the first night of the FSP. This is considered the first "post-partnership" living arrangement of the partnership. A living arrangement must be indicated in the "tonight" column on the baseline.	None	Need to examine the correct living arrangement type the client resides in on the 1st day (at 11:59pm) of the partnership	Provider is able to make the changes in the OMA
More than one Living Arrangement KEC on the Same Date	Two or more living arrangement KEC's filed for the same status change date. Client can only be in one residential placement per night at 11:59pm	None	Will have to determine which living arrangement KEC(s)is correct and which one(s) need to be deleted	Submit a Data Change/Request form to delete unneeded residential KEC(s) from the same status change date

Full Service Partnership Outcomes Measures Application Employment Exception Reasons and Corrections

Baseline Data

- **Total Weeks Not Equal to or Greater than 52:** Assessments where the total number of weeks for all employment statuses including unemployed and retired does not equal 52 weeks or greater.
- **Partnership Date Missing**: The Partnership Date signifies the start of the program (1st day of service claimed). For FSP, Partnership Date = enrollment date and cannot pre-date the Countywide Administration Authorization Date.
- **Duplicate Baseline Detected:** Only one baseline should be done for a client unless the client has been disenrolled from FSP for more than 365 days. The "new start of FSP" must be greater than 365 days from the date of disenrollment (partnership status change) in the disenrollment Key Event Change (KEC). The mistake often involves an agency creating a second baseline or when additional baselines are done for a client when he/she transfers to another agency or re-enrolls back to services when client has not been away for more than 365 days from the status change date on the disenrollment KEC.

Key Event Change (KEC) Data

- **Conflicting Current Employment/Unemployment:** When nothing is reported in all of the Current Employment fields and No is answered to the question: Is the client unemployed at this time?
- **Missing Date of Employment Change:** An employment change is indicated on the KEC but the Date of Employment Status Change is left blank.
- **Conflicting Employment/Unemployment KEC:** When there is nothing reported in all of the Current Employment fields and "No" is answered to the question, "Is the client unemployed at this time?"
- **Missing Partnership Status Change on Disenrollment or Reestablishment:** A disenrollment or reestablishment is indicated on the KEC but the Date of Partnership Status Change is left blank.
- **Employment Change Date on KEC Prior to Partnership Date:** A KEC should not reflect a change that occurred prior to the client's enrollment in the FSP program.
- **Unemployment Reason Reported and Unemployment Not Checked:** The KEC reported a reason for unemployment without indicating the client is unemployed.
- **Unemployment Checked and No Reason Given:** Unemployment is indicated on the KEC but the reasons for unemployment are left blank.
- **Unemployment Reason Conflicts with Unemployment Status:** The KEC indicates the client is employed at the time, but answered the reasons for unemployment.

Field Capable Clinical Services Outcomes Measures Application Baseline Exception Reasons and Corrections

Exception Reasons:

- Baseline excluded because the FCCS update is missing data.
- Baseline excluded because more than 1 update has the same assessment date.
- FCCS update is tied to a baseline that is excluded.
- Baseline is missing data.
- Multiple baselines for the same clinical episode.

Full Service Partnership Outcomes Measures
Employment Status Definitions

Competitive Employment: Paid employment in the community in a position that is also open to individuals without disability.

Supportive Employment: Competitive Employment (see above) with ongoing on-site or off-site job related support services provided.

Transitional Employment / Enclave: Paid jobs in the community that are 1) open only to individuals with a disability AND 2) are either time-limited for the purpose of moving to a more permanent job OR are part of a group of disabled individuals who are working as a team in the midst of teams of non-disabled individuals who are performing the same work.

Paid In-House Work (Sheltered Workshop / Work Experience / Agency-Owned Business): Paid jobs open only to program participants with a disability. A Sheltered Workshop usually offers sub-minimum wage work in a simulated environment. A Work Experience (Adjustment) Program within an agency provides exposure to the standard expectations and advantages of employment. An Agency- Owned Business serves customers outside the agency and provides realistic work experiences and can be located at the program site or in the community.

Non-paid (Volunteer) Work: Experience Non-paid (volunteer) jobs in an agency or volunteer work in the community that provides exposure to the standard expectations of employment.

Other Gainful / Employment Activity: Any informal employment activity that increases the client's income (e.g., recycling, gardening, babysitting) OR participation in formal structured classes and/or workshops providing instruction on issues pertinent to getting a job. (Does not include such activities as panhandling or illegal activities such as prostitution.)

A Summary of Findings for the Los Angeles County 241.1 Multidisciplinary Team

Report to the Los Angeles County Board of Supervisors—May 2015

Denise C. Herz, Ph.D.
School of Criminal Justice & Criminalistics
California State University—Los Angeles

Overview of the 241.1 MDT Research Project

The 241.1 Multidisciplinary Team (MDT) began as a pilot program in the Pasadena delinquency courts in May 2007 under the direction of Judge Michael Nash and the Crossover Committee (an interdisciplinary committee tasked with improving the 241.1 process in Los Angeles County). Since that time, all participating agencies have contributed to data collection efforts. The amount and type of data have varied over time because no resources were dedicated to data collection, and the task added to an already long list of responsibilities for these agencies. Nonetheless, the agencies were committed to driving practice with data and worked with Dr. Denise Herz to capture the evolution of the MDT program with as much data as possible.

With the passage of the Board Motion to provide funds to support the addition of DMH psychiatric social workers for the 241.1 MDT, the need for data grew to include the tracking of outcomes for youth who received a 241.1 MDT assessment and plan. To support this requirement, the agencies and Dr. Herz devoted their time to develop data collection tools, and DCFS committed resources through their Bureau of Information Systems to build a 241.1 web-based application to collect data from all agencies at the time of the referral, following the assessment, and following disposition. Their work is a testament to their commitment to the 241.1 MDT Program and youth impacted by it especially since no additional resources were provided to support the data collection requirement.

The 241.1 Data Subcommittee members include the following individuals (NBTE: a few of the original members listed below were promoted and moved into different assignments):

- Department of Children and Family Services (DCFS): Wilhelmina Bradley (241.1 Unit), and several representatives from the BCFS Education Unit including Patricia Armani, Denise Prybylla, Gerardo Beltran, and Marcelino Ramos
- Probation: Michael Verner, Mirsha Gomez, Suzanne Lyles, and Belores Bryant-White
- Department of Mental Health (DMH): Nancy Gilbert
- California State University—Los Angeles: Denise Herz

While designed by this committee, the 241.1 Application was programmed by Marcelino Ramos from BCFS-BIS. Without the commitment of all these individuals the 241.1 Application, the data it captures, or this report would not have been possible.

services status for tracked youth at two points in time: 6 months after their disposition and 1 year after their disposition or until both the dependency and delinquency cases close—whichever comes first. DMH is also responsible for reporting the services youth received from DMH during these two timeframes.

Types of 241.1 Referrals

There are several types of referrals made to the 241.1 Units. Youth who had an open 300 case and had a pending delinquency petition were the original target population for data collection and the development of the 241.1 MDT; however, the 241.1 Application collects data on all types of referrals.

The target group for this report is still youth with an open 300 case and a pending delinquency petition, but for the first time since data collection began on crossover youth in Los Angeles, we now can report the distribution of all types of referrals. For clarity, a brief description of the different types of referrals is provided below:

- *300 youth with a pending delinquency petition:* These youth have an open DCFS court-involved case, are charged with criminal charges, and are awaiting a delinquency court hearing (hereafter referred to as "300 youth").
- *Emergency Referral (ER), Voluntary Family Maintenance (VFM), Legal Guardian (LG) with a pending delinquency petition:* These youth do not have substantiated cases in dependency court, but they were involved with DCFS in some way when they were charged with a criminal offense and, consequently, face a delinquency court hearing.
- *Declared 602 youth with a pending dependency decision:* These youth are wards of the delinquency court at the time of their referral and subsequently, a case is opened on them in DCFS.
- *Reassessments:* Youth with reassessments were previously 241.1 referrals who received a delinquency disposition and are now returning to court because (1) the court has requested to see them; (2) they committed a new charge; and/or (3) they are being charged with a Probation violation.
- *Reverse 241.1 and AB 12 Referrals:* These are referrals for wards of the delinquency court who are requesting a return to dependency because their delinquency dispositions are coming to an end (NBTE: AB 12 is a bit more complicated than this description—readers are referenced to the protocols for AB 12 youth for more specific information).

It should be noted that except for reassessment referrals, all referrals are "new"—in other words, even though the youth referred may have been on Probation in the past, they are not under Probation supervision at the time of the referral. Additionally, some youth

The data system previously in place to record 241.1 referrals was a stand-alone ACCESS database that simply captured the referrals and limited information related to those referrals. All data presented in previous reports have required additional data collection above and beyond the ACCESS database due to limited information contained within it. The Data Subcommittee merged all previous research efforts with the information required by the Board Motion to create a comprehensive data collection tool. Marcelino Ramos, DCFS/BIS, was then tasked with building a 241.1 application to capture all of this information and give Probation and DMH access to limited screens for data entry. Additionally, Patty Armani, Education Consultant Services Program, was working with BIS to create the On-Line Education Consultant Services System. To avoid duplication of systems, BIS worked to connect the 241.1 Application to this system for efficient and effective data collection. The 241.1 Application was finished in two phases—the first phase was completed in January 2014 (Referral and Initial Form information) and the second phase was completed in February 2014 (Tracking Information).

Overview of Data and Methods Used for the Current Report

The use of the 241.1 Application to capture all 241.1 referrals made to the BCFS and Probation 241.1 Units began on October 1, 2013. The database was used to collect three types of data: Referral Information, Initial Data and Tracking Data.

Referral Information: Basic information is captured in the 241.1 Application for all 241.1 referrals received. In addition to demographic and type of 241.1 referral administrative, it also captures administrative information needed by the DCFS 241.1 Unit to process the referrals.

Initial Data: For all cases except reassessments, additional characteristics are captured in the 241.1 Application by each agency participating on the Team. For example, DCFS enters information on the youth's history in the agency. Probation enters information about the current offense and prior contact with the juvenile justice system, DMH enters general information on the youth's behavioral health needs (if applicable), and Education Consultants/contracted agencies provide information on the youth's educational status/background. These data reflect the youth's status at the time of the referral, and it is important to note that the information entered by the agencies reflects that contained in the 241.1 Joint Assessment and submitted to the delinquency court in preparation for the 241.1 hearings (i.e., no additional information is collected).

Tracking Data: The collection of "Tracking Data" is more limited in scope (i.e., it is only collected for a subsample of referred youth). The subsample of youth is identified each month (beginning in October 2013) from all youth who have an open 300 case prior to receiving a disposition from the delinquency court. Specifically, up to 30 of these youth in any particular month are selected as tracking cases. If this list is less than 30, all youth are selected for tracking, but when the number of youth exceeds 30, a random sample of 30 is selected. Both DCFS and Probation are responsible for reporting data on the educational status, placement status, and

receive multiple 241.1 referrals within the same timeframe; thus, unless the narrative in a particular section indicates otherwise, the unit of analysis is referrals not individuals. In the case of referrals, one youth may be represented several times due to multiple referrals.

Purpose of this Report

The current report presents a summary of 241.1 referrals in 2013 and 2014 and the dispositions received by "300 youth" in 2012, 2013, and 2014. Additionally, the characteristics of "300 youth" and tracked cases as well as the 6-month outcomes for tracked youths are presented.

Results for 241.1 Referral Types and Dispositions

Types of 241.1 Referrals *(Table 1)*

- The overall number of 241.1 referrals received in 2013 and 2014 was similar across years.
- When comparing the general categories of referrals, the distribution of referrals was similar across years—with about half of the cases falling into "new" cases with a pending delinquency petition, and more than a third of cases falling into "reassessment." One difference was noticeable though; the percentage of "new" referrals was slightly higher than reassessments in 2013, but in 2014, the percentage of reassessments was slightly higher than "new" cases.
- The data in 2014 allow for a deeper understanding of the general categories of referrals discussed above. Based on more detailed information, "300 youth" account for the largest proportion of "new" cases, but they do not represent the majority of all 241.1 referrals. For reassessments, "reassessment because of court request/order" is the slightly more prevalent than other types of reassessments.

Summary of Findings for LA County 241.1 MDT

Table 1: Type of 241.1 Referrals Received in 2013 and 2014*

Type of Referral	2013 Referrals (N=1,050)		2014 Referrals (N=1,021)	
	N	%	N	%
"New" 241.1 Refrrals				
300 w/pending delinquency hearing	592	56.0	311	30.5
ER, VFM, or LG w/pending delinquency	---	---	105	10.3
300 pending w/pending delinquency hearing	---	---	77	7.5
Declared 602 with ER, VFM, or LG	---	---	23	2.2
Declared 602 with pending 300	---	---	21	2.1
Reassessments—Hearings for 241.1 Cases Already Processed				
Reassessment-Any Type Combined	413	39.0	---	---
Reassessment-Court Request/Order	---	---	236	23.1
Reassessment-New Arrest	---	---	177	17.3
Reassessment-Violation (WIC 777)	---	---	59	5.8
Reverse 241.1	42	4.0	12	1.2
AB 12	11	1.0	---	---

** Data collected in 2012 was limited to "300 Youth with a Pending Delinquency Petition." In 2013, there were a total of 1,185 referrals; however, 112 (9.9%) were rejected for processing (i.e., they did not meet the criteria to be processed and were excluded from analysis in this report.*

Types of Dispositions for "300 Youth" 241.1 Referrals *(Table 2)*

- Even though the majority of youth received an informal probation disposition, type of informal probation varied by year. In 2012 and 2013, youth were most likely to receive WIC 790, and in 2014, youth were most likely to receive a WIC 654.2 disposition.
- When youth received dual jurisdiction, they were most likely to receive 300/602 Suitable Placement in 2013 and 2014. Although the pattern was similar in 2012, youth received a similar percentage 300/602 Home on Probation and 300/602 Suitable Placement dispositions.
- Youth were almost twice as likely to receive an informal probation disposition in 2012 as in 2013 and 2014. Conversely, 241.1 youth were nearly twice as likely to receive a dual jurisdiction disposition in 2014 compared to 2012 and 2013; and in 2013, youth were approximately twice as likely to become a 602 ward (300 case terminated) in 2012 and 2014.

Table 3: Distribution of Multiple "New" 241.1 Referrals for "300 Youth" (N=402)

	N	%
1 Referral	277	68.9
2 Referrals	78	19.4
3 Referrals	35	8.7
4 Referrals	9	2.2
5 Referrals	3	.8

Finally, it is important to note that 10% and 20% of Initial Data was missing across agencies. Even though missing data is always a concern, we do not believe the missing data, if completed, would change the results dramatically if at all. Moreover, missing data will be corrected in future reports.

Demographic Characteristics of 241.1 Referrals "300 Youth" Only (Table 4)

- Approximately two-thirds of these 241.1 referrals were male, and a third were female. The proportion of females in this population is higher than in the general juvenile justice system population (typically 20%).
- Just under half of these 241.1 referrals were African-American and a similar percentage were Latino. African-American youth were over-represented at much higher rates in this population compared to the general population as well as the child welfare or juvenile justice systems individually.
- These 241.1 referrals were 16 years old (on average) at the time of their current arrests.
- These youth were most likely to live in group homes at the time of their referral followed by home and with relatives, and just under a fifth of these youth were AWOL from their living situation at the time of their arrest.
- Just under half of these referrals were from only five DCFS Offices: South County, Wateridge, Vermont Corridor, Compton, and Belvedere.

Table 2: Dispositions for "300 Youth" 241.1 Referrals in 2012, 2013, and 2014*

	2012 Referrals (N=255)[1]		2013 Referrals (N=500)		2014 Referrals (N=311)	
	N	%	N	%	N	%
Case Dismissed	17	6.7	20	3.4	13	4.2
Informal Probation						
WIC 654.2	54	21.2	88	15.0	51	16.4
WIC 725(a)	56	22.0	81	13.8	44	14.2
WIC 790	69	27.1	108	18.4	36	11.6
Dual Jurisdiction						
300/602 Home on Probation	19	7.5	19	3.2	29	9.3
300/602 Suitable Placement	18	7.1	60	10.2	65	20.9
300/602 Camp	7	2.8	5	.9	10	3.2
602 Wardship (300 Closed)						
602 Home on Probation	2	.8	17	2.9	1	.3
602 Suitable Placement	5	2.0	27	4.6	4	1.3
602 Camp	---	---	6	1.0	4	1.3
602 Off	---	---	1	.2	---	---
Other: Missing/Pending	8	3.1	156	26.5	54	17.4

**NOTES: Data reflect all referrals rather than unique youth—i.e., one youth may have multiple referrals within one timeframe. [1]In contrast to 2013 and 2014 which contain a year's worth of data, the data in 2012 were only available for the months of January through June, but there is no reason to suspect that the second half of the year would alter the findings of the first half. Finally, the data for 2012 include the beginning of the 241.1 MDT expansion across all delinquency courts.*

Characteristics of 241.1 Referrals

The data presented in this section are taken from the Initial Forms completed by all agencies for "300 youth" between October 2013 and December 2014. No other 241.1 referral types are included in this analysis. The unit of analysis for this section is the individual youth rather than referrals; thus, no youth is represented more than once in the findings presented. During this timeframe, there were 427 241.1 referrals for "300 Youth," which yielded a total of 402 unique youth. The table on the next page shows the number of referrals across these youth. As shown in Table 3, the majority (68.9%) only had one "new" 241.1 referral during this time, but 19.4% had two, 8.7% had three, and 3.0% had four or five referrals.

Table 4: Demographic Characteristics of 241.1 Referrals—"300 Youth" Only (N=402)

	%
Demographics	
Female	36.6%
Male	63.4%
African-American	44.5%
Latino	43.3%
Caucasian	8.2%
Rounded Average Age at Time of 241.1 Referral	16 years old
Living Situation at Time of Referral	
Group Home	32.3%
Home	17.2%
Relative (Legal Guardian and Not)	16.6%
Foster Care or Legal Guardian	9.9%
Other	20.0%
Missing	16.7%
AWOL at Time of Arrest	15.2%
DCFS Office	
South County	10.7%
Wateridge	10.4%
Vermont Corridor	9.7%
Compton	6.7%
Belvedere	6.2%
Lancaster	5.5%
Pasadena	5.5%
Glendora	5.2%
Torrance	5.0%
San Fernando Valley	4.7%
Santa Clarita	4.7%
Metro North	4.5%
Pomona	4.5%
Palmdale	4.2%
All Other Offices	12.4%

Summary of Findings for LA County 241.1 MDT

Involvement with the Child Welfare System (Table 5)

- At the time of their 241.1 referral, the average number of previous referrals to DCFS for 241.1 tracked youth and/or their families was 10.3.
- The average number of years 241.1 tracked youth spent in the child welfare system was 5 years, and this time was consecutive for half of these youth.
- The permanency plan for a third of these youth at the time of their 241.1 referral was permanent planned living arrangements followed by reunification, remain at home, and guardianship.
- The Children's Law Center provided counsel for almost all these youth, with more youth in Unit 1.

Table 5: Involvement in Child Welfare System for 241.1 Referrals "300 Youth" Only (N=402)

	%
Average # of Referrals for Youth's Family	10.3 Referrals (SD=7.4 Ref.)
Average Length in the System	5.4 Years (SD=4.70 Years)
Time is Consecutive	50.5%
Has Prior 241.1 Referral	12.4%
Permanency Goal at Time of Referral	
Permanent Planned Living Arrangements	32.8%
Reunification	23.6%
Remain at Home	18.9%
Guardianship	6.5%
Other	2.1%
Missing	16.3%
Dependency Counsel	
Children's Law Center Unit 1	33.3%
Children's Law Center Unit 2	22.6%
Children's Law Center Unit 3	20.9%
Panel Attorney	4.2%
Other	2.7%
Missing	16.2%

Involvement with the Juvenile Justice System (Table 6)

- Just over a third of these 241.1 referrals were detained at juvenile hall at the time of their arrest.
- These youth were most likely to be charged with a violent charge in the current arrest followed by property offenses, and other offenses. Three-quarters of the violent charges involved an assault of some sort, and over half of the charges were felonies.
- Slightly more than one-quarter of the charges occurred at the youths' living situations and just under a fifth occurred at school.
- Less than 10% of female 241.1 referrals were recommended for the STAR Court—a program specifically designed for sexually exploited youth.
- One-quarter of youth had a prior criminal charge, and just under a fifth had a prior status offense at the time of their 241.1 referral.
- The majority (three-quarters) of these 241.1 referrals were represented by the Public Defender's Office.

Table 6: Involvement in Juvenile Justice System for 241.1 Referrals "300 Youth" Only (N=402)

	%
Detained at Time of Arrest	35.1%
Most Serious Current Charge	
Violent Offense	40.2%
% Violent Offenses Involving an Assault	76.2%
Property Offense	35.3%
Other Offense	28.1%
Type of Charge	
Felony	51.7%
707b Offense	7.5%
Misdemeanor	43.5%
Was Offense Related to...?	
Living Situation	28.6%
School	15.4%
Missing	9.7%
Recommendation to STAR Court (% of Female Youth)	6.1%

Prior Offenses	
Criminal Charges	23.4%
Status Offenses	17.7%
Missing Data	9.7%
Delinquency Counsel	
Public Defender	74.4%
Alternate Public Defender	9.7%
Panel Attorney	5.2%
Other	4.7%
Missing	9.7%

*Youth may have multiple charges across offense categories, thus, the offense categories do not add up to 100%.

Mental Health and Substance Abuse Problems (Table 7)

- One-quarter to one-third of 241.1 referrals had a history of hospitalization for mental illness, were prescribed medication, and/or experienced suicide ideation. Just about one-tenth of these youth had attempted suicide at some point in the past.
- Three-quarters of these 241.1 referrals had a mental health diagnosis, and slightly more than half had a pattern of alcohol/drug use and/or diagnosed abuse or dependency.

Table 7: The Prevalence of Mental Health and Substance Abuse Problems for 241.1 Referrals "300 Youth" Only (N=402)

	%
Mental Health History	
Ever Placed in Psychiatric Hospital	31.6%
Experienced Suicidal Ideation	23.7%
Ever Attempted Suicide	9.9%
Prescribed Psychotropic Medication	26.6%
Mental Health Diagnoses	
No	1.7%
Yes	73.9%
Unknown/Missing	24.4%
Current Mental Health and/or Substance Abuse Problems	
No Substance Abuse Problem	21.4%
Misuse/Pattern of Use	23.1%
Abuse/Dependency	35.6%

Unknown/Missing	19.9%

Educational Status and Characteristics (Table 8)

- Partial school records were available for 241.1 referrals more often than complete school records.
- More than a third of these youth did not have an active educational rights holder at the time of the 241.1 assessment.
- Only two-thirds were enrolled in school at the time of the 241.1 assessment, and a few of these youth were enrolled during their detention in juvenile hall.
- Only one-fifth of these youth were attending school regularly; fewer were doing well or doing average academically, half were credit deficient, and a third were either special education eligible or needed in he assessed for eligibility.

Table 8: Educational Status and Characteristics for 241.1 Referrals "300 Youth" Only (N=402)

	%
School Records Available	
Yes-Partial Records	66.9%
Yes-Complete Records	3.7%
Missing	19.4%
Youth Does Not Have an Active Educational Rights Holder	40.1%
Enrolled in School at Time of 241.1 Assessment	
In the Community	53.7%
In Juvenile Hall	16.1%
Missing	20.9%
Regular Attendance at School within Past Year	20.9%
Doing Well or Average at Time of 241.1 Assessment	17.5%
Credit Deficient at Time of 241.1 Assessment	49.0%
Special Education	
Receiving	11.1%
Needs/Assessment Recommended by MDT	16.3%

Summary of Findings for LA County 241.1 MDT

241.1 MDT Meetings: Assessment and Post-Disposition "3DD Youth" Only (N=402)

MDT Meetings for "300 Youth" (Tables 9 and 10)

- According to the 241.1 Application data available, fewer than three-quarters of these 241.1 youth received an Assessment 241.1 MDT meeting.
- Assessment meetings were attended by a 241.1 DCFS social worker, a 241.1 Deputy Probation Officer, a DMH representative/psychiatric social worker, and an educational consultant (DCFS or contracted agency) nearly all the time. Advocates and program representatives were in attendance much less, and parents/caregivers as well as youth rarely, if ever, attended this meeting.
- Slightly less than one-third of these youth received a Post-241.1 MDT meeting.
- Post-241.1 MDT meetings were most likely to be attended by the 241.1 DCFS social worker, the case-carrying social worker, a DMH representative/psychiatric social worker, the parents/caregivers/family, and the youth. Also in attendance, albeit less often, were Probation representatives, educational consultants, and advocates (e.g., CLC) and program representatives (NOTE: Probation may have attended most if not all the meetings but the Probation representatives covered meetings individually rather than together).

Table 9: Assessment 241.1 MDT Meetings and Who Attended for 241.1 Referrals "3DD Youth" Only (N=402)

	%
Received an Assessment 241.1 MDT Meeting	71.9%
Who Attended the Assessment 241.1 MDT Meeting	
241.1 Unit DCFS CSW	99.6%
241.1 Unit Probation Officer	99.0%
DMH/Psychiatric Social Worker	96.5%
Education Consultant	93.0%
Other DCFS Social Worker (e.g., case-carrying CSW)	99.6%
Children's Law Center	10.3%
Other Program Representative/Advocate	10.3%
Parents/Caregivers	1.0%
Youth	.7%

Table 10: Post-241.1 MDT Meetings and Who Attended for 241.1 Referrals "3DD Youth" Only (N=402)

	%
Received a Post 241.1 MDT Meeting	36.8%
Who Attended the Post 241.1 MDT Meeting	
241.1 Unit DCFS CSW	99.1%
241.1 Unit Probation Officer	49.3%
DMH/Psychiatric Social Worker	91.4%
Education Consultant	28.4%
Other DCFS Social Worker (e.g., case-carrying CSW)	91.4%
Supervising Deputy Probation Officer	55.2%
Children's Law Center	16.4%
Other Program Representative/Advocate	29.3%
Parents/Caregivers/Other Family	81.2%
Youth	92.2%

Results for Services Received by Tracked Youth

Tracking data collected in the first period provided insight into which services youth received and the extent to which they were participating in those services as well as which Probation conditions tracked youth received. Specifically, this section identifies the services tracked 241.1 youth received and their status in those services at the end of tracking period 1 (i.e., 6 months after disposition).

Mental Health Services Received During Tracking Period 1 (Tables 11 and 12)

- Based on the prevalence of diagnoses and history of mental health problems, it would appear that at least three-quarters of 241.1 tracked youth need mental health services. According to the service data provided, nearly all youth received some type of mental health service (NOTE: The data currently available do not allow for testing the "appropriateness" of services).
- The top four mental health services received by 241.1 tracked youth were: (1) individual counseling, (2) group counseling, (3) medication monitoring, and (4) family counseling.
- Half or more of these youth were participating in services at the end of the tracking period, but between a quarter and a third of youth were not participating in these services.

Table 11: Prevalence of Mental Health Problems for 241.1 Tracked Youth (N=62)

	%
Does Youth have a Mental Health Diagnoses	75.8%
Unknown/Missing	12.6%
Mental Health History	
Ever Placed in Psychiatric Hospital	33.9%
Experienced Suicidal Ideation	27.4%
Ever Attempted Suicide	12.9%
Prescribed Psychotropic Medication	27.4%
241.1 Tracked Youth Receiving Mental Health Services in Tracking Period 1	55 (88.7%)

Table 12: Top Four Mental Health Services Received and Youth Status in Those Services at the End of Tracking Period 1 (N=55)

Type of Service Received	N (%)	Status in Services at End of Tracking Period				
		Refer	Part	Not Attending	Comp	Term
Individual Treatment	55 (100%)	---	71.2%	25.4%	3.4%	---
Group Treatment	29 (52.7%)	6.8%	65.5%	31.0%	3.4%	---
Medication Monitoring	24 (43.6%)	---	66.7%	30.0%	---	---
Family Treatment	18 (32.7%)	16.7%	55.5%	27.8%	5.6%	---

NOTE: "---" denotes "Not Applicable." Percentages across the types of services do not necessarily add to 100% because the status could be missing for a particular service. Additionally, percentages may add to more than 100% if a particular service was entered more than once.

Substance Abuse Services Received During Tracking Period 1 (Tables 13 and 14)

- Based on the prevalence of substance abuse problems for 241.1 tracked youth, it would appear that at least one-half of youth need substance abuse services, with a third needing services more intensive than alcohol and drug education. According to the service data provided, just over half of the tracked youth received some type of substance abuse service (NOTE: The data currently available do not allow for testing "appropriateness" of services).
- Over half of youth receiving substance abuse services received drug and alcohol education, one quarter received outpatient treatment, and less than one-fifth were placed in inpatient treatment.
- Half or more of these youth were participating in services at the end of the tracking period, but between a quarter and a third of youth were not participating in these services.

Table 13: Prevalence of Substance Abuse for 241.1 Tracked Youth (N=62)

	%
Current Mental Health and/or Substance Abuse Problems	
No Substance Abuse Problem	40.3%
Misuse/Pattern of Use	21.0%
Abuse/Dependency	33.8%
Unknown/Missing	4.8%
241.1 Tracked Youth Receiving Substance Abuse Services in Tracking Period 1	34 (54.8%)

Summary of Findings for LA County 241.1 MDT

Table 14: Substance Abuse Treatment Services Received and Youth Status in Those Services at the End of Tracking Period 1 (N=34)

Type of Service Received	N (%)	Status in Services at End of Tracking Period				
		Refer	Part	Not Attending	Comp	Term
Drug/Alcohol Education	18 (52.9%)	22.2%	50.0%	---	27.8%	---
Drug/Alcohol Outpatient	9 (26.5%)	---	44.4%	55.6%	---	---
Drug/Alcohol Inpatient	6 (17.6%)	---	40.0%	40.0%	40.0%	---

NOTE: "---" denotes "Not Applicable." Percentages across the types of services do not necessarily add to 100% because the status could be missing for a particular service. Additionally, percentages may add to more than 100% if a particular service was entered more than once.

Behavioral/Social Services During Tracking Period 1 (Table 15)

- Of all 241.1 tracked youth, over three-quarters received at least one behavioral/social service.
- The top four behavioral/social services were (1) anger management (Not ART); (2) independent living programs; (3) life skill programs; and (4) mentoring programs.
- Participation rates were highest for 241.1 tracked youth placed in life skills training and anger management (Not ART). Participation was lowest for independent living programs and for mentoring programs—in both situations, a high percentage of youth were referred only and had not been able to access those services yet.

Table 15: Behavioral/Social Programs Received and Youth Status in Those Programs at the End of Tracking Period 1 (N=52)

NOTE: 52 out of the 62 (83.9%) Tracked Youth Received a Behavioral/Social Service

Type of Service Received	N (%)	Status in Services at End of Tracking Period				
		Refer	Part	Not Attending	Comp	Term
Anger Management	33 (63.4%)	18.1%	60.1%	9.0%	6.8%	3.0%
Independent Living Program	13 (25.0%)	53.8%	23.1%	23.1%	---	---
Life Skills Program	11 (21.2%)	27.2%	63.6%	9.0%	---	---
Mentoring Program	8 (15.4%)	37.5%	37.5%	12.5%	12.5%	---

NOTE: "---" denotes "Not Applicable." Percentages across the types of services do not necessarily add to 100% because the status could be missing for a particular service. Additionally, percentages may add to more than 100% if a particular service was entered more than once.

Educational Services During Tracking Period 1 (Table 16)

- Of all 241.1 tracked youth, over three-quarters received at least one educational service.
- The top three educational services received by 241.1 tracked youth were (1) tutoring; (2) attendance monitoring; and (3) referrals for AB 167 and 317E (combined in this analysis).
- "Referral only" rates were highest for scheduling an individualized education plan meeting, making an AB 126/317E referral, and accessing assistance for the CAHSEE. Participation rates were highest for tutoring and attendance monitoring but non-attendance was highest among tutoring services as well. Non-attendance was also high for credit recovery and CAHSEE assistance programs.

Table 16: Educational/School-Based Services Received and Youth Status in Those Services at the End of Tracking Period 1 (N=53)

NOTE: 53 out of the 62 (85.5%) Tracked Youth Received an Educational Service

Type of Service Received	N (%)	Status in Services at End of Tracking Period				
		Refer	Part	Not Attending	Comp	Term
Tutoring Services	35 (66.0%)	17.1%	48.6%	31.4%	2.8%	---
Attendance Monitoring	32 (60.4%)	9.4%	56.2%	15.6%	9.4%	6.3%
AB 126 & 317E Combined	24 (45.3%)	25.0%	12.5%	12.5%	16.7%	16.7%
Credit Recovery	22 (41.5%)	27.2%	36.4%	22.7%	9.1%	---
Individual Educ. Plan Meeting	21 (39.6%)	38.1%	23.8%	14.3%	19.8	---
CAHSEE Assistance	16 (30.2%)	43.7%	6.2%	31.2%	18.8%	---

NOTE: "---" denotes "Not Applicable." Percentages across the types of services do not necessarily add to 100% because the status could be missing for a particular service. Additionally, percentages may add to more than 100% if a particular service was entered more than once.

Probation Conditions (Table 17)

- Based on the data provided in the 241.1 Application, all but two of the 241.1 tracked youth received probation conditions.
- The top four Probation conditions received by 241.1 tracked youth were: (1) attend school and maintain grades; (2) participate in family counseling; (3) perform community service; and (4) do not drink alcoholic beverages.
- *NOTE: Due to time constraints, youth status on each of the conditions is not reported but will be included in the next report.*

Table 17: Probation Conditions Received by Type (N=58)

NOTE: 58 out of the 62 (93.5%) Tracked Youth had Probation Conditions from the Court.

Probation Condition Received	N (%)
9-Attend School and Maintain Grades	55 (94.8%)
30-Participate in Family Counseling	46 (79.3%)
8-Perform Community Service	41 (70.7%)
17-Not Drink Alcoholic Beverages	36 (62.1%)
9a-Participate in HS Grad/GED/WIN Program	29 (50.8%)
19-Must Submit to Drug Testing	22 (37.9%)
10-Participate in Afterschool/Tutoring Program	22 (37.9%)
18-Not Be Around Using or Selling Drugs	20 (34.5%)
13h-Do Not Participate in Gang Activity	18 (31.0%)
20-Random Testing for Drugs/Alcohol	17 (29.3%)

Findings for 241.1 Tracked Youth Outcomes

Using data collected from the first tracking period, this section explores how youth are doing on the following measures: school performance, reassessments, and new violations and/or arrests.

Educational Outcomes at the End of Tracking Period 1 (Table 18)

- Between the 241.1 assessment and the end of tracking period 1, enrollment in school dropped slightly (-2%).
- The percentage of credit deficient youth dropped slightly (-3%).
- Regular attendance increased dramatically (+39%) while sporadic attendance and poor attendance dropped (-24% and -3%, respectively).
- Doing poorly at school dropped 25 percentage points while doing average (mostly C's) increased 24 percentage points.

Summary of Findings for LA County 241.1 MDT

Table 18: Educational Outcomes for Tracked Youth at the End of Tracking Period 1 (N=62)

	At the Beginning of Period 1	At the End of Period 1
Enrolled in School	90.4%	88.3%
Graduated/GED	--	3.2%
Credit Deficient	61.3%	58.1%
School Attendance		
Attends Regularly	34.2%	62.9%
Attends Sporadically	38.7%	14.5%
Poor Attendance	22.6%	19.4%
Academic Performance at the End of Period 1*		
Doing Well	15.9%	11.3%
Doing Average	8.1%	32.3%
Doing Poorly	64.5%	42.0%
Unknown	15.5%	15.5%

Recidivism at the End of Tracking Period 1 (Table 19)

- Between the 241.1 assessment and the end of tracking period 1, one-fifth of 241.1 tracked youth were referred for a 241.1 reassessment.
- One third of these youth had a court violation (e.g. a bench warrant) during the tracking period, and slightly less than one-fifth had a WIC 777 probation violation filed.
- 14.5% of 241.1 tracked youth had a new citation and 16.1% were re-arrested for a new criminal offense within 6 months of their disposition.

- These youth are struggling at school and engaged in behavioral problems that often lead to their current arrest (i.e., the charge occurred at school).
- Almost all of these youth have an indication of a mental health problem and/or an alcohol/drug problem.

System Responses

- Almost all of the 241.1 tracked youth received mental health services and most were participating in those services during Tracking Period 1; non-attendance rates were highest for group treatment and family treatment. Slightly less than a fifth were referred but hadn't accessed services yet.
- Only half of 241.1 tracked youth received alcohol/drug services, but half these services were alcohol/drug education. Non-attendance rates exceed participation rates for outpatient treatment and the two rates were equivalent for inpatient services.
- More than three-quarters of 241.1 tracked youth received behavioral/social interventions. Participation rates were highest for anger management and life skills programming, and non-attendance rates were highest for independent living programs. "Referral only" rates were also very high for independent living and mentoring.
- Over three-quarters of 241.1 tracked youth received educational services related to tutoring, enrollment or credit recovery. Most youth were participating in these services.
- Over three-quarters of 241.1 tracked youth also received one or more educational services. Tutoring and attendance monitoring had the highest rates of participation but tutoring also had one of the highest non-attendance rates. Non-attendance was also high for credit recovery programs. "Referral only" rates were high for all educational services except tutoring and attendance monitoring.
- The top four Probation conditions received by 241.1 tracked youth were: (1) attend school and maintain grades; (2) participate in family counseling; (3) perform community service; and (4) do not drink alcohol or beverages.

Outcomes for 241.1 Tracked youth

- 241.1 tracked youth appeared to improve their attendance and their academic performance over time; however, the change, while positive, was modest and greater

Table 19: Reassessments and Recidivism for Tracked 241.1 Youth (N=62)

	At the End of Period 1
Referred for a 241.1 Reassessment Hearing	19.4%
Violations During Period 1	
Court Violations During this Period	30.6%
WIC 777 Violations During this Period	17.7%
New Charges During Period 1	
New Citations During this Period	14.5%
New Arrests During this Period	16.1%

Summary of Findings

The findings from the 241.1 data collected by DCFS, Probation, and the Department of Mental Health provide unprecedented insight into "who" 241.1 youth are, the challenges they face, the services and conditions they receive, their participation/adherence to those services and conditions, and their outcomes. Although the numbers for tracked cases was still relatively small, the findings are consistent with last year's report and previous research completed in Los Angeles County and nationwide on crossover youth. Confidence in these findings and increased insight into these youths' experiences will continue to grow as the number of 241.1 youth included in analysis for future reports increases over time. In sum, this is what the current findings tell us:

Characteristics

- Females are more likely to be in the crossover population (i.e., WIC 241.1/involved in both child welfare and juvenile justice systems) than in the general juvenile justice population.
- The overrepresentation of African-American youth is greater within the crossover population than in the child welfare and juvenile justice systems individually.
- These youth and their families have multiple contacts with child welfare and the youth have long lengths of stay in the child welfare system.
- By the time they reach the 241.1 referral stage, many of these youth have had previous contact with the juvenile justice system by way of a criminal charge and/or a status offense.
- They are most likely to live in a group homes or with relatives, and at least a third of their arrests are related to their living situations.

with youth on the margins of poor performance.

- Recidivism, as measured by new arrests, at the end of tracking was only 16.1%. *NOTE: Given recidivism rates are measured at 1 year after disposition, the performance of these youth can be compared to the recidivism rates of 241.1 youth not served by the MDT (collected from a previous study).*
- It should be noted, though, that a significant number had received bench warrants and/or were referred for a 241.1 reassessment.

Conclusion and Recommendations

Similar to last year's report, these findings indicate that youth are receiving services related to the challenges they face. However, it appears that substance abuse continues to be an issue for some youth. Such problems can, in turn affect their placement, education, and recidivism outcomes. The results presented in this report raise questions about the appropriateness of treatment as well as the ability of agencies to connect youth and families to appropriate services.

The literature on effective programming and outcomes for youth with complex needs and risk factors is clear. Effective services require (1) matching youth needs and risks to appropriate levels of service, (2) using multi-modal treatments to address different risks and needs (often related) simultaneously, and (3) meaningfully engaging youth and their families in services. The findings presented in the current report lay the foundation for looking at these issues more directly for dually-involved youth in Los Angeles County, and as the data continue to grow, it will be possible to track trends for these youth and determine what characteristics and services are related to more positive outcomes and how strategies can be built to address the characteristics of youth with more challenging outcomes.

One final note is on the need to provide appropriate resources for data collection mandates is necessary. As mentioned earlier in this report, the design and implementation of the 241.1 Application is a major accomplishment and "labor of love" for a number of agency staff who work with dually-involved youth on a daily basis. Despite the Board's mandate to collect data, no resources were provided to support this work. Consequently, staff workloads continuously impact the timeliness and accuracy of data entered into the database (e.g., in theory, this report should have contained information on tracked youth for six to eight months rather than three months). If resourced appropriately (i.e., each agency would have daily access to a staff person who is knowledgeable in data information systems and data collection), the data produced in the 241.1 Application could be used for

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

FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
ANXIETY	Managing and Adapting Practice (MAP) - Anxiety & Avoidance[11]	3 - 19	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Revised Child Anxiety and Depression Scales - Parent (RCADS-P) Revised Child Anxiety and Depression Scales (RCADS)	8 - 19	RCADS-P English, Korean, Spanish RCADS, Chinese, English, Korean, Spanish
	Individual Cognitive Behavioral Therapy - Anxiety (CBT-Anxiety)	16+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire 45.2	16 - 17 18 - 18 19+	Generalized Anxiety Disorder - 7 (GAD-7)	18+	Arabic, Chinese, English, Korean, Russian, Spanish, Tagalog
	Mental Health Integration Program (MHIP) - Anxiety	18+	**No general measure is required**				
TRAUMA	Child Parent Psychotherapy (CPP)	0 - 6	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Trauma Symptom Checklist for Young Children (TSCYC)	3 - 6	Armenian, Chinese, English, Korean, Spanish
	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10 - 15					
	Alternatives for Families-Cognitive Behavioral Therapy [formerly Abuse Focused-Cognitive Behavioral Therapy] (AF-CBT)	8 - 15	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	UCLA PTSD-RI-5 – Parent[111] UCLA PTSD-RI-5 – Child/Adolescent[111]	7 - 18 7 - 18	PTSD-RI-5 Child/Adolescent English, Spanish
	Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)[1]	3 - 18					
	Managing and Adapting Practice (MAP) - Traumatic Stress[11]	2 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	7 - 17 12 - 18	UCLA PTSD-RI-5 – Parent[111] UCLA PTSD-RI-5 – Child/Adolescent[111]	7 - 18 7 - 18	PTSD-RI-5 Parent English, Spanish
	Seeking Safety (SS)	13+	Outcome Questionnaire - 45.2	19+	PCL-5[111]	19+	PCL-5 English, Spanish
	Individual Cognitive Behavioral Therapy - Trauma (CBT-Trauma)	18+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	16 - 17 16 - 18 19+	UCLA PTSD-RI-5 – Parent[111] UCLA PTSD-RI-5 – Child/Adolescent[111] PCL-5[111]	16 - 18 16 - 18 19+	
	Prolonged Exposure for PTSD (PE)	18 - 70	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Posttraumatic Stress Diagnostic Scale (PDS)	18 - 85	English
	Mental Health Integration Program (MHIP) - Trauma	19+	**No general measure is required**		PTSD Checklist-Civilian (PCL-C)	18+	Chinese, English, Spanish

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FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE?	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
CRISIS	Crisis Oriented Recovery Services (CORS)	3+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 18+	[redacted]		
FIRST BREAK / TAY	Center for the Assessment and Prevention of Prodromal States (CAPPS)	18 - 25	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 - 17 18 - 18 18+	Scale of Prodromal Symptoms (SOPS)	18 - 35	English, Spanish
DEPRESSION	Interpersonal Psychotherapy for Depression (IPT)	12+	Youth Outcome Questionnaire - 2.01 (Parent)	8 - 17	Patient Health Questionnaire - 9 (PHQ-9)	12+	Available in all 13 threshold languages
	Depression Treatment Quality Improvement (DTQI)	12 - 20	Youth Outcome Questionnaire - Self-Report - 2.0	12 - 18			
	Managing and Adapting Practice (MAP) - Depression and Withdrawal**	8 - 23	Outcome Questionnaire - 45.2	18+			
	Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	18+	Youth Outcome Questionnaire - 2.01 (Parent)	16 - 17	Patient Health Questionnaire - 9 (PHQ-9)	18+	Available in all 13 threshold languages
			Youth Outcome Questionnaire - Self-Report - 2.0	16 - 18			
	Individual Cognitive Behavioral Therapy - Depression (CBT-Depression)	18+	Outcome Questionnaire - 45.2	18+			
	Problem Solving Therapy (PST)	60+	Outcome Questionnaire - 45.2	19+			
	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+					
	Mental Health Integration Program (MHIP) - Depression	18+	[redacted]				
EMOTIONAL DYSREGULATION DIFFICULTIES	Dialectical Behavioral Therapy (DBT) DIRECTLY OPERATED CLINICS	18+	Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	18 19+	Difficulties in Emotional Regulation Scale (DERS)	18+	English

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FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
DISRUPTIVE BEHAVIOR DISORDERS	Aggression Replacement Training (ART)	12 - 17	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Eyberg Child Behavior Inventory (ECBI)	2 - 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Aggression Replacement Training - Skillstreaming (ART)	5 - 12	Youth Outcome Questionnaire - Self-Report - 2.0	12 - 18			
	Promoting Alternative Thinking Strategies (PATHS)	3 - 12					
	Managing and Adapting Practice (MAP) - Disruptive Behavior[1]	0 - 21	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	Sutter Eyberg Student Behavior Inventory - Revised (SESBI-R) [if parent is unavailable]	2 - 16	SESBI-R: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
SEVERE BEHAVIORS/ CONDUCT DISORDERS	Brief Strategic Family Therapy (BSFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	Revised Behavior Problem Checklist - Parent (RBPC)	5 - 18	Armenian, Cambodian, English, Spanish
	Multidimensional Family Therapy (MDFT)	11 - 18	Youth Outcome Questionnaire - Self-Report - 2.0	12 - 18	Revised Behavior Problem Checklist - Teacher (RBPC) [if parent is unavailable]		
	Strengthening Families Program (SFP)	3 - 16					
	Functional Family Therapy (FFT)	10 - 18	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18	**Developer Required:** **Child Services System:** **• Counseling Process Questionnaire** **• Client Outcome Measure** **• Therapist Outcome Measure** **• YOQ/YOQ-SR/OQ**	18 - 18	English
	Multisystemic Therapy (MST)	11 - 17			**Developer Required:** **Therapist Adherence Measure** **Supervisor Adherence Measure**	11 - 17	English
PARENTING AND FAMILY DIFFICULTIES	Triple P Positive Parenting Program (Triple P)	0 - 18					
	Incredible Years (IY)	0 - 12					
	Parent – Child Interaction Therapy (PCIT)	2 - 7	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	4 - 17 12 - 18	Eyberg Child Behavior Inventory (ECBI) Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [if parent is unavailable]	2 - 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	UCLA TIES Transition Model (UCLA TIES)	0 - 9					
	Caring For Our Families (CFOF) CDE as of 12/1/12	5 - 11					
	Loving Intervention Family Enrichment (LIFE) CDE as of 12/1/12	10 - 17					
	Reflective Parenting Program (RPP) CDE	0 - 12					
	Mindful Parenting Groups (MPG) CDE	0 - 3	No general measure is required		Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	1m - 36m	English, Spanish

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FOCUS OF TREATMENT	EVIDENCE-BASED PRACTICE (EBP) COMMUNITY-DEFINED EVIDENCE (CDE) PROMISING PRACTICE (PP)	AGE	GENERAL OUTCOME MEASURE[1]	AGE	SPECIFIC OUTCOME MEASURE	AGE	AVAILABLE THRESHOLD LANGUAGES
PARENTING AND FAMILY DIFFICULTIES	Caring For Our Families (CFOF) CDE prior to 12/1/12	5 - 11	Youth Outcome Questionnaire - 2.01 (Parent)	4 - 17	As of 12/1/12, the Eyberg Child Behavior Inventory (ECBI) and Sutter Eyberg Student Behavior Inventory-Revised (SESBI-R) [if parent is unavailable] are being used for all new clients instead of the Child Behavior Checklist for Ages 1 ½ - 5 (CBCL 1.5-5) Child Behavior Checklist (CBCL) Caregiver-Teacher Report Form for Ages 1 ½ - 5 (C-TRF) Teacher Report Form (TRF) Youth Self-Report (YSR)	2 - 16	ECBI: Armenian, Chinese, English, Japanese, Korean, Russian, Spanish SESBI-R: Arabic, Armenian, Chinese, English, Japanese, Korean, Russian, Spanish
	Loving Intervention Family Enrichment (LIFE) CDE prior to 12/1/12	10 - 17	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.0	10 - 17 12 - 18			
	Families OverComing Under Stress (FOCUS)	5+	Youth Outcome Questionnaire - 2.01 (Parent) Youth Outcome Questionnaire - Self-Report - 2.8 Outcome Questionnaire - 45.2	4 - 17 12 - 18 19+	McMaster Family Assessment Device (FAD)	12+	English

* Providers started collecting outcomes for TF-CBT in December 2010 (MHSA Implementation Memo, dated 12/14/2010).
** Providers started collecting outcomes for MAP-Anxiety and Avoidance, MAP-Traumatic Stress, and MAP-Depression and Withdrawal in February 2011 (MHSA Implementation Memo, dated 2/22/2011).
*** For treatment cycles beginning before November 1, 2015 the DSM-IV UCLA PTSD-RI Child/Adolescent, Parent, and Adult Short Form will be required.
PEI EBP's that are not entered into PEI OMA are shaded.
1. Youth Outcome Questionnaire - 2.01 (Parent), Youth Outcome Questionnaire-Self-Report - 2.0, Outcome Questionnaire - 45.2, and PHQ-9 are available in all 13 threshold languages: English, Arabic, Armenian, Cambodian, Chinese (Modern), Chinese (Traditional), Farsi, Tagalog, Japanese, Korean, Russian, Spanish, and Vietnamese.

Pacific Clinics
ADVANCING BEHAVIORAL HEALTHCARE

SCHOOL BASED SERVICES

FOR

Latina Youth Program

Evaluation Report

CONTRACT YEAR 2014-2015

THE PURPOSE OF THIS REPORT:

The purpose of this report is to summarize progress with regard to ongoing operation and outcomes of Pacific Clinics' School Based Services for the Latina Youth Program (LYP), for the Fiscal Year 2014-2015 (FY14-15). This includes documentation of education and outreach activities as well as prevention and intervention activities. Additionally, information on client demographics is provided.

Data for this evaluation was gathered through various sources. There was a review of past program reports, printed materials, and forms. Client data has been reviewed through various reports used by Pacific Clinics to monitor programs. An analysis of outcomes based on this data was carried out.

SUMMARY

The program provided services to 214 participants in this, its 14th year. Participants ranged in age from 6 to 21 years, and were distributed among first through 12th grades, and some college students. With regard to language 45% speak English as their primary language at home. Nineteen percent speak Spanish as their primary language at home. And, in 36% of the homes the children prefer English while the parents prefer Spanish. During this FY 54% of the program participants were female and 46% were male. The greatest majority of program participants were Latinas/os (74%). Caucasian participants made up 13% of the program population. The following ethnic groups represented one percent of the program population, each: African American (AA), Asian/Pacific Islanders (API) and American Indians. Participants endorsing the "Other" category with regard to ethnicity or not providing information represented 10% of the total participant population. Program participants accessed services in multiple locations. They had the option of receiving services at the schools, their homes, other locations within the community or at the program headquarters. And, while the average cost per client served in Los Angeles through PEI funding in FY 13-14 was $4,539 (figures not yet available for FY 14-15) for children, and $4,223 for TAY, Pacific Clinic's average cost per client served through the LYP was $3,130 in FY 14-15. There was one incident of a completed suicide during the fiscal year 2013-2014, despite the fact that the program targets those at higher risk for suicidality. Thus, although more students may be attempting suicide, the availability of easily accessible intervention, including hospitalization is helping keep even these most severe of cases safe.

In addition to direct services, Pacific Clinics provided a number of Outreach and Engagement activities throughout FY 14-15. These include, but were not limited to Anti-Stigma and Discrimination presentations; Suicide Prevention Trainings; Mental Health Promotion Presentations; as well as Services to Community Residents. These activities resulted in a total number of 2114 contacts and represent 1830 hours of trainings, presentations and other services.

Table 1:

Program Area	**7495, 7896, 7902**
Anti-Stigma and Discrimination	66
FSP	1
Community Capacity Building	15
Education/Training	95
Employment/Vocational	11
IMD/Residential and Building	5
Suicide Prevention	118
LSP- Public Guardian	1
Wellness Client-run	1
Community Client Services	1164
Mental Health Promotion	950
Total Number of Contacts	**2114**

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

Table 2:

YEAR	2014-2015	2001-2002	2002-2003	2003-2004	2005-2006	2008-2009	2010-2011 & 2011-2012 extension
Open Cases		105	126	253	259	202	116
Gender		100% Female	67.5% Female 32.5% Male	64.1% Female 35.9% Male	46.7% Female 53.3 Male	48.5% Female 51.5% Male	48% Female 52% Male
Age Range (in years)		11 to 18	4 to 18	4 to 17	3 to 18	6 to 18	3 to 25
Grade		6th to 12th	Pre-K to 12th	Pre-K to 12th	Pre-K to 12th	1st to 12th	Pre-K to College
Primary Language at Home		34% Eng 47% Spanish 19% Both	49% Eng 21% Spanish 30% Both	41.7% Eng 18% Spanish 41.3% Both	48.6% Eng 19% Spanish 32.4% Both	43% Eng 20% Spanish 37% Both	53% Eng 5% Spanish 42% Both
Ethnicity		100% Latinas	100% Latinas	92.4% Latinas 5.3% Caucasian 2.3%AA	84.2% Latinas 9.5% Caucasian 2% AA 4.3% Other	92.5% Latinas 4% Caucasian 1.5% AA 1.5% API 0.5% Other	88% Latinas 8% Caucasian 1% AA 2% API 1% Other

Table three below reflects the number of individuals and their families who received services in each of the indicated contract years, as well as their gender, age and grade ranges. The primary language spoken at home is reported as either English, Spanish or both and the ethnic breakdown of the participants, with the majority being Latinas/os, as this is the focus population of the program. At intake, participants are asked to endorse a number of problem areas reflecting those that are risk factors for suicidal behavior. The table above reflects the number of participants who endorsed Substance Abuse, Past Suicidal Attempts and Suicidal Ideation as issues they confronted within the past six months before participating in the LYP.

Table 3:

A summary of program participant characteristics is provided in the table below for the FY 14-15 and select previous years:							
Substance Abuse	**20.50%**	**26%**	**19%**	**11.40%**	**8.50%**	**16%**	**19%**
Past Suicide Attempt	**[illegible]%**	**24%**	**10%**	**5%**	**5%**	**13%**	**8%**
Suicide Ideation	**33%**	**55%**	**26%**	**27%**	**21%**	**29%**	**25%**
Health Insurance Coverage	**[illegible]% None** **35% EPSDT** **23% Other**	**23% None** **32% MediCal** **45% Other**	**27% None** **42% MediCal-EPSDT** **31% Other**	**88.6 % MediCal** **3% Healthy Families** **8.4% Other**	**18.6% None** **75.3% EPSDT** **6.2% Other**	**28% None** **71% EPSDT** **1% Other**	**68% None** **21% EPSDT** **11% Other**

Pacific Clinics - PEI Suicide Prevention Program
Client Demographics
FY2014-2015

PROGRAM	Male	Female	Ethnicity	Total	Age	Total
7495 SFS	-	8	American Indian	0	6	0
	Total	15	Black/African	0	7	0
			Filipino	0	8	0
			Latino/Hispanic	9	9	2
			Laotian	0	10	1
			Samoan	0	11	0
			White/Caucasian	4	12	0
			Other	2	13	0
			TOTAL	15	14	1
					15	2
					16	5
					17	0
					18	2
					19	1
					20	0
					21	1
					TOTAL	15

PROGRAM	M	F	Ethnicity	Total	Age	Total
7896	62	71	American Indian	1	6	0
SB	T	133	Black/African	0	7	0
Whittier			Filipino	1	8	3
			Latino/Hispanic	100	9	1
			Laotian	3	10	3
			Samoan	0	11	4
			White/Caucasian	18	12	10
			Other	10	13	13
			TOTAL	133	14	20
					15	20
					16	23
					17	17
					18	10
					19	7
					20	1
					21	1
					T	133

PROGRAM	Male	Female	Ethnicity	Total	Age	Total
7902 SFS	-	11	American Indian	0	6	0
	Total	18	Black/African	0	7	1
			Filipino	0	8	0
			Latino/Hispanic	12	9	2
			Laotian	0	10	1
			Samoan	0	11	1
			White/Caucasian	1	12	0
			Other	5	13	0
			TOTAL	18	14	3
					15	1
					16	4
					17	3
					18	1
					19	1
					20	0
					21	0
					TOTAL	18

PROGRAM	M	F	Ethnicity	Total	Age	Total
95A	12	21	American Indian	0	6	1
Monarovia	T	33	Black/African	0	7	0
			Filipino	1	8	0
			Latino/Hispanic	25	9	0
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	4	12	0
			Other	3	13	1
			TOTAL	33	14	2
					15	5
					16	8
					17	5
					18	5
					19	3
					20	3
					21	
					T	33

PROGRAM	*Male*	*Female*	*Ethnicity*	*Total*	*Age*	*Total*
95A	8	7	American Indian	0	6	0
Pasadena	Total	15	Black/African	1	7	0
SEA			Filipino	0	8	0
			Latino/Hispanic	13	9	0
			Laotian	0	10	0
			Samoan	0	11	0
			White/Caucasian	1	12	0
			Other	0	13	0
			TOTAL	15	14	0
					15	2
					16	2
					17	8
					18	0
					19	3
					20	0
					21	0
					TOTAL	15

TOTAL CLIENTS ***214***

PROGRAM GOALS AND OBJECTIVES

The primary goals of the Program are:

- To promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide
- To increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services.
- To increase access to services while decreasing barriers and stigma among youth in accepting mental health services.
- To increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion.
- To enhance awareness and education among school staff and community members regarding substance abuse and depression.

Progress on these goals is measured by the following objectives:

Partner with the program's core schools in the program service area to develop and conduct parents' workshops to raise family and community awareness about youth high-risk behaviors, cultural variance, stigma around mental illness, and communication strategies. Program activities in this area have yielded 950 unduplicated contacts during this fiscal year.

Based on promising and best practice models of care, program staff will provide individual and family treatment interventions to consumers to improve their level of functioning and reduce risky behaviors. Direct mental health services were delivered to 214 children/youth and their families during this fiscal year.

Based on best practice models, the program will organize and conduct parenting classes in English and in Spanish. Ninety-five parents participated in parenting classes during this fiscal year.

Train new program staff in evidence-based (EBP) or best practice models. During this FY staff have received training in the following EBPs: Aggression Replacement Therapy (ART), Crisis Oriented Recovery Services (CORS), Child-Parent Psychotherapy (CPP), Interpersonal Psychotherapy (IPT), Managing and Adapting Practice (MAP), Trauma-focused Cognitive Behavioral Therapy (TFCBT), Promoting Altemative Thinking Strategies (PATHS), Seeking Safety, Positive Parenting Program (TRIPLE P), Incredible Years (IY), and Cognitive Behavioral Therapy (CBT). In addition to these, in the past program years, staff have received training in Parent Child Interaction Therapy (PCIT), Dialectical Behavior Therapy (DBT), and Functional Family Therapy (FFT), as well as integrated mental health and substance abuse treatment including techniques like motivational interviewing. Additionally, the Latina Youth Program has been recognized by the Los Angeles County Department

of Mental Health as a Community Based Practice, recognizing its status as a set of interventions which in effect comprise a promising approach to preventing suicide among Latina youth.

Provide education sessions for local school staff on youth high-risk behaviors, mental health stigma, and youth communication strategies for staff at each of the schools in the program service area, where services are co-located. During this fiscal year 82 unduplicated school staff participated in these activities.

Organize and conduct peer groups to provide support and education for participants on issues of youth violence, substance abuse, family conflict, anger management, healthy relationships, peer pressure, safe sex practices, and effective interpersonal communication. A total of 118 individuals participated in program activities related to these topics.

Briefly, the program provided outreach and education as well as crisis intervention and urgent response to service area residents, for a total of 2114 individuals through 10 distinct activity categories. Additionally, the program provided mental health treatment to 214 individuals and their families. Parents received topic-specific education in areas related to program goals and participated in weekly parenting groups. Clinical staff received training on various Evidence Based Practice models, and all program participants were screened to assess whether they met the criteria for inclusion in one of these practices. School staff received training on high-risk behaviors, mental health stigma and other important issues. Peer support groups had weekly participation of students. Overall, the program, as in past years continues to successfully address important unmet needs in an effective manner to traditionally underserved communities. The program takes into account the community's cultural values and linguistic needs, and addresses these with a great deal of expertise.

PROGRAM APPROACH

ENGAGEMENT OF PARTICIPANTS AND FAMILY MEMBERS

The program's success in engaging and retaining clients and their families to participate in the program, is attributable to their philosophy of being culturally humble at all phases of client interaction, from outreach, to engagement, treatment and termination. The program staff receives training, supervision and consultation when working with families from cultural groups other than the Latino community. In this regard, the LYP is fortunate to have access to Pacific Clinics' multicultural staff and training opportunities. With regard to Latinos, not only are staff alert to the cultural nuances of the community, but they are also keenly aware of any particular family's culture. This is important as different members of a family may be at various levels of acculturation. Being able to ask questions and understand how this level may vary among extended family, parents and child/youth clients, is an important aspect of successfully connecting with and engaging a family into treatment.

Research (Dillman Carpentier, et. al., 2007) supports this approach as one which provides Latino clients the greatest opportunity to access services. There is a strong sense that investing a great deal of time and effort "up front" inevitably results in more successful working relations with the participants and their families. For example, in the past, staff's ability to advocate for families within the school, community, and other social service agencies although very time and effort intensive, earns them a

great deal of trust with program families. So much so, that when it comes to having to initiate difficult procedures such as a mandated child abuse report, hospitalization or other types of difficult processes involving families, the participants are able to work through their anger, confusion, sense of being betrayed, etc., and learn new techniques, such as different discipline approaches, different communication and anger management skills, etc., and continue to successfully work with program staff.

Staff is trained to attend to factors related to language; ethnicity; and cultural values. Additionally, staff are also encouraged to attend to issues related to socioeconomic status, gender and sexual orientation. With regard to language, the majority of program staff are able to communicate effectively, but informally in English and Spanish. Additionally, they are familiar to different extents with idiomatic expressions, which can vary depending on a client's country of origin. This is important because so many of the program participants, even within one single family, are at different levels of language proficiency, whether their primary language is Spanish or English. With regard to ethnicity, the clinicians expressed awareness of the differences that occur within the Latino community based on country of origin, regional differences within certain Latin American countries, issues related to varying colors of skin among Latinos and the idea of a Mestizo identity, or one which combines both the indigenous and foreign cultural/racial roots. Additionally, as stated above, staff is aware of and seek consultation on issues which vary within other cultures such as the API, Native American and African American ethnic communities. Issues related to LGBTQ2SI (Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Two-Spirited and Intersex) individuals and families, challenge the administration and staff to develop further awareness and sources of training and consultation opportunities.

With regard to cultural considerations, the program approach is to gather information about the family's values; economic functioning; health beliefs; spiritual/religious beliefs; myths they associate with mental illness and substance use; as well as sociopolitical issues including those related to immigration and legal status for immigrant communities. Having this information enables clinicians to help the family identify areas of strength on which to build new skill sets or expand support, which helps them better manage the challenges of dealing with an at risk youth. There exists a need to develop this astuteness with other communities. For example, the staff needs to develop awareness about how sexism, homophobia, and stigma related to transgenderism impact the communities within which the program staff works.

Staff is aware that despite varying levels of acculturation, Latinos are generally considered to be family oriented. Thus, the program has adopted the cultural values of **Familismo**, **Respeto**, **Collectivismo**, and **Personalismo** as described in the Maternal & Child Health Bureau, 1999. These values are incorporated in all aspects of the program, from development of new service provision strategies, to client engagement, through to service delivery and termination. As a point of reference the values are described below:

Familismo recognizes the immediate and extended family as the backbone of the Latino community. Positive relationships among family members are highly valued. And these relationships are viewed as preventive and protective factors which reduce the incidence of high-risk behavior in

youth. The program emphasizes this value by directly discussing strategies to improve communication skills and mutual respect in all aspects of the work with participants and their families, as well as actively engaging families in all areas of decision making and service delivery.

Collectivismo extends the value placed on positive working relationships out into the community. The literature indicates that Latinos prefer to work in groups and generally live in close knit communities. Latino students have been known to do better in goal attaining activities, when working in groups with other students. The program incorporates this value by emphasizing the involvement of the entire community in identifying and addressing the stressors which lead to high-risk behavior and suicide in youth. School staffs, as well as staff in other agencies are engaged in learning about high-risk behavior identification. Strong collaborative relationships with schools, community and government agencies helps students and their families access the program readily. Likewise, program staff is better able to refer and advocate for program participants in other agencies because of the trust and respect the program has earned in the community.

Respeto as a value places emphasis on social status and bestows ultimate decision making power on authority figures. The value of mutual respect as well as respect for elders is taught to youth participants. Parents and other authority figures are taught about the developmental needs of youth in establishing autonomy. Additionally, parents are supported in becoming empowered by gaining new parenting tools which help them regain their appropriate place as authoritative leaders of their families. This happens through family therapy and parenting groups. Parents are encouraged to explore their own issues and supported in increasing their skills and confidence with regard to parenting their children at different developmental stages.

Personalismo as a value highlights the importance placed on interpersonal relationships. Latinos use relationships as the context within which information is obtained and goals are attained. Young people, particularly those in middle school, are more likely to turn to family for advice, as opposed to unfamiliar others. Research has found that young Latinas state that they turn to their mother, father or sister when they have a problem. By becoming an integral part of school communities and integrating the family into treatment, the program builds on this value. By being available to the entire family in a proactive and practical manner, the program builds strong relationships and becomes an important resource for participants, their families and the community.

With regard to gender and sexual orientation, the staff has made greater efforts to be proactive in discussing issues related to participants' gender and sexual identity. In the past, "Safe Zones" were established by simply having visual cues throughout the program offices, such as posters expressing the importance of respect for all, or small cards with the rainbow flag and "Safe Zone" design, which let participants know that the staff was welcoming and respectful of all. However, these interventions are dependent on staff with sensitivity to LGBTQ2SI, and are not sustainable once that staff leave and the practices are not systematized.

PROGRAM DESIGN

The program's design incorporates five key components which fit well with the above approach and directly address the community's cultural values as well as issues related to access. These

components are Prevention, Outreach, Educational and Support Groups, Comprehensive Mental Health and Substance Abuse Treatment Services, and the use of Evidence Based or Community Based Practices. The program's goals and objectives are directly addressed by these components.

Prevention is one of the five key design components of the program. In recognition of the need for comprehensive approaches to suicide prevention the U.S. Department of Health and Human Services published the National Strategy for Suicide Prevention. The document outlines 11 specific objectives:

- Promote awareness that suicide is a public health problem that is preventable.
- Develop broad-based support for suicide prevention.
- Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
- Develop and implement community-based suicide prevention programs.
- Promote efforts to reduce access to lethal means and methods of self-harm.
- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Develop and promote effective clinical and professional practices.
- Increase access to and community linkages with mental health and substance abuse services.
- Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.
- Promote and support research on suicide and suicide prevention.
- Improve and expand surveillance systems.

These 11 principles, to some extent or another, are incorporated throughout all program activities, including design, outreach, education and support groups, school and community presentations, individual and family therapy, and community and school collaborations. Likewise, program staff strives to contribute to large scale suicide prevention and education efforts by participating in and contributing to media presentations and community events.

Outreach efforts target various segments of the community and reflect the cultural value of "collectivismo". The school community, including teachers and other guidance staff are engaged through educational workshops and by having program staff at the school sites be available for consultation on a very accessible basis. For example, program clinicians help teachers include clinical as well as behavioral principles into their lesson plans, to help better address the needs of students with various emotional needs. Youth outreach efforts include presentations by program staff at school assemblies and classroom lectures. These activities have resulted in a high number of self-referrals and referrals of friends by word of mouth to the program. Parent outreach takes place via formal presentation to parent organizations, sending information home with students and parent-to-parent word of mouth. Outreach to community agencies is achieved via formal program presentations, as well as networking by program staff. These activities have resulted in a number of formal and informal collaborative relationships. Community members are engaged through

presentations at local churches, county offices and word of mouth. Additionally, efforts which expand the program's reach beyond the local community, include trainings to students at the university level and training to professionals through conferences, as well as media presentations.

Educational and support groups are offered to youth, parents, and community members. These provide an opportunity to address prevention and to identify needs for services. Education groups focus on specific topics related to high risk behavior, including substance abuse, and suicide. They are offered in various formats to allow for reaching a large number of community members as well as provide an opportunity for more in depth discussion in smaller groups. Peer support groups for students and parenting groups for parents help connect program participants to others with similar issues and concerns.

Comprehensive Mental Health as well as Substance Abuse Treatment Services are offered to consumers and their families in a flexible manner. The focus here is on accessibility. Thus, services are offered at the school sites, in the home, at the program offices, and in other places in the community that are most convenient to consumers and their families. The program services include Comprehensive Individual and Family Assessment; Case Management; Support and Advocacy; Mental health Counseling; Medication Support; Substance Abuse Prevention and Treatment Services; and Crisis Intervention.

PERFORMANCE ON CONTRACT OBJECTIVES

Objective 1: *Partner with schools in the program service area to develop and conduct parent workshops, to raise family and community awareness about youth high-risk behaviors, cultural variance, stigma around mental illness, and communication strategies.*

During the current evaluation period staff provided 1829 contact hours of services, for a total of 2114 contacts, in addition to direct services to 214 individuals and their families, to raise awareness about youth high-risk behaviors, cultural diversity, stigma, communication strategies and many other topics, to parents, family members and community at large. The activities were divided into four types: Support groups; Community Outreach and Presentations; Presentations to Students and Presentations to School Staff. Community outreach presentations are conducted at monthly school district meetings, the Board of Education meetings, and Service Area meetings. Additionally, program staff have developed and implemented a number of "Wellness Conferences "and media presentations.

Objective 2: *Based on evidence-based and best practice models of care, program staff provides individual and family treatment interventions to consumers to improve level of functioning and reduce risky behaviors.*

During this contract year the program clinicians provided individual and family ongoing treatment to 214 student participants and their families. This group's specific demographics are listed earlier in this

report. To summarize, 54% of participants were female and 46% male. They ranged in age from six to twenty-one years and were within the first grade to college level, with regard to school. Forty-five percent of the participants spoke English as their primary language, and nineteen percent spoke Spanish as their primary language, while in thirty-six percent of the homes, both languages were spoken. Seventy-four percent of the program participants were Latinas/os; thirteen percent were Caucasian and one percent each were African American, Asian/Pacific Islander or American Indian. Ten percent of participants either endorsed "Other" for ethnicity or did not provide the information requested. Twenty and one-half percent of participants endorsed having substance use or abuse issues within the past six months before enrolling in the program. Likewise, eleven percent endorsed past suicide attempts or suicidal ideation.

Objective 3: *Based on best practice models, the program organized and conducted parenting classes in English and in Spanish.*

The program provided parenting and related information to parents, through a number of distinct activities. These included parenting classes, parenting workshops and educational presentations to parents, presented in English and Spanish. Additional groups focused on the following topics: Trauma and Parenting; Crisis Management; Substance use and abuse in the family and its impact on teens; Domestic Violence at home and in dating relationships; Child and Adolescent Development; and Communication. Program activities targeted school problems, minority mental health issues, community resources as important areas about which to provide education. Ninety-five parents participated in parenting classes and a total of 950 contacts were made in the community with various other activities.

Objective 4: *Train new program staff in evidence-based or best practice models, and integrated mental health and substance abuse treatment including techniques like motivational interviewing.*

Clinicians, Team Supervisors, and administrative staff have all received training in Evidence Based and Community Based Practices. Each staff has received training and supervision on a minimum of two and a maximum of four Evidence Based Practices. In total, consumers in the program have access to twelve different Evidence Based Practices, depending on whether they meet criteria for that practice. The twelve available options are: Aggression Replacement Therapy (ART), Crisis Oriented Recovery Services (CORS), Child-Parent Psychotherapy (CPP), Interpersonal Psychotherapy (IPT), Managing and Adapting Practice (MAP), Trauma-focused Cognitive Behavioral Therapy (TFCBT), Promoting Alternative Thinking Strategies (PATHS), Seeking Safety, Positive Parenting Program (TRIPLE P), Incredible Years (IY), and Cognitive Behavioral Therapy (CBT). In addition to these, in the past program years, staff have received training in Parent Child Interaction Therapy (PCIT), Dialectical Behavior Therapy (DBT), and Functional Family Therapy (FFT), as well as integrated mental health and substance abuse treatment including techniques like motivational interviewing. Additionally, the Latina Youth Program has been recognized by the Los Angeles County Department of Mental Health as a Community Based Practice, recognizing its status as a set of interventions which in effect comprise a promising approach to preventing suicide among Latina youth.

All program participants are screened to assess whether they meet the criteria for participation in the programs. Once eligibility is confirmed, the participants are offered services under these intervention models. If the participants are in agreement, the lead clinician in the specific intervention model is consulted, and a referral made. The evidence based models are by design, very specific and fidelity to the model is important. In consultation with the trainers, some adjustments have been made, to provide for cultural appropriateness. Training on motivational interviewing has been done in past years and is consistently used in the work particularly when substance abuse is an issue.

Objective 5: *Provide education sessions for local school staff on youth high-risk behaviors, mental health stigma, and youth communication strategies for staff at each of the schools in the program service area.*

Education for local school staff has taken place in a variety of ways during this contract year. Eighty-two school staff has received education regarding mental health issues impacting students and families. The topics covered high-risk behavior, specific symptoms of ADHD, depression, mental health stigma, communication strategies, positive discipline, accessing community resources, and general information about the program services and how to refer students. In addition to this, program staff based in the school sites provided consultation to school personnel, including teachers, counselors, school psychologists, principals, assistant principals, speech therapist, and others, on child abuse and neglect; developing lesson plans for at- risk youth; what risk factors are most commonly faced by students and other mental health issues impacting individuals in the program service area.

Objective 6: *Organize and conduct peer groups to provide support and education for participants on issues of youth violence, substance abuse, family conflict, anger management, healthy relationships, peer pressure, safe sex practices, and effective interpersonal communication.*

Weekly peer support groups were provided to students during this contract year. Girls' Process groups were developed and provided at the middle and high school levels. These groups covered topics ranging from depression, impulse control, youth violence, substance abuse, communication, healthier relationships, self-cutting behavior, safer sex and other issues salient to the participants. Students were encouraged to use journaling, along with ongoing group participation to develop healthier social skills and stronger boundaries. Boys' groups also held at the middle and high school level addressed masculinity, respect, conflict resolution, substance abuse, safe sex, cyber bullying, school bullying and communication skills. Aggression Replacement Training (ART) groups met for 12 weeks each, and taught participants skills relevant to decision making, impulse control and anger management. Additional groups met which addressed issues impacting impulse control, social skills, anger management, time management and boundaries. All groups were held at the various school sites and had weekly attendance ranging from 2 to 12 students.

OUTCOMES

A number of risk factors have been associated with higher risk for suicidality in adolescents. The program identified a number of risk factors, which were targeted for prevention, education and treatment activities, in addition to treatment of diagnosed mental health illnesses. The risk factors include: Presence of substance use or abuse, suicidal ideation and past suicide attempts. These risk factors have been perceived in the professional literature as most predictive of suicidal ideation. In addition, in past years, the program has also tracked other risk factors such as, running away from home, communication problems at home, poor school functioning, difficulty regulating emotions, involvement with the legal system, negative peer relations and issues related to sexual identity and poverty.

As stated previously, the Latina Youth Program was implemented to address the rising incidence of suicidality in Latina youth. Risk factors associated in the literature with research on suicide, were targeted for prevention and intervention. The program has been consistently successful at preventing suicide in the participants. As supported by the program experience over it's fourteen years of operation, participants who endorsed suicide ideation as a significant problem at intake decreased in severity after participating in treatment, based on participant and parent report. This points to a decrease in thinking about committing suicide and in developing or carrying out a plan for suicide. A trend has been noted during recent evaluation periods, clinicians reported dealing with students who thought about or attempted suicide at a higher incidence rate than in previous years. During these 14 years we had one completed suicide on May 2014 despite the fact that the program targets those at higher risk for suicidality. Thus, although more students may be attempting suicide, the availability of easily accessible intervention, including hospitalization is helping keep even these most severe of cases safe.

MHSA ANNUAL UPDATE FISCAL YEAR (FY) 2016/17
AVAILABLE FOR PUBLIC REVIEW

March 22, 2016

The Los Angeles County Department of Mental Health (LACDMH), as required under the Mental Health Services Act (MHSA), is opening a Public Review and Comment period for the MHSA FY 2016/2017 Annual Update. The Public Review and Comment period will begin March 22, 2016 and expires April 20, 2016. During the Public Review and Comment period, an open Public Hearing will be held at St. Anne's, 155 N. Occidental Blvd., Los Angeles, CA 90026. The Public Hearing will be hosted by the Los Angeles County Mental Health Commission on April 28, 2016 and the reception is scheduled to begin at 11:00 AM.

The document under review is posted on the LACDMH website (http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements), and hard copies are available at the LACDMH MHSA Implementation and Outcomes Division, 695 South Vermont Avenue, 8th Floor, Los Angeles, CA 90005. Any member of the public may request a hard copy of the document by contacting Debbie Innes-Gomberg, Ph.D. at 213-251-6817.

To provide input, recommendations and comments, please email your comments to DIGomberg@dmh.lacounty.gov or submit written comments to:

Los Angeles County Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: MHSA Annual Update FY 2016/2017
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005
Fax: (213) 351-2762

County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)

MHSA Annual Update Fiscal Year (FY) 2016/17

30-day Public Review and Comment Period
March 22, 2016 – April 20, 2016

PUBLIC REVIEW

Personal Information (OPTIONAL)	
Name:	
Agency/ Organization:	**E-mail address:**
Mailing Address:	

Comments:

Any member of the public may submit written comments on or before April 20, 2016. Written comments can be submitted on this form by e-mail to DIGomberg@dmh.lacounty.gov or by letter addressed to:

County of Los Angeles - Department of Mental Health
MHSA Implementation and Outcomes Division
Attention: Debbie Innes-Gomberg
695 S. Vermont Ave, 8th Floor
Los Angeles, CA 90005
Fax # (213) 351-2762

PUBLIC ANNOUNCEMENT

PUBLIC HEARING OF THE MHSA ANNUAL UPDATE FISCAL YEAR 2016/17

LOS ANGELES COUNTY MENTAL HEALTH COMMISSION
Dr. Larry Gasco, Chairperson, Presiding

Thursday, April 28, 2016
11:00 AM – 2:00 PM
St. Anne's Auditorium
155 N. Occidental Blvd.
Los Angeles, CA 90026

Public Hearing Goals

- An open forum featuring a presentation on the status of programs funded by the Mental Health Services Act and an opportunity for public comments and feedback on the Department's MHSA's programs.

Agenda

11:00 – 11:30	Reception (Lunch provided)
11:30 – 11:40	Opening Session (Welcome & Introductions) - Dr. Gasco
11:40 – 11:50	Overview of Public Hearing Process - Susan Rajlal
11:50 – 12:35	MHSA Annual Update - Dr. Innes-Gomberg
12:35 – 1:35	Public Comments Period - Dr. Gasco
1:35 – 1:45	*Next Steps – May 26, 2016 Full Commission Meeting

- Spanish & Korean translation services will be available
- For American Sign Language and other translation services contact Aleksan Meymaryan at (213) 251-6525 by Thursday, April 14, 2016
- MHSA documents and meetings are posted for public review and comments at: http://dmh.lacounty.gov/wps/portal/dmh/press_center/announcements
- Media inquiries: Kathleen Piche, PIO, (213) 738-4041

The Commission will be conducting its regular full meeting on May 26, 2016.

For more information, please contact the Office of the Mental Health Commission at (213) 738-4772 or email your questions to Mentalhealthcommission@dmh.lacounty.gov

Mental Health Services Act (MHSA) Annual Update Fiscal Year 2016-17 Summary

Debbie Innes-Gomberg, Ph.D.
Mental Health Commission Public Hearing
April 28, 2016

Purpose and Facts

- The Mental Health Services Act stipulates that counties shall prepare and submit an MHSA Three-Year Program and Expenditure Plan with Annual Updates
- The Plan requires a 30 day public comment period and a public hearing
- Mental Health Director and County Auditor Controller Certification as to compliance with laws and regulations
- The plan must be approved by the Mental Health Commission and adopted by the Board of Supervisors
- Information and data presented is from the prior Fiscal Year (FY) 2014-15

2

Content of Annual Update

- Executive Summary
- Community Services and Supports (CSS) plan programs
  - Unique clients served
  - Cost
  - Average cost per client
  - Program outcomes
  - Any significant changes for Fiscal Year 2016-17
- Prevention and Early Intervention (PEI) programs
  - Unique clients served, countywide and by service area
  - Primary language and ethnicity, countywide and by service area
  - Average cost per practice
  - Outcomes per practice
- Innovation
- WET
- Capital Facilities and Technological Needs
- Budget

3

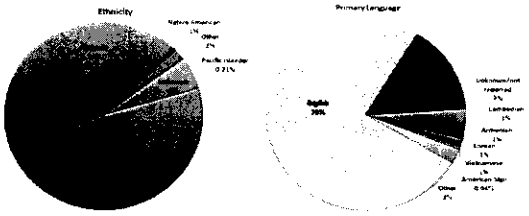
Key Dates

March 16, 2016	Presentation of the Annual Update to the System Leadership Team (SLT)
March 22 – April 20, 2016	Public posting for 30 days
April 20, 2016	Review with SLT of any significant public comments
April 28, 2016	Public Hearing convened by the Mental Health Commission
May 26, 2016	Mental Health Commission deliberation on approval of the Annual Update
June – July 2016	Board letter submission and adoption, posting of final Annual Update on website and submission to the Mental Health Services Oversight and Accountability Commission

4

Community Services and Supports (CSS) Plan

- Unique clients receiving a direct mental health service: 102,088
  - 32,705 were new clients with no previous CSS outpatient mental health services



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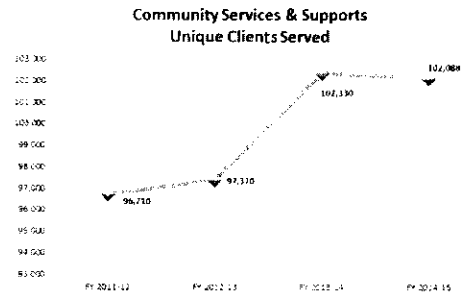
CSS Unique Clients Served by FY



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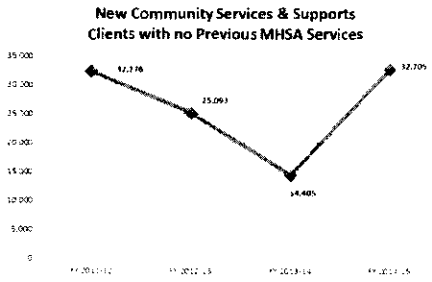
CSS Clients with no Previous MHSA Services by FY



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CSS Unique Clients Served by Service Area

Service Area	Unique Clients Served	New Clients Served
1	6,517	2,841
2	16,300	5,726
3	8,903	3,358
4	25,234	10,899
5	6,069	1,968
6	19,742	8,438
7	7,148	2,252
8	18,609	6,475

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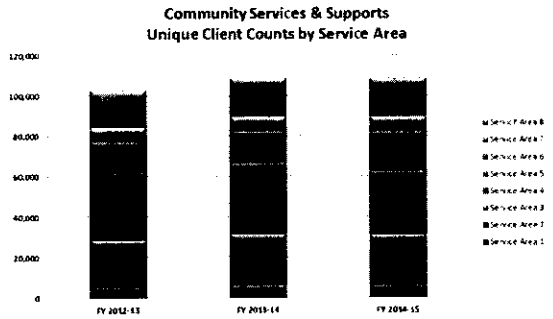
CSS Unique Client Counts by Service Area by FY



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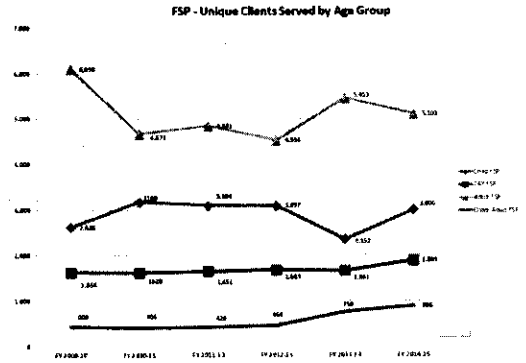
Full Service Partnership (FSP) FY 2014-15

Age Group	Unique Clients Served	Average Cost/Client*	Slots Allocated
Child	2,258	$13,697	1,771
Child Wraparound	781	$12,102	523
TAY	1,772	$11,249	1,300
TAY Wraparound	123	$8,883	226
Adult	5,103	$10,857	4,485
Older Adult	896	$8,446	709

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

FSP Unique Clients Served by FY



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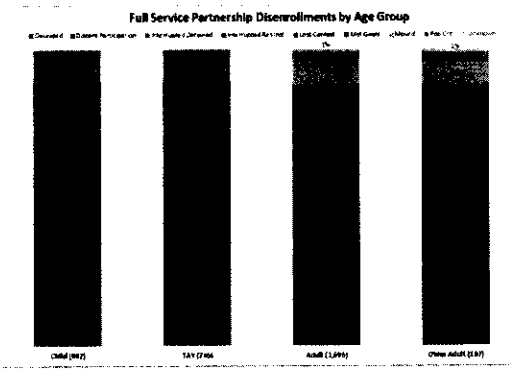
FSP Disenrollment



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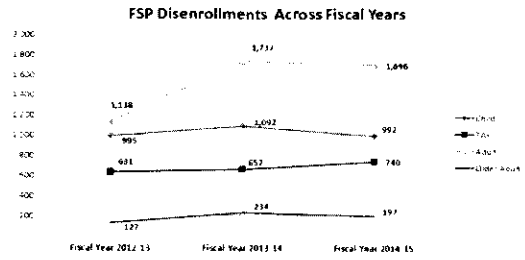
FSP Disenrollment



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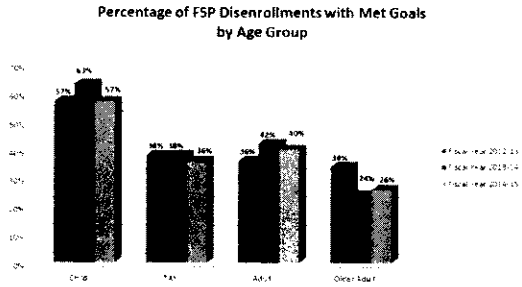
FSP Disenrollment



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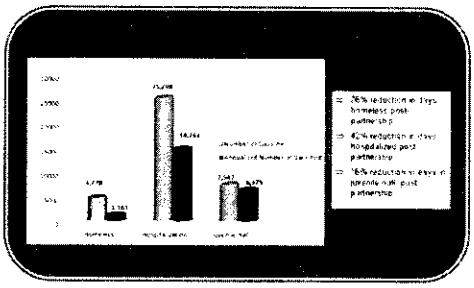
FSP Living Arrangement Outcomes-Child



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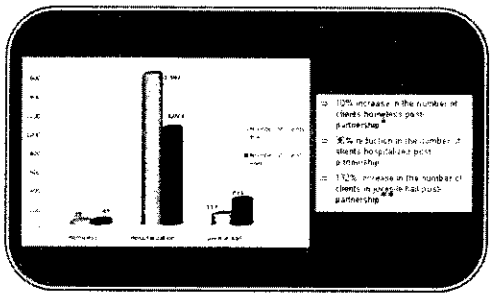
FSP Living Arrangement Outcomes-Child



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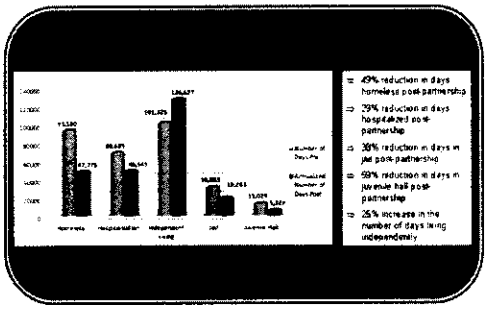
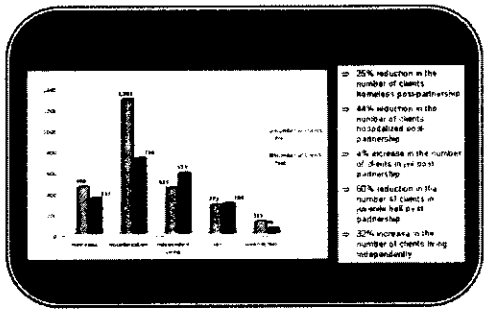
FSP Living Arrangement Outcomes-TAY

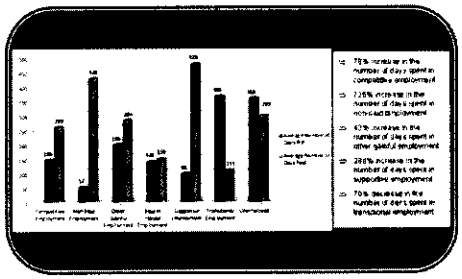


FSP Living Arrangement Outcomes-TAY



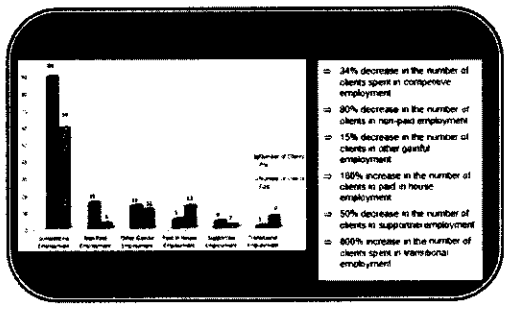
* There was a 4% increase in the number of clients incarcerated post-partnership. Data indicated 272 TAY FSP clients (approximately 7% of the TAY baseline individuals) reported being in jail 365 days prior to partnership and 264 TAY FSP clients (approximately 7% of the TAY baseline individuals) after partnership – as established

FSP Employment Outcomes-TAY



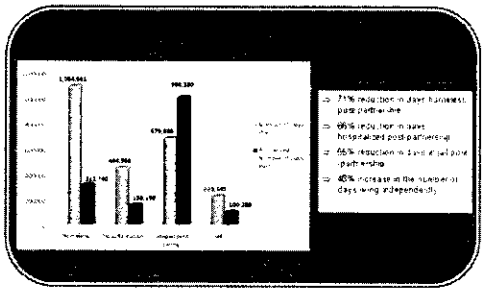
Clients can participate in more than one employment category at a time.

FSP Employment Outcomes-TAY



Clients can participate in more than one employment category at a time.

FSP Living Arrangement Outcomes-Adult



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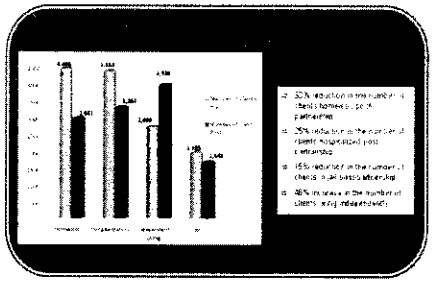
FSP Living Arrangement Outcomes-Adult



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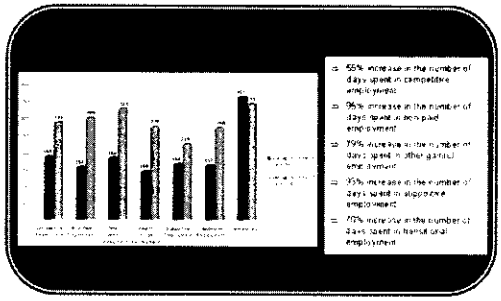
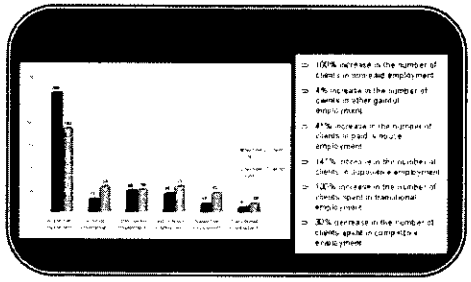
FSP Employment Outcomes - Adult



Clients can participate in more than one employment category at a time.

23

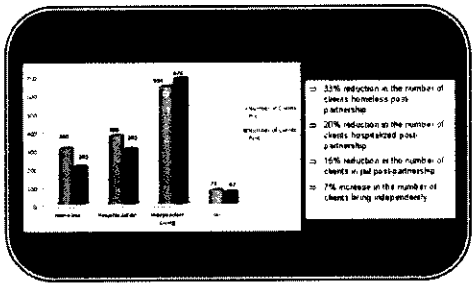
FSP Employment Outcomes - Adult



Clients can participate in more than one employment category at a time.

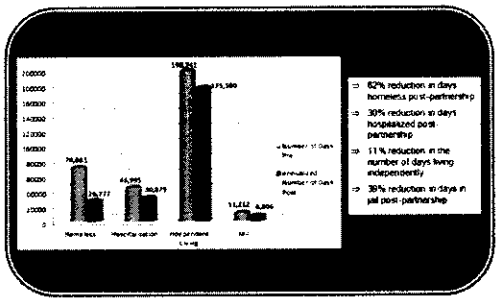
24

FSP Living Arrangement Outcomes-Older Adult



25

FSP Living Arrangement Outcomes-Older Adult



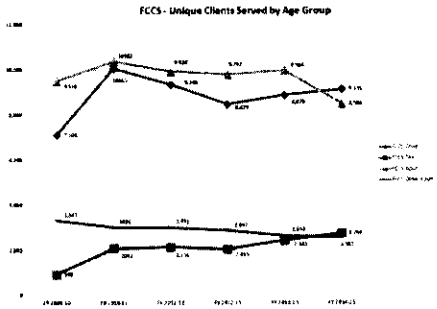
26

Field Capable Clinical Services (FCCS) for FY 2014-15

Age Group	Unique Clients Served	Average Cost/Client
Child	9,135	$5,488
TAY	2,766	$4,683
Adult	8,504	$4,665
Older Adult	2,581	$5,560

27

FCCS Unique Clients Served by FY



28

Wellness & Client Run Centers

- 54,521 unique clients served (direct mental health service)
- 85,843 client contacts (as reported through peer services, Mode 45)

Proposal*	Status	Implementation Date
Adjunct services for clients in Wellness Centers	Providers have been providing services.	2014
The addition of Peer Staff to Wellness Centers	Contracts have been amended. Directly operated clinics have started hiring.	Contractors: February 2015 Directly Operated: November 2015
Expand Client Run Centers	Client run centers will be added to Service Areas VI and III. Developing solicitation.	June 2016 (estimated)
Supported Employment in Wellness Centers	Rio Hondo Mental Health Center and San Fernando Mental Health Center will participate in a pilot project implementing a supported employment model.	December 2016 (estimated)
Housing Specialists in Wellness Centers	In the process of developing a housing specialist training.	Contractors: July 2015 Directly Operated: December 2015
Pilot Employment Program	A Request for Statement of Qualifications has been released.	June 2016 (estimated)

*Proposals approved and presented in the MHSA Three Year Program & Expenditure Plan Fiscal Years 2014-15 through 2016-17

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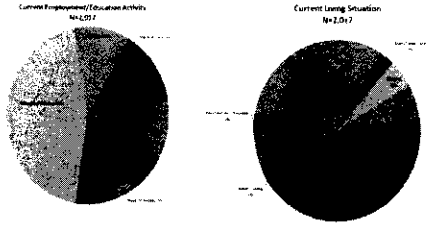
Wellness & Client Run Centers

- 69 Housing retention specialist positions added
- Supported Employment – Individual Placement and Support modules added at 2 county operated Wellness Centers



30

IMD Step-Down Facilities

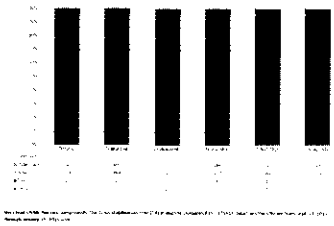
- Fiscal Year 2014-15 expanded program by 82 beds
- Total beds: 545
- Client contacts: 998

31

Alternative Crisis Services: Urgent Care Centers (UCCs)

- 26,338 clients served in Fiscal Year 2014-15
- New UCC opened on the campus of Martin Luther King Community Hospital

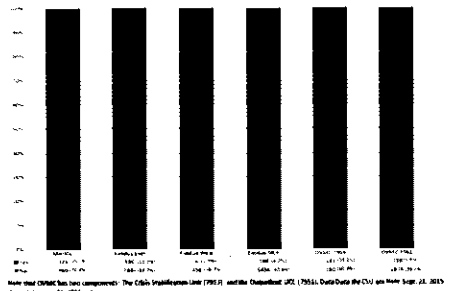
New Admissions at UCCs by Age Category 7/1/15 – 1/31/16



32

Alternative Crisis Services: UCCs

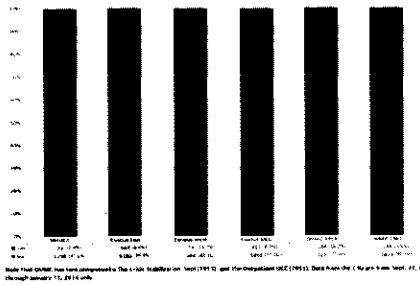
New Admissions at UCCs Who Were Homeless upon Admission
7/1/15 – 1/31/16



33

Alternative Crisis Services: UCCs

Percent of Those with an Assessment at a Psychiatric Emergency Room within 30 Days of a UCC Assessment
7/1/15 – 1/31/16



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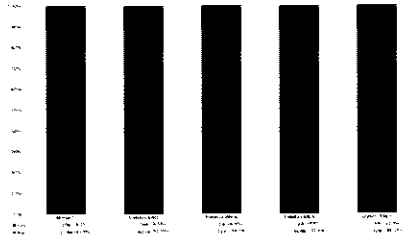
Alternative Crisis Services: UCCs

Percent of Those Who Return to a UCC within 30 Days of a UCC Assessment
7/1/15 – 1/31/16



35

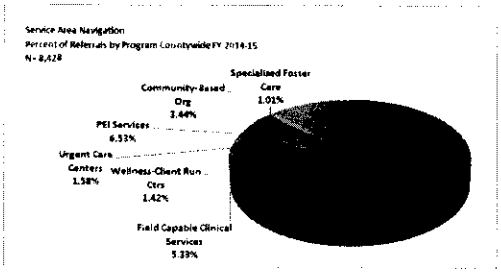
Housing Services

- Housing specialists provided housing placement services to 1,555 adult clients and 847 transition age youth clients
- The MHSA Housing program funded 4 housing projects that opened during FY 2014-15, for a total of 167 units
- Women's Shelter of Long Beach opened serving men, women and transgender victims of domestic violence

36

Linkage Services

- Jail Linkage: 27,441 contacts
- Service Area Navigation: 17,565 contacts



37

Systems Development Supports

- Family Support Services (Children's work plan)
  - Client contacts: 294
  - Enhanced Respite Care Pilot
    - 8 child FSP providers participated
    - 82 child FSP partners received respite care services
    - Parents/caregivers reported respite services allowed them more time to focus on personal needs and more than half reported significant stress reduction
- Service Extenders (Older Adult work plan)
  - 30 older adults received stipends
  - 2 have successfully sought employment in system

38

Systems Development Supports

TAY Probation Camp Services

- 6 camps have an array of mental health services including:
  - Aggression Replacement Treatment
  - Adapted Dialectical Behavior Therapy
  - Seeking Safety
- Multi-Disciplinary Team (MDT) meeting 45 days prior to release focused on aftercare plan

39

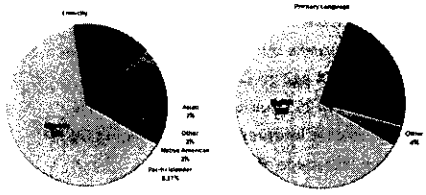
Planning, Outreach and Engagement

- Client contacts: 14,312
- Underserved Cultural Communities (UCC) Projects
- Homeless outreach
- Crossover Youth Multi-Disciplinary Team (WIC 241.1)

40

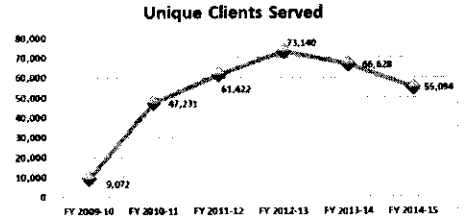
Prevention & Early Intervention (PEI)

- Unique clients served: 55,094
  - 28,613 were new clients with no previous MHSA service



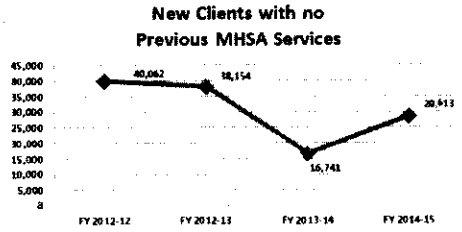
41

PEI Unique Clients Served by FY



42

PEI New Clients with no Previous MHSA Services by FY



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PEI-Early Intervention Practices

- Symptom improvement exceeded 40% after completion of an evidence-based, promising or community-defined evidence practice for several practices including:
  - Trauma:
    - Alternatives for Families - Cognitive Behavioral Therapy
    - Individual Cognitive Behavioral Therapy
    - Trauma Focused Cognitive Behavioral Therapy
    - Child Parent Psychotherapy
  - Severe Behaviors/Conduct Disorders:
    - Brief Strategic Family Therapy
    - Multisystamic Therapy
  - Depression: Depression Treatment Quality Improvement
  - Anxiety and Depression: Mental Health Integration Program
  - Parenting Difficulties:
    - Parent-Child Interaction Therapy
    - Triple P Positive Parenting Program
  - Managing and Adapting Practice

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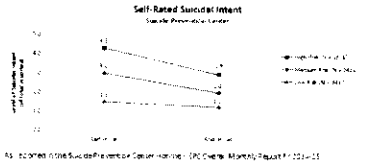
PEI-Suicide Prevention

- Suicide Prevention Center
  - Responded to 61,231 calls including 3,744 Spanish language calls
  - Responded to 4,898 chats
  - Responded to 102 texts
  - 37% of callers identified between the ages of 15-24
  - Self-rated suicidal intent reduced for those identified as low, medium and high risk



45

PEI - Suicide Prevention

- Latina Youth Program:
  - Outreach and education to 2,114 contacts
  - 214 open cases
- Partners in Suicide Teams:
  - Goal is to increase public awareness of suicide
  - 8 staff across 4 age groups
  - Participated in 193 suicide prevention events
  - Applied Suicide Intervention Skills Training (ASIST)
  - Question, Persuade, Refer (QPR)
  - Recognizing and Responding to Suicide Risk (RRSR)

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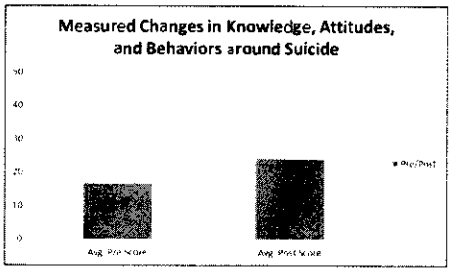
PEI - Suicide Prevention



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Prevention & Early Intervention (PEI)

Prevention program focus:

- Parenting
- Outreach and education for underserved of all ages, TAY population at risk of juvenile justice involvement, substance abuse and school failure

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Innovation 1

- Promoted data-driven decision making at the program and system level
  - Use of an evaluation rubric
  - Department was able to identify a threshold level of success within each model
  - Department was able to continue funding those providers through the Community Services and Supports Plan
- 3 successful Integrated Mobile Health Team (iMHT) providers continued through the development of a specialized FSP program
- 14 successful Integrated Clinic Model (ICM) and Community-Designed Integrated Service Management Model (ISM) providers continued through the development of a new work plan entitled Integrated Care Program

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Innovation 1-Peer Run Model

Peer Run Respite Care Homes (PRRCH):

- For mental health clients experiencing a crisis
- Safe and supportive living environment
- Short term (less than 30 days)
- Operated entirely by individuals with lived experience of mental illness

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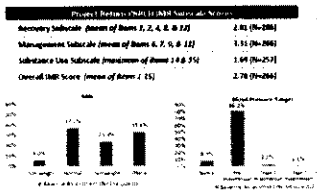
Innovation 1-Peer Run Model PRRCH

- Project Return: 310 Clients Served
- Guests were more likely to identify as White (43.9%), followed by African/African American (30.3%)
- Most prevalent linkages: Educational, living arrangement support, social skills self-help, community events



The average scores indicate that guests were less impacted by alcohol/drug use or further along in their substance use recovery when they enrolled in the program than with self-management and coping with their mental health and/or wellness.

In general, most Project Return PRRCH guests had BMIs that were normal (37.1%) or obese (33.1%). The majority of guests at Project Return had pre-hypertension blood pressure (86.2%).

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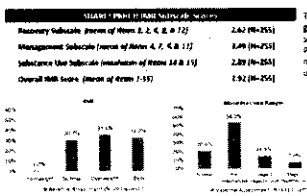
Innovation 1-Peer Run Model PRRCH

- SHARE!: 296 Clients Served
- Guests were most likely to identify as African/African American (32.4%) and White (27.7%)
- Most prevalent linkages: Social skills self-help, substance abuse self-help, emotional wellness



The average scores indicate that SHARE! guests were experiencing more difficulty with self-management when they enrolled in the PRRCH program than with coping with their mental health and/or wellness and substance use.

In general, SHARE! PRRCH guests had BMI's fairly evenly distributed among normal, overweight and obese categories. The majority of guests at SHARE! had pre-hypertension blood pressure (54.1%)

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Innovation 1-Peer Run Model

Peer Run Integrated Services Management Model (PRISM):

- A completely peer run alternative or supplement to public mental health services
- Empowers clients
  - To improve their lives
  - Increase and/or develop their skills
  - Improve their social support system
  - Lead productive lives
- Key services
  - Linkage
  - Peer Support
  - Housing Support (including providing rental subsidies)

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Innovation 1-Peer Run Model PRISM

Project Return: 168 Clients Served

Most participants at Project Return identified as White (34.5%) and African/African American (31.0%)

Most prevalent linkages: Physical health-related, assistance with living arrangements, emotional self help

Project Return PRISM MHI Subscale Scores at Baseline	
Recovery Subscale (mean of items 1, 2, 4, 8, & 12)	3.00 (N=144)
Management Subscale (mean of items 6, 7, 9, & 11)	3.20 (N=144)
Substance Use Subscale (mean of items 14 & 15)	1.47 (N=139)
Overall MHI Score (mean of items 1-15)	2.78 (N=144)

The average scores indicate that participants were less impacted by alcohol/drug use or further along in their substance use recovery when they enrolled in the program than with self-management and coping with their mental health and/or wellness

In general, most participants had BMIs that were normal (39.2%) or obese (39.2%). The majority of participants had normal or pre-hypertension blood pressure (83.8%).

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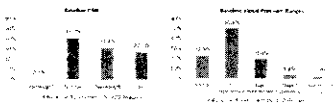
Innovation 1-Peer Run Model PRISM

- SHARE!: 364 Clients Served
- Most of the participants at SHARE! identified as African/African American (34.9%) and White (25.3%)
- Most prevalent linkages: Emotional self-help, referral to PRRCH, social skills self-help, money management, occupational

SHARE! PRISM MHI Subscale Scores at Baseline	
Recovery Subscale (mean of items 1, 2, 4, 8, & 12)	3.21 (N=278)
Management Subscale (mean of items 6, 7, 9, & 11)	3.30 (N=276)
Substance Use Subscale (mean of items 14 & 15)	2.20 (N=203)
Overall MHI Score (mean of items 1-15)	2.98 (N=227)

The average scores indicate that SHARE participants were experiencing more difficulty with self-management when they enrolled in the PRISM program than with coping with their mental health and/or wellness and substance use



In general, most SHARE! PRISM participants had BMI's that were normal (41.0%), but the majority of participants were overweight or obese (58.5%). Half of participants had pre-hypertension blood pressure (50.8%).

55

Innovation 1-Peer Run Model Measures

PRRCH Measures:

- Physical health indicators, including height, weight, and blood pressure
- Guest feedback survey- 55% completion rate for Project Return and 66% completion rate for SHARE!
- 3-6 month follow-up survey with 45 guests

PRISM Measures:

- Physical health indicators (BMI and BP), PROMIS Global Health, Creating Healthy Outcomes: Integrated Self-Assessment (CHOIS)
- Internalized Stigma
- Illness Management and Recovery Scale
- Linkages

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Innovation 1-Peer Run Model Learning

Essential Trainings:

- Intentional Peer Support
- Peer Advocate Certification Training
- Wellness Recovery Action Plan (WRAP)Training

Peer Roles:

- Facilitating and providing social support
- Finding appropriate linkages and referrals for clients
- Helping clients improve their quality of life by reducing dependency on the system (finding employment, housing, health navigation)

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Innovation 1-Peer Run Model Key Findings

PRRCH:

- Service utilization, including cost study, is in process
- Increased quality of life-physical, mental, social and/or spiritual
- Increased social support and coping skills

PRISM :

- 65% of linkages with housing resources and support were successful
- 75% of linkages with emotional self-help support and educational groups were successful
- Mental health and physical health change unable to be assessed due to law number of matched pairs
- Reductions in average number of days spent homeless but not statistically significant
- SHARE! Achieved a statistically significant reduction in emergency department utilization 12 months after the start af services
- High levels of satisfaction

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Innovation 2

- Building Trauma Resilient Communities through Community Capacity Building:
  - over 20 presentations completed
  - Solicitation completed and being reviewed by DMH→ County Counsel & CEO
  - Anticipated release – May 2016
  - Implementation anticipated – October 2016
  - Evaluation RFS to be submitted for DMH review by March 25, 2016

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Workforce Education and Training

- Health Navigators Skills Development Program: 33 trained, 100% represent UREP while 54% spoke a threshold language.
- Interpreter Training: 94 (duplicated) participated in the basic 3 day and advanced trainings
- Intensive Mental Health Recovery Specialist: 70 participants completed training to qualify as; 81% represent UREP and 54% spoke a threshold language
- Stipend Program Awards: 52 MFT, 52 MSW, and 4 Nurse Practitioner students and 73% spoke a threshold language
- Peer Advocates Training: 18 individuals, 89% represented individuals from un- or under-served populations, 28% spoke a threshold language, and 39% have secured employment in the public mental health system

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Capital Facilities and Information Technology Needs

Information Technology Needs Projects

- Contract Provider Technology Project
- Integrated Behavioral Health Information System (IBHIS)
- Personal Health Record Awareness & Education
- Consumer/Family Access to Computer Resources
- Data Warehouse Re-Design
- Telepsychiatry Implementation

Capital Facilities

- Downtown Mental Health Center, Sup District 2
- Arcadia Mental Health Center, Sup District 5
- San Fernando Courthouse, Sup District 3
- Exodus Recovery, Sup District 2

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Estimated MHSA Annual Allocation By Fiscal Year

Fiscal Year	CSS	PEI	INN	Total
2014-15	$366.2	$91.6	$24.1	$481.9
2015-16	$307.5	$76.9	$20.2	$404.6
2016-17	$382.9	$95.7	$25.2	$503.8
2017-18	$397.6	$99.4	$26.2	$523.2

- Projections are in millions. Los Angeles estimate is based on 28.56% of State allocation outlined in DHCS info notice 13-15.
- Allocations don't include Medi-Cal or EPSDT or unspent funds from previous fiscal years.

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For More Information Contact:

Debbie Innes-Gomberg, Ph.D.
Los Angeles County Department of Mental Health
Program Support Bureau
MHSA Implementation and Outcomes Division
DIGomberg@dmh.lacounty.gov
(213) 251-6817

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THURSDAY, APRIL 28, 2016
MENTAL HEALTH SERVICES ACT
ANNUAL UPDATE FISCAL YEAR 2016-17 SUMMARY
155 N. OCCIDENTAL BLVD.
LOS ANGELES, CA 90026
CAPTIONED BY TOTAL RECALL, WWW.YOURCAPTIONER.COM

Larry Gasco, Chair of the Mental Health Commission, welcomed to group.

Susan Rajlal, Legislative Analyst for the LACDMH, discussed the purpose and relevant details related to requirement of a Public Hearing.

Debbie Innes-Gomberg, Program Manager III – MHSA Implementation and Outcomes Division, presented slides summarizing the components of the Annual Update and took questions intermittently.

>> AUDIENCE MEMBER: CAN YOU HELP ME UNDERSTAND UNIQUE CLIENT?

>> DEBBIE INNES-GOMBERG: A UNIQUE CLIENT IS ONE INDIVIDUAL WHO MAY HAVE BEEN SERVED ACROSS PROGRAMS. SO, FOR EXAMPLE, IF I'M A CLIENT IN A FULL SERVICE PARTNERSHIP PROGRAM, AND I GRADUATE TO A WELLNESS CENTER, I'M COUNTED ONCE. THAT'S A UNIQUE CLIENT. THANK YOU FOR ASKING THAT.

>> COMMISSIONER: ARE THOSE POWERPOINTS AVAILABLE?

>> DEBBIE INNES-GOMBERG: YES, THEY HAVE THE SLIDES, CORRECT?

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: COPIES THE SLIDES; YOU DON'T HAVE COPIES OF THE SLIDES?

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: OUR APOLOGIES. WE'LL GET YOU THOSE TO YOU IMMEDIATELY.

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> AUDIENCE MEMBER: DEBBIE, I LIKE TO ASK FOR THOSE WITH VISUALLY-IMPAIRED THAT GRAPHS BE LARGER, BECAUSE I'M HAVING A PROBLEM. I HAVE A READER. SO I LIKE TO MAKE SURE I CAN HAVE THIS INFORMATION IN A FORM THAT I CAN REALLY REVIEW IT. AND IT'S JUST TOO SMALL, BECAUSE I HAVE BEEN THROUGH IT.

>> DEBBIE INNES-GOMBERG: OKAY, SO WE WILL GET YOU FULL SIZE SLIDES. ONE PER PAGE [AUDIENCE MEMBER IMMEDIATELY RECEIVED LARGER SLIDES] OKAY, SO GOING ON NOW TO FULL SERVICE PARTNERSHIP PROGRAMS. YES, JUDY.

>> AUDIENCE MEMBER: HOW ARE YOU DISCERNING THE PILOT?

>> DEBBIE INNES-GOMBERG: OKAY, ANYTIME ANYBODY ASKS A QUESTION, WE NEED TO GET THE MICROPHONE. AND IT'S JUDY RIGHT HERE. OH, YOU'VE GOT A MICROPHONE. OKAY. SORRY. WE'RE RECORDING THIS.

>> AUDIENCE MEMBER: HOW ARE YOU DISCERNING BETWEEN REGULAR FSP AND THE PILOT?

>> DEBBIE INNES-GOMBERG: THE PILOT IS ACTUALLY FSP. SO THE PILOT, AND WHAT JUDY IS REFERRING TO IS AN INTEGRATED PILOT THAT IS INCLUSIVE OF PEOPLE THAT ARE AT RISK OF THE FOCAL POPULATIONS FOR FSP. AND THAT'S INCLUDED IN THE 5,100 THERE, BECAUSE IT'S FSP. MS. LAMONT.

>> AUDIENCE MEMBER: I JUST WANT TO SAY THAT MAYBE YOU ALSO NEED FOR OTHER PEOPLE TO TELL YOU WHAT THE MHSA SERVICE ACTS SAYS WHO YOU SHOULD SERVE.

>> DEBBIE INNES-GOMBERG: THAT'S A GOOD SUGGESTION. IN A FULL SERVICE PARTNERSHIP, WHAT WE CALL THE FOCAL POPULATION OR THE TARGET POPULATIONS ARE INDIVIDUALS EITHER AT RISK OF OR EXPERIENCING HOMELESSNESS, INCARCERATIONS, HOSPITALIZATIONS, AND INSTITUTIONALIZATION IN GENERAL. AND THAT'S PRIMARILY AN ADULT, AN OLDER ADULT FOCAL POPULATION.

FOR CHILDREN, IT'S REALLY KIDS AT RISK OF FAILING IN SCHOOL, KIDS THAT HAVE A SERIOUS EMOTIONAL DISTURBANCE AND HAVEN'T RECEIVED SERVICES YET BUT THEY NEED THAT LEVEL OF CARE. THOSE DEFINITIONS ARE IN THE MHSA CSS REGULATIONS.

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: OH, SURE. UMM-HMM.

>> AUDIENCE MEMBER: IS IT REALLY 17% OF TAYS ARE DECEASED AND THAT'S WHY THEY'RE NOT? IS THAT WHAT --

>> DEBBIE INNES-GOMBERG: THAT IS WHAT THE DATA SAYS. YOU'RE RIGHT.

>> AUDIENCE MEMBER: WAIT. THE DECEASED; WHAT'S THE 17%? I CAN'T TELL -- YEAH, DECEASED, RIGHT; THE DARK BLUE?

>> DEBBIE INNES-GOMBERG: YOU KNOW, SOMETHING? I'M SORRY. THAT'S LOST CONTACTS. MY APOLOGIES.

Q: OH, OKAY. ALL RIGHT, SO THERE'S TWO DARK BLUES. I DIDN'T SEE THE BOTTOM ONE. OKAY. I'M LIKE, -- I WAS THINKING, WOW, THEY'RE DECEASED. THANK YOU.

>> DEBBIE INNES-GOMBERG: YEAH, THE PROBLEM IS, THE COLORS, WHEN IT GETS PROJECTED, THEY'RE SLIGHTLY DIFFERENT. I APOLOGIZE FOR THAT.

>> AUDIENCE MEMBER: I DIDN'T SEE THAT DOWN THERE. OKAY.

>> AUDIENCE MEMBER: HI, I'M PHYLLIS KODO AND I HAVE A QUESTION ABOUT OUTCOMES AND MENTAL HEALTH CLIENTS THAT ARE BEING DUMPED FROM HOSPITAL. IS THERE GOING TO BE LIKE AN OUTCOME FOR THAT, MAYBE NEXT YEAR? OR IS THERE SOME INFORMATION ON THAT NOW?

>> DEBBIE INNES-GOMBERG: DID YOU SAY CLIENTS BEING DUMPED FROM HOSPITALS?

>> AUDIENCE MEMBER: YEAH.

>> DEBBIE INNES-GOMBERG: THE MENTAL HEALTH SERVICES ACT, WHICH IS WHAT THIS IS ABOUT DOESN'T FUND HOSPITALS. SO YOU'RE NOT GOING TO SEE THAT IN AN ANNUAL UPDATE. BUT, OBVIOUSLY, THAT IS A BIG CONCERN FOR THIS DEPARTMENT.

>> AUDIENCE MEMBER: DEBBIE?

>> DEBBIE INNES-GOMBERG: HI, ROBERT.

>> ROBERT: HI, DEBBIE. HOW ARE YOU DOING? MY QUESTION IS, IT GOES TO THE YOUNG TEENAGERS. I GO THROUGH A PROGRAM IN UCLA, WHERE I WORK AND DO RESEARCH STUDY THERE AND THERE'S A LOT OF YOUNG PEOPLE THERE. SOME OF THE YOUNG PEOPLE DON'T HAVE A JOB OR HAVE MENTAL HEALTH, AND THEY'RE TRYING TO FIND A JOB TO NOT GET INVOLVED WITH GANGS. AND THIS HAS NOTHING TO DO WITH THAT AND THEY GET IN TROUBLE. SO WHAT CAN WE DO ABOUT THOSE KIDS? WHAT KIND OF PROGRAMS CAN WE DO FOR KIDS TO STAY OUT OF GANGS AND ANYTHING WE CAN DO ABOUT THOSE?

>> DEBBIE INNES-GOMBERG: THAT'S A WONDERFUL QUESTION. THERE ARE TRANSITION AGE YOUTH PROGRAMS IN PARTICULAR, WE'RE STARTING TO FOCUS ON THE RISK FACTORS ASSOCIATED WITH MENTAL ILLNESS. AND I KNOW THAT OUR INNOVATION 2 PLAN IS FOCUSING ON NOT NECESSARILY AS MUCH ON GANGS, BUT ON INDIVIDUALS WHO ARE HOMELESS OR PREVIOUSLY HOMELESS. I'M NOT SURE IF TRANSITION AGE YOUTH -- DOES ANYBODY WANT TO SAY SOMETHING ABOUT THAT? DO YOU WANT TO SAY ANYTHING?

>> TAY REPRESENTATIVE: WE'RE DOING A LOT OF OUTREACH AND ENGAGEMENT IN THE COMMUNITY TO TRY TO OUTREACH TO THOSE YOUTH. PARTICULARLY THOSE YOUTHS THAT ARE DISENFRANCHISED AND GANG CONNECTED. AND WE DO HAVE A LOT OF PROGRAMS FOR FSP, FCCS AND WE ALSO HAVE PREVENT AND EARLY INTERVENTION PROGRAMS AS WELL.

>> AUDIENCE MEMBER: [AWAY FROM MICROPHONE].

>> AUDIENCE MEMBER: HI, MY NAME IS MS. JACKSON. AND TO ANSWER YOUR QUESTION, ROBERT, THEY DO HAVE PROGRAMS. ALL COLLEGES IN CALIFORNIA HAS A PROGRAM FOR THOSE INDIVIDUALS. WHETHER THEY'RE MENTAL CLIENTS THAT COME OUT OF JAILS, PRISONS, WE HAVE DIFFERENT OUTREACHES OUT HERE THAT

WE DEAL WITH IN THE COMMUNITY ALSO. AND WE'RE OUT HERE SPREADING THE WORD, AND WE'RE OUT HERE PUSHING IT TO MAKE SURE ALL THE EACH INDIVIDUALS, EVEN THE HEALTH WHOLE FAMILIES [SIC] AND CONSIDERS THE HOMELESS ONES AS WELL. THE HOMELESS ONES HAVE THEIR OWN PROGRAM. AND EVERYBODY WANTED TO KNOW, BUT DUE TO THE FACT, YOU CAN BE HOMELESS, BUT ACCORDING IF YOU FALL UNDER THAT UMBRELLA, UNDER YOUR CO-STATUS, BECAUSE I COULD BE HOMELESS AND GOT DIAMONDS ON ME, BUT I STILL WON'T BE CONSIDERED HOMELESS.

NOW DUE TO GANGS, I DO GANG PREVENTION. I HAVE HELPED PARENTS OR YOUNG ADULTS, I HELP THEM GET EMPLOYMENT. THEY DO HAVE PROGRAMS OUT HERE FOR EACH INDIVIDUAL AND IF THEY WANT TO WORK, THEY HAVE TO GO TO THE UNEMPLOYMENT OFFICE, THE YOUTH UNEMPLOYMENT OFFICE. NOT THE ADULT UNEMPLOYMENT OFFICE. IT'S TWO DIFFERENT UNEMPLOYMENT FOR EACH INDIVIDUAL OUT HERE.

SO THERE'S A GANG OUTREACH FOR EACH INDIVIDUAL OUT HERE CONSIDERING THE CHILDREN OF THE UNITED STATES OF AMERICA.

>> DEBBIE INNES-GOMBERG: THANK YOU VERY MUCH. WE'RE GOING TO GO ONE MORE AND THEN I'M GOING TO MOVE US ALONG ONLY BECAUSE OF TIME.

>> AUDIENCE MEMBER: YES, JUST TO PIGGYBACK, THANK YOU MS. JACKSON FOR THAT. BUT OVERALL THERE ARE NOT ENOUGH PERFORMING ARTS INITIATIVE PROGRAMS FOR THE YOUTH, WHICH IS WHAT WE SPECIALIZE IN. MY NAME IS MELLA DESIRE AND I'M A FILMMAKER FOR INTERCITY YOUTH, PARTICULARLY FOR FOSTER AGE KIDS, GANG AND VIOLENCE, AND EVERYTHING. THESE KIDS NEED AN OUTLET. THIS IS THE PROBLEM. WE HAVE EMPTY BUILDINGS IN L.A. AND TON OF STREETS. AND WHAT WE WANT TO DO IS COMBINE THE FORCES BY HAVING PRODUCTS, VIDEOS, MUSIC, FILM THAT WILL BE MENTORED, WRITTEN, PRODUCED BY KIDS. YOU HAVE HOLLYWOOD NEXT DOOR. THEY'RE GIVING HOLLYWOOD ALL THIS MONEY BY WATCHING AND BUYING THEM MUSIC. NOW IS THE TIME FOR HOLLYWOOD TO GIVE ONE PERCENT OF THEIR INCOME TO BUILDING A STUDIO SPECIFICALLY FOR THESE AGE YOUTH 24 HOURS 7 DAYS A WEEK. SO IF YOU HAVE A YOUTH ORGANIZATION, IF YOU WORK FOR FOSTER CARE, IF YOU WORK IN TAY, IF YOU WORK ANYWHERE WITH YOUNG PEOPLE UNDER THE AGE OF 24, WE'RE CURRENTLY DOING CASTING RIGHT NOW.

WE ARE CASTING MAY 20TH AND 21ST IN SOUTH L.A. AND ALL OF THIS IS FREE REGISTRATION. YOU CAN SIGN UP OR TAKE A FLYER BEFORE YOU GO. I WOULD LOVE TO GET YOUR CONTACT INFORMATION. THE POINT IS THE PERFORMING ARTS INITIATIVE. SOMETHING FOR THE KIDS TO DO FOR FUN SO THEY CAN GET THEIR ANGER OUT. IF THEY HAVE BEEN ABUSED, THEY DON'T WANT TO BE TRIGGERED THAT EVERY TIME. THEY WANT TO DO SOMETHING TO GET THEM OUT OF THE ENVIRONMENT AND IT'S PERFORMING ARTS. THAT'S THE KEY. UNTIL WE DO THAT, THERE'S ALWAYS GOING TO BE THIS PROBLEM.

>> DEBBIE INNES-GOMBERG: THANK YOU. I APPRECIATE THAT. I'M GOING TO MOVE US ALONG SO PLEASE HOLD YOUR QUESTION AND COMMENTS. THERE WILL BE PUBLIC COMMENTS, OBVIOUSLY, AT THE END. BUT I WANT TO MAKE SURE YOU HAVE THE INFORMATION BEFORE THE END OF THIS PUBLIC HEARING.

[MOVING ON TO SLIDE 25]

>> REBA STEVENS: QUESTION IN REGARDS TO THE WELLNESS CENTER. ARE WE GOING TO TALK ABOUT THE CENTERS THAT ARE THE SERVICE AREAS WHERE LIKE SERVICE AREAS 6? I UNDERSTAND THAT WE DON'T HAVE ANY WELLNESS CENTERS. NOTHING THAT'S UP AND OPERATING, BUT WE'RE OFFERING WELLNESS SERVICES. CAN YOU BETTER HELP ME UNDERSTAND WHETHER OR NOT THAT'S GOING TO BE INCLUDED IN THE REPORT THAT WHERE IT DOESN'T SPECIFY WELLNESS CENTERS, BUT IT SPECIFIES SERVICE AREA 6 ONLY HAVING RECEIVING WELLNESS SERVICES?

>> DEBBIE INNES-GOMBERG: EVERYTHING THAT IS REPORTED IN THIS ANNUAL UPDATE IS REPORTED AT THE LEVEL OF THE WORK PLAN WITHIN A COMPONENT OF MHSA, IN THIS CASE CSS. CLIENTS AT HIGHER LEVELS OF CARE MAY HAVE ACCESS TO WELLNESS CENTER SERVICES AT A WELLNESS CENTER. I DON'T KNOW IF WENDI OR ANYBODY, DENNIS FROM ADULT SYSTEM OF CARE WANTS TO SAY ANYTHING MORE ABOUT THAT?

>> AUDIENCE MEMBER: I WISH SOMEBODY WOULD.

>> DEBBIE INNES-GOMBERG: SHE STEPPED OUT. OKAY. WE'LL COME BACK TO THAT.

ALL RIGHT, VERY IMPORTANT, I'M GOING TO ASK YOU TO HOLD ON FOR A SECOND.

[CONTINUING ON SLIDE 31]

>> AUDIENCE MEMBER: MY NAME IS ANTHA ABRAHAM, AND I HAVE A QUESTION. WHY DOES ALL OF URGENT CARE CENTERS, MOST OF THEM DON'T HAVE FACILITIES FOR HOMELESS PEOPLE?

>> DEBBIE INNES-GOMBERG: I'M GOING TO GO TO A SLIDE FOR THAT IN JUST A SECOND. THE MAJORITY OF THE CLIENTS ARE NOT ACTUALLY HOMELESS THAT COME TO AN URGENT CARE CENTER. BUT I DON'T KNOW IF MARY MARX OR ANYBODY CAN ADDRESS – OH MARY, THERE YOU ARE, IF YOU WANT TO ADDRESS THAT MORE SPECIFICALLY?

AND THE QUESTION WAS: ARE THERE WITHIN AN URGENT CARE CENTERS ARE THERE SERVICES FOR HOMELESS OR HOMELESS?

>> AUDIENCE MEMBER: WELL, SOME OF THEM, I UNDERSTAND, HOMELESS PEOPLE. BUT CERTAIN AREAS – THERE'S ONE IN HOLLYWOOD AND THEY DON'T FOCUS ON HOMELESS PEOPLE.

>> MARY MARX: SO WE DON'T HAVE AN URGENT CARE CENTERS IN HOLLYWOOD. BUT A NUMBER OF OUR URGENT CARE CENTERS, LIKE THE EXODUS EASTSIDE AND WESTSIDE HAVE SOME SHORT-TERM SHELTER BEDS FOR INDIVIDUALS THAT ARE NEEDING TO BE IN SOME TYPE OF HOUSING WHEN THEY LEAVE THE PROGRAM IF IT'S NOT AVAILABLE. BUT THEY DO HAVE SOCIAL WORKERS ALSO IN ALL THE UCC'S THAT CONNECT TO THE RESOURCES AVAILABLE AND WORK WITH THE HOMELESS PEOPLE THAT COME IN THERE TO CONNECT THEM TO SERVICES.

>> AUDIENCE MEMBER: DO YOU HAVE ANYTHING THAT YOU CAN SHOW ME ON PAPER WRITTEN OUT THAT WHERE THESE PLACES THAT ARE AVAILABLE FOR HOMELESS PEOPLE?

>> MARY MARX: SURE, I CAN GET THOSE FROM OUR PROVIDERS.

>> AUDIENCE MEMBER: THANK YOU.

>> MARY MARX: UMM-HMM.

>> AUDIENCE MEMBER: I WOULD LIKE A COPY OF THAT ALSO.

>> MARY MARX: OKAY.

>> DEBBIE INNES-GOMBERG: WE CAN CERTAINLY MAKE IT AVAILABLE. AND JUST TO ADD TO THE HOMELESS, MARY HAS INCREDIBLE STAFF THAT PUT THESE CHARTS TOGETHER. AND WHAT YOU SEE HERE, NEW ADMISSIONS TO URGENT CARE CENTERS WHO WERE HOMELESS UPON ADMISSION TO THAT URGENT CARE CENTERS, AND THIS IS ABOUT A YEAR AND A HALF WORTH OF DATA, OR 7/1/15 THROUGH 1/31/16, I SHOULD SAY. AND THE BLUE REPRESENTS NOT HOMELESS. SO THERE'S ONE OF THE OLIVE VIEW FACILITIES TENDS TO ADMIT MORE HOMELESS PEOPLE, BUT FOR THE MOST PART, YOU'RE SEEING PEOPLE THAT ARE NOT HOMELESS IN THESE URGENT CARE CENTERS.

AND ONE OF THE MARKERS OF THE SUCCESS OF AN URGENT CARE CENTERS IS WITHIN 30 DAYS OF AN URGENT CARE CENTER VISIT, DOES THE INDIVIDUAL PRESENT AT A EMERGENCY DEPARTMENT, HOSPITAL, RECEIVE PMRT SERVICES OR BECOME INCARCERATED. ALMOST 96% ACROSS-THE-BOARD OF INDIVIDUALS THAT ARE ADMITTED INTO AN URGENT CARE CENTERS DO NOT HAVE A PSYCHIATRIC EMERGENCY ROOM VISIT WITHIN 30 DAYS OF BEING SEEN AT A UCC. SO IT'S PRETTY SIGNIFICANT. [CONTINUING ON SLIDE 34]

>> PHILLIS: THERE'S ONE PROGRAM CALLED THE BACK UP LIFE CENTER. IT'S A PRETTY GOOD PROGRAM, BUT THEY NEVER HAVE MORE THAN COUPLE OF PEOPLE IN THERE. AND I REALLY FEEL THAT THE COUNTY IS PAYING A LOT OF MONEY FOR RENTAL AND STAFF. THERE'S SOMETIMES MORE STAFF THAN CLIENTS. AND I FEEL A LOT MORE PEOPLE COULD BE SERVED BEING IN THE BACK UP LIFE CENTER. THAT SHOULD BE LOOKED INTO I BELIEVE.

>> DEBBIE INNES-GOMBERG: WHAT SERVICE AREA IS THAT IN? DO YOU KNOW?

>> PHYLLIS: SERVICE AREA 4.

>> DEBBIE INNES-GOMBERG: 4? OKAY. THANK YOU. [NOT A DMH SERVICE PROVIDER]

[CONTINUING ON TO SLIDE 37]

>> PAT: COUPLE OF SLT MEETINGS AGO, I ASKED IF WE COULD GET A LIST OF WHO THE JAIL LINKAGE PEOPLE ARE AND SPREAD THEM OUT TO THE SERVICE AREA CO-CHAIRS SO WHEN PEOPLE ASK US WHO THEY COULD CALL IF THEY HAVE A FAMILY MEMBER IN JAIL. SO IT WOULD BE REALLY GREAT TO GET WHO THOSE PEOPLE ARE.

>> DEBBIE INNES-GOMBERG: THANK YOU. I THOUGHT WE HAD DONE THAT, BUT I'M GOING TO ASK MY STAFF JUST TO NOTE THAT. ROBIN'S GOT IT. OKAY, GREAT. THANK YOU. THANKS, I APPRECIATE THAT. [LIST SUBSEQUENTLY SENT]

PAM, YES? UMM-HMM.

>> PAM: HI, I WAS WONDERING ON THE LINKAGE SERVICES, SERVICE AREA AND NAVIGATION, WHEN YOU SAY "CONTACTS" IS THAT CONTACTS, LIKE THEY GOT SOME RESOURCES? AND THEY WERE GIVEN THE RESOURCES AND THEN SOMEBODY FOLLOWED UP ON WHETHER THEY DID MORE THAN THAT? OR WAS IT JUST THE SERVICE WAS – THE INFORMATION WAS GIVEN TO THEM, AND THEN – I MEAN, HOW DO YOU KNOW WHAT HAPPENED AFTER THAT, AFTER THEY GOT THE INFORMATION?

>> DEBBIE INNES-GOMBERG: YOU'RE ASKING A REALLY, REALLY GOOD QUESTION. WHAT WE REPORTED ON RIGHT HERE IS JUST THAT A CONTACT WAS MADE. SO IT MIGHT HAVE BEEN A REFERRAL, THE NAVIGATOR MAY HAVE FELT THAT A QUESTION FROM THE FAMILY MEMBER WERE ABOUT THE MOST APPROPRIATE SERVICE OR SOME ALONG THOSE LINES. BUT THE QUESTION I THINK YOU ASKING IS HOW DO WE MEASURE THE EFFECTIVENESS OF NAVIGATION? HOW DO WE KNOW THE INDIVIDUAL GOT THERE SUCCESSFULLY? IN THE COMING YEAR, WE'RE GOING TO, WE ALREADY STARTED TO WORK WITH THE NAVIGATORS ON GETTING THEIR FEEDBACK ABOUT HOW THEY MEASURE THE IMPACT OF THEIR SERVICES. AND THE COMING YEAR, WE'RE GOING TO BE INTRODUCING THAT MEASURE.

[CONTINUING ON TO SLIDE 38]

>> ROBERT: YEAH, I WANT TO TALK ABOUT, I GOT THIS THING CALLED PAINTED BRAIN. I DON'T KNOW IF YOU KNOW WHAT THAT IS. IT'S A PROGRAM FOR YOUTH. IT'S AN ART PROGRAM. THEY DO MUSIC. THEY DO ART.

AND I MET THIS GUY THERE, AND HE'S THE HEAD OF MUSIC. HE'S IN A HEAVY METAL BAND. AND I SO I WENT TO SEE HIM ON SUNSET AND HE STARTED HIS OWN HEAVY METAL BAND WITH MENTAL HEALTH CLIENTS. AND THEY'RE GETTING A LOT OF GIGS. SO HE INVITED ME TO GO SEE HIM AGAIN IN LONG BEACH. AND, SO, I MIGHT DO THAT NEXT MONTH. AND IT'S PART OF A MENTAL HEALTH CLIENT YOUTHS, HE'S ABOUT 20. AND HE'S GOT A FAMILY. AND HIS

PARENTS. GO SEE HIM IN CONCERTS. IT'S A GREAT PROGRAM. THE YOUTH SHE WAS TALKING ABOUT; HOW THEY HAVE ART AND MUSIC. IF WE CAN HAVE PROGRAMS FOR THE YOUTH, IT'S A GREAT PROGRAM.

>> DEBBIE INNES-GOMBERG: THANK YOU. WE APPRECIATE THAT COMMENT. I'M GOING TO MOVE US ALONG.

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: ARE YOU SAYING YOU DON'T HAVE A COMPLETE PACKET OF SLIDES?

>> AUDIENCE MEMBER: NO, WE HAVE ONLY UP TO PAGE 32. YOU'RE ON PAGE 39 RIGHT NOW.

>> DEBBIE INNES-GOMBERG: SLIDE 39? MAYBE IF SOMEBODY COULD CHECK HER SLIDE PACKET. THANK YOU. IN THE MEANTIME THOUGH, JUST FOCUS ON WHAT YOU'RE SEEING ON THE SCREEN.

>> AUDIENCE MEMBER: SHE WAS LOOKING AT THE WRONG SLIDE. SHE WAS LOOKING AT 8.

>> DEBBIE INNES-GOMBERG: YEAH, WHAT I'M PRESENTING TO YOU IS A SYNOPSIS OF A LOT OF WORK.

>> AUDIENCE MEMBER: 39. OKAY.

>> DEBBIE INNES-GOMBERG: IN TERMS OF PLANNING OUTREACH ENGAGEMENT. THAT'S A THIRD COMPONENT OF COMMUNITY AND SUPPORT PLAN.

[SLIDE 40]

Q: I'M SORRY FOR THE SAKE OF US WHO DON'T REGULARLY ATTEND, LIKE THE SLT'S, WHEN YOU MENTION FSP, CAN YOU AT LEAST NAME WHO THEY ARE?

>> DEBBIE INNES-GOMBERG: IT WOULD PROBABLY BE MIRTALA PARADA-WARD [WRITTEN PHONETICALLY] BUT I HAVEN'T TALKED TO HER YET.

>> DEBBIE INNES-GOMBERG: SO I'M GOING TO GO INTO PREVENTION AND EARLY INTERVENTION NOW, BUT WHAT I WANTED TO DO WAS ASK THE COMMISSIONS SPECIFICALLY WHETHER THEY HAD ANY QUESTIONS ABOUT CSS BEFORE WE GO INTO PEI? LARRY.

>> LARRY: I WAS TRYING CATCH UP TO YOU WITH THE SLIDE. THIS IS BACK EARLIER WHEN YOU MENTIONED, WHEN WE'RE LOOKING AT THE -- WAY BACK WHEN WE TALKED ABOUT LIVING ARRANGEMENTS, FSP LIVING ARRANGEMENTS AT LEAST, I THINK IT WAS FOR CHILDREN AND TAY, THERE WAS AN INCREASE IN JUVENILE HALL POST PLACEMENT. AND MAYBE I WASN'T PAYING ATTENTION. I DON'T KNOW IF THERE'S SOME UNDERSTANDING OF WHY THAT WAS?

>> DEBBIE INNES-GOMBERG: YEAH, WE'VE BEEN LOOKING INTO THAT. AND I'M LOOKING FOR THE CHILDREN'S SYSTEM OF CARE REPRESENTATIVE. NO, OKAY. SO THERE'S A VERY LARGE TRAINING, AS I THINK YOU'VE HEARD EARLIER IN

MONTEBELLO TODAY. HERE'S WHAT THE CHILDREN'S SYSTEM OF CARE TOLD US AT THE SYSTEM LEADERSHIP TEAM. THERE ARE RISK FACTORS THEY'RE LOOKING INTO AND I THINK SOME OF THE CHILD FSP PARTNERS OR CLIENTS ARE STARTING TO ENDORSE MORE OF THOSE RISK FACTORS THAT ARE THEN RESULTING IN A JUVENILE HALL VISIT OR DETENTION.

THIS IS HAPPENING IN CHILD FSP PROGRAMS IN OTHER COUNTIES AS WELL AND ONE EXPLANATION WAS THAT THEY TEND TO BE AGING IN TO THESE SORTS OF ACTIVITIES.

BUT I DO THINK THAT ONE OF THE THINGS THAT WAS TALKED ABOUT AT SLT WAS, WELL, WHAT SORT OF EVIDENCE-BASED PRACTICES MIGHT BE EFFECTIVE IN REDUCING ACTING OUT BEHAVIORS THAT RESULT IN ARRESTS? SO CHILDREN SYSTEM OF CARE IS LOOKING INTO THAT.

WE SHOULD HAVE THEM COME BACK IN TWO TO THREE MONTH'S TIME AND TELL US WHAT THEY THINK THEY MIGHT DO ABOUT THAT.

>> LARRY: THANK YOU.

>> DEBBIE INNES-GOMBERG: THANK YOU. JUDY.

>> JUDY: A FEW YEARS AGO, THE DEPARTMENT OF FAMILY AND CHILDREN SERVICES DID A STUDY IN THE ANTELOPE VALLEY. WE HAVE A HIGH RATE OF FOSTER YOUTH UP THERE. AND THEY WERE FINDING THAT 20% TO 25% OF FORMER FOSTER YOUTH WERE DYING BY THE AGE OF 25. SO THAT'S ONE IN FOUR, ONE IN FIVE. SO THE FACT THAT THE FSP, THE TAY FSP IS SHOWING A 2% MORTALITY RATE IS PHENOMENAL, BECAUSE THAT POPULATION IS VERY MUCH AT HIGH RISK. SO THAT SHOWS THE SUCCESS OF THE TAY FSP PROGRAM.

>> DEBBIE INNES-GOMBERG: THANK YOU. THAT PLACES THAT INTO CONTEXT. I APPRECIATE THAT. THANK YOU.

YES?

>> AUDIENCE MEMBER: SO YOU MENTIONED THERE WERE TWO CATEGORIES THAT HAD ONE TIME FUNDS THAT NEEDED TO BE SPENT BY 2017-2018. IS THAT SEPARATE FROM – IS THAT SEPARATE FROM OUR REMAINING BUDGET? OR IS THAT JUST SORT OF LUMPED IN WITH THE DIFFERENT AMOUNTS? I DIDN'T UNDERSTAND THAT?

>> DEBBIE INNES-GOMBERG: OH, OKAY, I'LL GET TO THE BUDGET PIECE IN A LITTLE BIT. BUT IT'S ACTUALLY ONE-TIME ALLOCATION. AND IS IN THE ANNUAL UPDATE, IN THE BUDGET SECTION... LET'S SEE HERE. THIS IS ON PAGE 168 OF THE ANNUAL UPDATE.

YOU WILL SEE THAT IN FY 16-17, THE ANTICIPATED EXPENDITURES FOR WORKFORCE EDUCATION AND TRAINING WHICH IS ONE OF THOSE WOULD BE $13,239,087. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS WHICH WAS THE OTHER ONE, WE ANTICIPATED SPENDING $10,700,000. GOING DOWN TO FY 17-18.

YOU SEE THE REMAINDER OF THOSE FUNDS BEING SPENT BECAUSE BY THE END OF 17-18, WE HAVE TO SPEND THAT MONEY, OTHERWISE, IT COULD REVERT BACK TO THE STATE. DOES THAT MAKE SENSE SO FAR?

>> AUDIENCE MEMBER: YEAH, I MEAN, ALSO BECAUSE I SAW ON THE L.A. COUNTY WEBSITE THAT IT SAID WE WERE ALLOCATED $60 MILLION THAT HAD TO BE SPENT BY 2016-2017. SO I DIDN'T KNOW IF WE WERE GOING TO TAKE ON SOME SORT OF LARGER PROJECT IN ORDER TO SPEND THAT; OR IF WE HAD ALREADY SPENT IT?

>> DEBBIE INNES-GOMBERG: WE ALREADY SPENT IT. IT WAS ALREADY AN ALLOCATION PLAN TO DO THAT. SO, BASICALLY, WHEN OUR WORKFORCE EDUCATION TRAINING PLAN AND OUR CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS PLAN WAS APPROVED HERE LOCALLY AND AT THE STATE, IT INCLUDED A PLAN TO SPEND THAT MONEY.

SO, FOR EXAMPLE, THE TECHNOLOGICAL NEEDS FUNDED OUR ELECTRONIC HEALTH RECORD AND GAVE MONEY TO CONTRACTORS TO DO SIMILAR SORTS OF WORK.

AND THEN OUR WORKFORCE EDUCATION AND TRAINING, YOU'LL SEE THAT IN THE ANNUAL UPDATE, AS WELL AS IN SOME OF THESE SLIDES WHERE THERE WERE DIFFERENT PROJECTS THAT WE FUNDED. AND, SO, WE'RE GOING TO SPEND ALL OF THAT MONEY BY 17-18.

>> AUDIENCE MEMBER: OKAY, THANK YOU.

>> DEBBIE INNES-GOMBERG: YEAH. ABSOLUTELY, REBA.

>> REBA STEVENS: CAN YOU TELL US WHAT YOU'RE FUNDING IN SERVICE AREA 6; BECAUSE I'M SERVICE AREA 6. AND I'M A CONSUMER AND I RECEIVE SERVICES. I LIKE TO KNOW WHERE I CAN FIND THIS; SO THAT I CAN EXPERIENCE IT?

>> DEBBIE INNES-GOMBERG: SO REBA IS ASKING WHAT IS THE TOTAL MHSA FUNDING SERVICE AREA? THAT'S ACTUALLY NOT SOMETHING WE'RE REQUIRED TO REPORT, BUT IT'S SOMETHING WE CAN PUT TOGETHER. SO WE WILL TAKE A SHOT AT THAT. THAT MIGHT BE PARTICULARLY IMPORTANT FOR OUR NEXT 2- OR 3-YEAR PLAN PROCESS.

[THE LINK TO THE DMH SERVICE DIRECTORY BY SERVICE AREA:
http://psbqi.dmh.lacounty.gov/providerdirectory.htm]

SO LET ME GO INTO PREVENTION AND EARLY INTERVENTION.

[CONTINUING ON SLIDE 41]

>> DOROTHY: I HAD A QUESTION ABOUT THE PREVIOUS SLIDE. ABOUT THE DROP, AND WHO'S BEEN SERVED? AND I UNDERSTAND THAT YOU DON'T KNOW WHAT THE PARTICULAR REASON IS FOR IT.

BUT HAS THERE BEEN ANY SURVEYS OR ANYTHING TAKEN TO TRY TO FIND OUT THAT REASON?

>> DEBBIE INNES-GOMBERG: I'M GOING TO ASK EITHER LILLIAN OR DR. KAY IF THEY WANT TO, IF THEY KNOW THE ANSWER TO THAT. THE QUESTION WAS: DO WE KNOW ANYTHING ABOUT THIS DIP IN TERMS OF UNIQUE CLIENTS SERVED WITHIN THE LAST TWO FISCAL YEARS FOR PEI?

>> WE'VE BEEN CONDUCTING SITE VISITS TO EACH OF OUR AGENCIES AND WE'VE ASKED OUR AGENCIES WHY THIS IS OCCURRING? AND FOR SOME OF THEM, IT'S WITH THE HEALTH CARE REFORM THEY'RE NOT GETTING AS MANY REFERRALS, PEOPLE THAT THEY THOUGHT WOULD BE COMING IN. MAYBE, GETTING SERVICES ELSEWHERE? THEY'RE ALSO LOOKING MORE CLOSELY AT THE PEI GUIDELINES.

I THINK WHEN YOU SEE NEW CLIENTS, THAT OTHER CHARTS THAT FOLLOW THIS, THERE WERE LIKE 40,000 AND YOU TAKE A DIP IS THAT INITIALLY WHEN PEI WAS STARTED, A NUMBER OF CLIENTS WHO MAY HAVE BEEN CARRIED OVER FROM THE PREVIOUS FUNDING, AND MAY NOT HAVE NOT FIT THE PEI GUIDELINES NOW MORE CLOSELY IN LINE. THESE ARE SUPPOSED TO BE INDIVIDUALS WHO DON'T HAVE SEVERE MENTAL ILLNESS OR PRIOR HISTORY OF SERIOUS MENTAL DISTURBANCES. SO IT NOW BECOMES A MUCH MORE FOCUSED ON THE EARLY INTERVENTION AND THE EARLY ASPECT.

>> DEBBIE INNES-GOMBERG: THANK YOU; ANYTHING TO ADD ROBIN?

>> NOT REALLY. I MEAN THE ONE THING THAT THE DEPARTMENT IS GOING TO HAVE TO GRAPPLE WITH IS THAT THERE IS AN IMPACT OF NUMBER OF CLIENTS SERVED FOR ALL PROGRAMS BASED ON THE RATES THAT AGENCIES RECEIVED TO DELIVER SERVICES.

AND OVER TIME, AS RATES HAVE GONE UP, THERE'S SOME DECREASE IN THE AMOUNT OF SERVICE. THAT'S SOMETHING THAT THE DEPARTMENT IS GOING TO NEED TO TAKE A LOOK AT OVER THE COURSE OF THE COMING YEAR. IT'S TRUE FOR EVERY COUNTY. I'VE BEEN ON CONVERSATIONS WITH THE OTHER BEHAVIORAL HEALTH DIRECTORS, AND IT'S A GENERAL TREND. AND IT'S PART OF THE COURSE OF DOING BUSINESS. WE DO HAVE TO TAKE A LOOK AT IT AND FIGURE OUT HOW TO APPROACH IT GOING FORWARD.

>> DEBBIE INNES-GOMBERG: THANK YOU. THANK YOU. I'M SORRY, DOROTHY, DID YOU HAVE A FOLLOW-UP?

>> DOROTHY: YEAH. THE REASON I ASK THAT, AS YOU LOOK AT THE HOMELESS POPULATION, HOW IT HAS JUST, YOU KNOW, EXPLODED. AND I SEE ALONG WITH THAT IS A MAJORITY DEALING WITH MENTAL HEALTH ISSUES. SO, SOMETIMES A PERSON IS DEALING WITH THOSE ISSUES OUT THERE SO THEY'RE NOT GOING TO SEEK THE HELP. WHAT I'M NOTICING NOW WITH THIS SB82, WHERE THEY'RE GOING OUT, YOU KNOW, TRYING TO ADDRESS THE ISSUES WITH THOSE THAT ARE OUT THERE THAT'S HOMELESS, THAT MAYBE THOSE NUMBERS ARE GOING TO END UP SHOOTING BACK UP? SO THAT WAS MINE.

>> DEBBIE INNES-GOMBERG: OKAY. ONE MORE QUESTION OR COMMENT AND THEN WE'LL MOVE ON.

>> AUDIENCE MEMBER: YEAH, I JUST, UH...WOW, SORRY I'M LOUD, BUT REBA ASKED SOMETHING ABOUT FINDING FUNDING FOR SERVICE AREA 8. I'M SORRY, SERVICE AREA 6.

AND THE FACT THAT YOU SAID THAT YOU DON'T HAVE THAT AVAILABLE, BUT YOU'VE GOT PUT THAT TOGETHER. THAT SHOULD BE THE FIRST THING THAT SHOULD BE PUT TOGETHER AS FUNDING REFERENCES TO ANYTHING. THIS IS MY PROBLEM.

>> DEBBIE INNES-GOMBERG: OKAY, I'M GOING TO STOP YOU FOR A SECOND BECAUSE THE QUESTIONS ARE SUPPOSED TO BE ABOUT THESE SLIDES. PUBLIC COMMENTS WILL COME UP AND THAT WILL BE FINE.

>> AUDIENCE MEMBER: WILL I HAVE TIME TO ANSWER THE QUESTION?

>> DEBBIE INNES-GOMBERG: NO, THIS IS ABOUT THIS SLIDE, OKAY? SO WE'RE GOING TO MOVE ON.

>> AUDIENCE MEMBER: YES, BUT FUNDING IS VERY IMPORTANT AND SO WE NEED TO GET TO THAT.

>> DEBBIE INNES-GOMBERG: WE UNDERSTAND, THAT WAS NOTED. OKAY. SO THIS IS NEW CLIENTS WITH NO PREVIOUS MHSA SERVICES BY FISCAL YEAR.

[CONTINUING ON SLIDE 44]

>> AUDIENCE MEMBER: WHAT ARE CHATS?

>> DEBBIE INNES-GOMBERG: A CHAT IS, UMM, I'M TRYING TO THINK WHAT IS A CHAT VERSUS A TEXT? I SHOULD KNOW THIS.

>> AUDIENCE MEMBER: IS IT A FACEBOOK?

>> AUDIENCE MEMBER: IT'S ONLINE.

>> DEBBIE INNES-GOMBERG: ROBIN, IS THAT RIGHT? OKAY. WHAT'S THAT?

>> AUDIENCE MEMBER: ONLINE.

>> DEBBIE INNES-GOMBERG: ONLINE. OKAY.

>> COMMUNICATION CHAT LINE FOR ALL YOUTH, [AWAY FROM MIC]

>> AUDIENCE MEMBER: GIVE HER A MIC, PLEASE.

>> JACKSON: YES, MY NAME IS JACKSON. IT'S A CHAT LINE TO ALL YOUTHS USE TO COMMUNICATE ACROSS THE NATION. ACROSS THE CONTINENT, EVERYBODY USES THAT LINE. THEY HAVE ANOTHER LINE THAT FAMILIES USE IS AGAIN AND IT'S CALLED DOWNLOAD. WE'VE BEEN IN TRAINING SO WE'RE KEEPING UP WITH EVERYTHING OUT HERE FOR COMMUNICATION ON NETWORK. DOWN TO

THE YOUTH AND EDUCATING THEM; TO USE IT AS WELL. SO IN TRAINING, WE'VE BEEN TELLING ALL THE CAREGIVERS AND ADULTS AND PARENTS TO GET OUT THERE AND LEARN HOW TO CATCH THE COMMUNICATION THROUGH THE COMPUTER SYSTEM.

>> DEBBIE INNES-GOMBERG: THANK YOU. YOU'VE BEEN VERY HELPFUL. I APPRECIATE THAT.

>> AUDIENCE MEMBER: YOU'RE WELCOME.

[CONTINUING ON SLIDE 45]

>> AUDIENCE MEMBER: [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: IS REYNE HERE? DID THEY DO ECPR AS PART OF THE TRAINING?

>> MENTAL HEALTH FIRST AID.

YES. THEY DIDN'T DO ECPR. THEY DID MENTAL HEALTH FIRST AID.

>> REBA STEVENS: WHY, BECAUSE I WAS NEVER SURVEYED OR ASKED. I'M A CLIENT.

>> DEBBIE INNES-GOMBERG: REBA, YOU WEREN'T PART OF THE PROGRAM.

>> THIS WAS AN INNOVATION PROGRAM.

>> DEBBIE INNES-GOMBERG: NOW, INNOVATION 2 WHICH IS OUR SECOND INNOVATION PROJECT, THIS IS ABOUT BUILDING TRAUMA RESILIENT COMMUNITIES THROUGH COMMUNITY CAPACITY BUILDING. WE HAVE DONE OVER 20 PRESENTATIONS.

[CONTINUING ON SLIDE 59]

>> AUDIENCE MEMBER: ARE THOSE THE STIPEND PROGRAMS FOR THE PROFESSIONAL? SOCIAL WORKERS AND NURSES, ETCETERA?

>> DEBBIE INNES-GOMBERG: YES, SECOND PROGRAM IS 52 MFT'S. 52 MASTERS OF SOCIAL WORK, AND 4 NURSE PRACTITIONER STUDENTS AND 73% OF THOSE INDIVIDUALS SPOKE A THRESHOLD LANGUAGE. YES?

>> AUDIENCE MEMBER: WHEN YOU SAY 18 INDIVIDUALS, DO YOU MEAN THESE ARE STAFF MEMBERS THAT ARE CURRENTLY FACILITATING THESE TRAININGS OR 18 INDIVIDUALS THAT WERE TRAINED?

>> DEBBIE INNES-GOMBERG: I THINK THOSE WERE 18 THAT WERE TRAINED. ROBIN IS NODDING YES. OKAY.

>> AUDIENCE MEMBER: I'M ONE OF THE FACILITATORS AND COORDINATORS ONE OF THE FIVE CONTRACT PROVIDERS THROUGHOUT THE COUNTY TO PROVIDE THIS TRAINING. I'VE TRAINED JUST ABOUT 32 INDIVIDUALS LAST YEAR.

>> DEBBIE INNES-GOMBERG: OKAY, WE'RE GOING TO GO BACK AND LOOK AT OUR DATA THEN, THANK YOU.

[CONTINUING ON SLIDE 61]

>> AUDIENCE MEMBER: WHAT IS THE TOTAL BASED ON?

>> DEBBIE INNES-GOMBERG: SO THERE'S A FISCAL CONSULTANT THAT THE COUNTY OF DIRECTOR OF ASSOCIATION USES THAT TAKES THE DEPARTMENT OF FINANCE DATA, AND THEN GIVES US ON PRETTY MUCH ON A QUARTERLY BASIS THIS INFORMATION. SO WHAT I DO, EVERY TIME I GET IT, I'LL UPDATE MY CHARTS THAT ARE SIMILAR TO THIS TO INDICATE THE OVER MOST LIKELY TO HAVE IN TERM OF DOLLARS. AND THE DOLLARS COME TO THE COUNTY EVERY MONTH. AND THEY'RE DIFFERENT EVERY MONTH. YEAH. THIS IS MY CONTACT INFORMATION. AND, SO, NOW, WE ARE READY FOR PUBLIC COMMENTS.

[PUBLIC COMMENTS]

>> DEBBIE INNES-GOMBERG: SO WE'VE GOT MS. LAMONT OVER HERE. WE'LL START WITH MS. LAMONT.

>> MS. LAMONT: FOR THE INFORMATION, ANYBODY WORRIED ABOUT THE SERVICE AREA 6? FOR THE INFORMATION FOR ANYBODY WORRYING SERVICE AREA 6, THEY NEED TO ASK THE PEOPLE THAT'S BEEN IN MENTAL HEALTH FOR MANY YEARS. WHO WATCHES THE BUDGET FOR SERVICE AREA 6 ALL THE TIME?

>> AUDIENCE MEMBER: MS. LA MONT.

>> AUDIENCE MEMBER: AND IF I SEE ANYTHING THAT SOUNDS WRONG, THEY'LL HEAR FROM ME, OKAY? AND THAT IS THE TRUTH. AND I'VE ALWAYS DONE THAT.

>> DEBBIE INNES-GOMBERG: THANK YOU VERY MUCH; NEXT PUBLIC COMMENT.

>> JACKSON: HI, MY NAME IS JACKSON. I'M A FOSTER CARE KINSHIP APPLICANT ACROSS THE NATION FOR ALL AREAS 1 THROUGH 8. BUT I'M FROM REGION OF 6, SMALL 6, AREA 6. AND FOSTER CARE IS DIFFERENT FROM KINSHIP. FOSTER CARE IS DIFFERENT FROM THE HEALTHY WHOLE FAMILY. FOSTER CARE HAS ALL DAY TOOLS. BECAUSE; THE CAREGIVER BEING A FOSTER CARE GIVER HAS THE FUNDING TO CAKE OF THAT CHILD.

A KINSHIP IS CALLED KIN GAP FUNDING. THIS IS A RELATIVE CAREGIVER THAT HAS THE FUNDING FOR THAT CHILD; DEPENDS UPON IF THAT CASE IS CLOSED. NOW BACK TO FOSTER, IF YOU'RE A YOUTH AND YOU'RE UP THERE HOMELESS, YOU AUTOMATICALLY CAN CALL ANY SUBCRISIS STATION TO BE REALISTIC TO BE BACK IN FOSTER CARE UNDER AB12. FOSTER CARE CHILD WILL

STAY IN FOSTER CARE UNTIL THEY'RE 21 YEARS OLD. WE HAVE A LIFE SKILL TRANSITIONAL HOME THEY CAN GO TO.

EVEN IF THEY GO BACK IN THE SYSTEM, THEY STILL HAVE THEIR MONEY AND FUNDING SEPARATE TO PAY THEIR RENT WHICH IS $836 ON TOP OF WHAT THEY WOULD MAKE KEEPING ALL THE FUNDING TO THEMSELVES. KIN GAP IS KINSHIP YOU ONLY GET KIN GAP IF YOUR CASE IS OPEN. IT ALL DEPENDS ON HOW THAT CONFIDENTIAL PAPER IS.

FOR THE YOUTH, THEY'RE ALWAYS GOING TO HAVE THEIRS TOO. BECAUSE ALL SCHOOL DISTRICT HAS A PROGRAM FOR THE FOSTER CARE AND YOUTH IN THE COMMUNITY. FOR RESPITE AND FOSTER CARE KINSHIP, IN EACH INDIVIDUAL IN ALL AREAS, WE ALL HAVE TO BE OUR OWN RESPITE. EVEN IF YOU'RE A MENTAL CLIENT AND YOU HAVE TO USE THE DMH DEPARTMENT, THEY ALSO HAVE THE WRAPAROUND SHIELDS AND, ET CETERA AND, ET CETERAS.

NOW, I'M TALKING ABOUT ANYTHING ACROSS-THE-BOARD FOR THE DSM, DOING ANY OTHER ACTIVITIES OUT THERE, WHAT OUR MAIN GOAL IS TO GET THE OTHER CHILDREN UNDER 1% OR JUST AT THAT BORDER OF 1% SO THEY CAN HAVE SOME ACTIVITIES IN THE COMMUNITY AS WELL, BECAUSE THEIR PARENTS DON'T HAVE THE FUNDING. BECAUSE NOT EVERYBODY'S ECONOMICS KILL IS THE SAME.

>> DEBBIE INNES-GOMBERG: THANK YOU VERY MUCH.

>> STEVE MCNALLY: HI, MY NAME IS STEVE MCNALLY. I HAVE A QUESTION. FIRST THANKS VERY MUCH. I LOVE SEEING ALL THE RESULTS.

[APPLAUSE]

AND I HAVE ACTUALLY TWO QUESTIONS. ONE IS, AND IF THEY'RE TOO BIG, DON'T ANSWER THEM NOW. BUT ONE IS THE NUMBERS THAT YOU'RE REPORTING DO THEY COME FROM INTERNAL SYSTEMS THAT ARE AVAILABLE TO ANY COUNTY?

>> DEBBIE INNES-GOMBERG: SO, YES, YOU'RE TALKING CLIENT COUNTS, FOR EXAMPLE?

>> STEVE MCNALLY: YEAH ALL THAT KIND OF STUFF.

>> DEBBIE INNES-GOMBERG: YES, THE CLIENT COUNTS AND DOLLARS ASSOCIATED WITH THOSE ALL COME FROM OUR INTEGRATED BEHAVIORAL HEALTH SYSTEM. SO ANY TIME YOU ENTER A MENTAL HEALTH SERVICE, THEN THAT GETS— THAT'S HOW THAT GETS COUNTED. EVERY COUNTY IS GOING TO HAVE A LITTLE BIT OF A DIFFERENT SYSTEM.

>> STEVE MCNALLY: AND THEN THE SECOND THING IS, IT'S REALLY WHEN YOU LOOK AT THESE THREE-YEAR PLANS AND THEY'RE UPDATED ANNUALLY, IT'S HARD TO SEE, AND WITH THE RFP PROCESS, IT'S HARD TO SEE WHAT'S ACTUALLY SPENT AND UNSPENT; AND WHEN THE STATE MIGHT BE LOOKING TO TAKE THE MONEY BACK FOR OTHER STUFF. SO IS THERE A RISK TO ANY PART OF YOUR BUDGET?

>> DEBBIE INNES-GOMBERG: ROBIN? OUR ACTING DIRECTOR IS GOING TO ANSWER THAT.

>> ROBIN: SO, NO. IN SHORT, IT ISN'T. BECAUSE WE HAVE A SYSTEM, IN SLT SYSTEM LEADERSHIP TEAM, BUDGET MITIGATION WORK GROUP THAT MEETS SOMEWHAT REGULARLY. WHAT WE DO IN L.A. IS THAT WE ROLL MONEY FORWARDS SO IT'S FIRST DOLLAR IN, FIRST DOLLAR OUT.

USING THAT ACCOUNTING PRINCIPAL HAS ENABLED US TO CONTINUE TO FLOW THE MONEY WITHOUT RISK OF REVERSION. WE ALSO DO, AS DEBBIE MENTIONED, WHEN WE DEVELOP A LARGE ENOUGH POOL OF UNSPENT MONEY, WE DO A NEW PLAN AND WE SPEND IT. AND WE'VE BEEN VERY SUCCESSFUL AT DOING THAT. SO WE'RE FINE RIGHT NOW.

>> DEBBIE INNES-GOMBERG: THANK YOU.

>> ROSIE TAYEZ: HELLO, MY NAME IS ROSIE TAYEZ. I'M THE COORDINATOR FACILITATOR FOR MENTAL HEALTH ADVOCATE TRAINING WITH THE WESTSIDE CENTER FOR INDEPENDENT LIVING. AND AS I'VE MENTIONED BEFORE, DEBBIE, I'M ONE OF THE FIVE CONTRACT PROVIDERS TO FACILITATE THE SPECIFIC TRAINING FOR WHAT USED TO BE PEER ADVOCACY. NOW IT'S MENTAL HEALTH ADVOCACY.

MY THOUGHT WAS, I WANTED TO SHARE WITH YOU THAT IN THE PAST, WE HAD EXPRESSED INTEREST FOR THE COMMISSIONERS TO REQUEST A DIALOGUE WITH CONTRACT DIVISIONS IN ORDER TO COUNTYWIDE DISCUSSION BE TALKED ABOUT REGARDING TO DEVELOP A FIVE ITEM CONTRACT WITH ANY CONTRACT OR, IN FACT, DIRECT PROVIDER TO PROVIDE PEER STAFF. AND THAT WOULD BE SUGGESTED FROM THE SPECTRUM OF ENTRY LEVEL POSITION FROM MENTAL HEALTH ADVOCATE AS A COMMUNITY WORKER AND SENIOR COMMUNITY WORKERS. SO I WANTED TO HAVE THIS OPPORTUNITY TO EXPRESS THAT WE CONTINUE TO FEEL THAT AS WE TRAIN INDIVIDUALS, THE CHALLENGE AND THE BARRIERS HAS BEEN THAT THERE HAS NOT BEEN MUCH EMPLOYMENT OUT THERE FOR MENTAL HEALTH ADVOCATES ON THE ENTRY LEVEL POSITION. SO HAVING TO THINK THAT IF WE CAN – IF THERE WOULD BE A CONSIDERATION FOR DISCUSSION REGARDING MAKING IT, OR IMPLEMENTING OR MANDATE IT THAT WE HAVE THESE POSITIONS SPECIAL FOR MENTAL HEALTH ADVOCATES. BECAUSE WHAT IS THE PURPOSE OF TRAINING INDIVIDUALS AND THEN WE CAN'T PLACE THEM FOR EMPLOYMENT?

ANOTHER CHALLENGE HAS BEEN THAT AS PART OF OUR PROGRAM, THERE IS A PEER INTERNSHIP COMPONENT TO OUR TRAINING THAT ALSO HAPPENS TO DEVELOP A BROADER COLLABORATION AMONG CONTRACT PROVIDERS AND DIRECT PROVIDERS TO ALLOW THE OPPORTUNITY FOR THESE INDIVIDUALS TO HAVE INTERNSHIP, TO BE CONSIDERED AT ALL THESE DIFFERENT AGENCIES.

>> DEBBIE INNES-GOMBERG: THANK YOU. WHAT I'M GOING TO ASK YOU YOU TO DO IS SEND ME AN E-MAIL. AND I CAN CONNECT YOU WITH COUPLE OF INDIVIDUALS THAT WOULD LIKE TO TALK TO YOU FURTHER ABOUT YOUR IDEAS. THANK YOU.

>> [AWAY FROM MIC]

>> DEBBIE INNES-GOMBERG: THANK YOU.

>> ROSE: THANK YOU FOR LETTING ME SPEAK; MY NAME IS ROSE I'M WITH THE LACC, LOS ANGELES COUNTY CLIENT COALITION. ALL I WAS GOING TO SAY IS SOMETHING REAL SHORT. IN CONNECTION WITH WHAT ROBERT KODO HAD TO SAY AND YOU WITH THE PROGRAMS FOR YOUTH AND WHAT SEEMS TO BE BENEFICIAL IN HELPING THEM TO STOP FALLING INTO THE GANG SITUATION. GOOD FRIEND OF MINE WHO WAS AN AUTHOR AND WRITER, WE HAD THIS DISCUSSION SEVERAL YEARS AGO AND HE MADE A COMMENT THAT I NEVER FORGOT. AND HE SAID THAT IT'S BASICALLY, WHEN SOCIETY FALLS APART, PEOPLE SEEK STRUCTURE. THEY FIND THAT STRUCTURE, UNFORTUNATELY, IN GANGS. AND THE KEY WORD, I BELIEVE HERE IS "STRUCTURE."

SO, PROGRAMS THAT ARE BEING DEVELOPED THAT WILL BE MOST BENEFICIAL, SIMPLY, I THINK SHOULD HAVE MORE STRUCTURE. THAT'S WHAT THEY'RE SEEKING -- STRUCTURE. AND IT'S A VERY TRUE STATEMENT. HIS NAME IS LIONEL ROTH. THANK YOU.

>> DEBBIE INNES-GOMBERG: THANK YOU. WELL SAID. WE HAVE ANOTHER PUBLIC COMMENT RIGHT THERE.

>> AUDIENCE MEMBER: MY MAIN PROBLEM IS LACK OF STAFF TRAINING IN FACILITIES SUCH AS THE LAMP.

A LOT OF FINANCES IS GOING, BUT IT'S NOT GOING INTO PROPER STAFF TRAINING. SO YOU HAVE A LOT OF WOMEN IN A FACILITY THAT ARE LOOKING FOR COUNSELING. THERE'S TO PEER GROUPS, THERE'S NO CONFIDENCE BUILDING CLASSES, THERE'S NOTHING. THERE'S A WOMAN THAT'S BEEN THERE FOR 20 YEARS – 20 YEARS SITTING THERE POOPING ON HERSELF, ASKING FOR A CIGARETTE EVERY MINUTE, BUT APS SAYS, THAT SHE HAS TO STAY THERE BECAUSE THERE'S LACK OF FUNDING.

I GO TO THE DOWNTOWN WOMEN CENTER TO PRINT SOME ITEMS, AND BECAUSE THERE'S NOT A PRINTER THERE FOR THE LAST THREE WEEKS, COLOR PRINTER, FORGET IT. YOU'VE GOT SOME NICE COLOR PRINTING RIGHT HERE. BLACK AND WHITE IS WHAT WE GET.

WHAT I'M TRYING TO SAY IS THERE'S LACK OF FUNDING FOR A LOT OF THINGS THAT WE NEED FOR DOWNTOWN L.A., FOR HOMELESS, FOR FOSTER, BUT YET, THERE'S ALWAYS A LOT OF MONEY GOING TO THE SHERIFF'S DEPARTMENT, ALWAYS GOING TO INCARCERATION. BUT WHEN IT COMES TO PROGRAMS WE NEED FINANCES, WE NEED SOLUTIONS, AND YOU GUYS ARE MEETING ON TAXPAYER'S DOLLARS SAYING WE'RE MEETING EVERY WEEK ON SOLUTIONS AND WE SAYING FOR THE LAST FOUR YEAR. PUT BACK ARTS, PUT BACK SOMETHING POSITIVE. YOU HAVE TO PUT BACK SOMETHING SIMPLE.

BECAUSE WE'RE LIVING IT AND WHEN YOU INSULT US BY SAYING THAT YOU GOT A FINE SOMEWHERE TO FIND THE PROPER FUNDINGS, NOBODY IS GOING TO GIVE YOU PROPER NUMBERS, AND EVERYTHING IS GOING TO BE SHADY. AND YOU'VE GOT POLITICIANS THAT ARE TAKING OUR MONEY AND WE'RE TIRED OF GETTING LESS THAN SERVICES, BECAUSE YOU GUYS WANT TO PUT THE MONEY SOMEWHERE ELSE.

AND AFTER A WHILE, YOU CAN'T KEEP SAYING THE SAME THING YEAR AFTER YEAR AND EXPECTING US TO LEAVE IN THE LACK OF AND EXPECT US TO BETTER OURSELVES. YOU HAVE TO START PUTTING MONEY IN THESE KIDS TRIGGER AND TRAUMA AND ALL THIS STUFF.

IF YOU HAVE TO PREVENT THE PROBLEM, YOU'VE GOT TO PUT YOUR MONEY WHERE YOUR MOUTH IS. THAT'S WHERE IT IS. THAT'S WHERE IT STARTS. I'M SITTING HERE LISTENING TO THIS, BUT QUESTIONS ON WHERE CAN WE FIND CONCRETE NUMBER IS ALL OVER THE PLACE. I JUST WANT TO KNOW WHERE I CAN GO ON THE INTERNET THAT I CAN PRESS TO SAY, THIS IS HOW MUCH MONEY THE LAMP GETS FOR STAFF SERVICES. THIS IS HOW MUCH MONEY DOWNTOWN WOMEN CENTER GETS FOR DONATION.

ALL OF THIS STUFF, WE NEED TO FIND SOMEWHERE WE COULD JUST ONE CLICK AWAY AND SAY THERE'S THE NUMBERS. ALL THIS SHADINESS AND THE WAY WE'RE LIVING IS NOT MATCHING UP. SO I NEED TO KNOW WHO I TALK TO. DR. KAY, IF YOU CAN GIVE ME A DIRECT ANSWER, OKAY? I NEED TO KNOW WHERE I CAN FIND NUMBERS SO WE CAN BRING IN THE FUNDING THAT'S NEEDED FOR THESE PLACES.

THIS IS WHAT MY JOB WOULD LIKE TO BE. I'M NOT ASKING FOR YOU TO EVEN PAY ME. I JUST WANT DIRECT ANSWERS. DON'T GIVE ME THE RUN AROUND, BECAUSE I WILL TELL SOMEBODY OFF, BECAUSE I'M TIRED OF BURYING OUR KIDS, I'M TIRED OF LOOKING AT WOMEN THAT ARE SAYING I NEED HELP. AND YOU'VE GOT STAFF THAT'S NOT EVEN TRAINED, BUT THEY'RE SITTING THERE AND THEY'RE TAKING MONEY. AND THEY'RE SUPPOSED TO BE ADVOCATES, AND THEY'RE MAKING YOU GO TO DO RESEARCH.

>> DEBBIE INNES-GOMBERG: CAN I MAKE A RECOMMENDATION, PLEASE?

>> AUDIENCE MEMBER: YES, PLEASE DO BEFORE I GO OFF THE TANGENT HERE.

>> DEBBIE INNES-GOMBERG: OKAY. MY RECOMMENDATION IS THAT THE WAY THE DEPARTMENT OF MENTAL HEALTH IS STRUCTURED, AND THE MENTAL HEALTH SERVICES ACT IN PARTICULAR WHICH FUNDS OUTPATIENT MENTAL HEALTH SERVICES IS STRUCTURED IS THAT WE HAVE A SERVICE AREA ADVISORY PROCESS. AND THE OTHERS SACS, AS DOROTHY AND OTHERS, MS. LAMONT KNOW THE SACS ARE VERY IMPORTANT IN TERMS OF LOCAL PLANNING. AND THAT'S WHERE I WOULD START. SERVICES ARE ALSO ON OUR WEBSITE.

WHAT ARE THE NEEDS OF THE DOWNTOWN MENTAL HEALTH AREAS? I UNDERSTAND THAT.

THANK YOU.

>> REBA STEVENS: GOOD AFTERNOON. REBA STEPHENS. WHO ARE THE SERVICE PROVIDERS CURRENTLY BEING FUNDED IN THE SECOND DISTRICT?

>> DEBBIE INNES-GOMBERG: REBA, WE CAN GET THAT INFORMATION BUT WE'RE NOT REQUIRED TO REPORT THAT AS ANNUAL UPDATE.

>> AUDIENCE MEMBER: WHY NOT? THAT'S THE PROBLEM.

>> AUDIENCE MEMBER: OKAY, WAIT. HOLD ON. IT'S MY QUESTION TIME.

>> AUDIENCE MEMBER: SORRY.

>> DEBBIE INNES-GOMBERG: I'M GIVING YOU AN ANSWER.

>> REBA STEVENS: AND I APPRECIATE YOUR SUPPORT. PLEASE PROVIDE THE LOCATIONS FOR WELLNESS CENTERS IN SERVICE AREAS 6 AND THE DESCRIPTION OF THE SERVICE IN DETAIL.

>> DEBBIE INNES-GOMBERG: OKAY. SO YOU'VE WRITTEN THAT DOWN? YOU'LL GET A RESPONSE.

>> REBA STEVENS: OKAY, AND THEN THE NEXT QUESTION IS. IN REFERENCE TO TAY, HOW MANY TAY MOBILE UNITS ARE THERE FOR SERVICE AREA 6?

SO WE DON'T HAVE AN ANSWER TO THAT EITHER?

>> DEBBIE INNES-GOMBERG: DO YOU KNOW THE NUMBER OF TAY MOBILE UNITS IN SERVICE AREA 6? IS THAT SOMETHING THAT IS – WE CAN CERTAINLY GET THAT YOU INFORMATION.

>> REBA STEVENS: OKAY. IN ADDITION TO THAT INFORMATION, I WOULD LIKE TO KNOW THE TARGET WHERE POPULATION FOR TAY. I'D LIKE TO ALSO KNOW AS A CONSUMER WITH A DEPARTMENT OF MENTAL HEALTH LIVING IN THE SECOND DISTRICT, WHERE CAN I FIND PEI IN MY COMMUNITY? HOW CAN I SEE IT AND ACTUALLY EXPERIENCE IT SO I CAN SAY, THAT THERE IT IS. IT'S RIGHT THERE.

>> DEBBIE INNES-GOMBERG: IN YOUR ANNUAL UPDATE, WE LIST THE SERVICES BY SERVICE AREA, INCLUDING THE DIFFERENT TYPES OF PROGRAMS BY SERVICE AREAS.

>> DEBBIE INNES-GOMBERG: YES. MS. LAMONT.

>> MS. LAMONT: OKAY, I THINK THERE STILL NEEDS TO BE BETTER UNDERSTANDING. MAYBE NOT. MAYBE I'M WRONG. AND I CAN STAND TO BE WRONG, YOU KNOW? IF I'M WRONG, CORRECT ME.

WHEN YOU SPEAK OF SERVICE AREA, THE SAAC, THIS IS JUST PART OF THE FUNDING FOR THE DEPARTMENT OF MENTAL HEALTH. ALL OF THE – WHAT PEOPLE SHOULD UNDERSTAND, THIS IS JUST A SPECIFIC AMOUNT OF MONEY.

BUT THERE'S ANOTHER AMOUNT OF MONEY THAT THE DEPARTMENT HAS TO FUND WHATEVER, YOU KNOW, DOWNTOWN MENTAL HEALTH AND ALL THAT. THAT'S NOT PART OF THIS DISCUSSION. BUT YOU NEED TO FIND OUT. WE HAVE THE SERVICE AREA – MHSA (MENTAL HEALTH SERVICES ACT).

THAT'S WHAT I WANTED YOU TO SAY, DEBBIE, A CHARGE TO SERVE THE UNDERSERVED, THE INAPPROPRIATELY SERVED, AND THE UNSERVED, AND DOES IT SAY ETHNIC MINORITY PEOPLE? IT'S JUST A PART OF A PORTION OF THE MONEY THAT WE'RE TRYING TO SHOW THAT IT CAN BE DONE.

IT'S NOT THE TOTAL FUNDING OF DEPARTMENT OF MENTAL HEALTH. AND, YOU KNOW, SOMETIMES PEOPLE WILL HAVE TO LEARN THESE THINGS. THE REASON I KNOW WAS THAT I WAS THERE IN THE BEGINNING. AND I'M STILL HERE.

[APPLAUSE]

AND I DO – NOW. I WAS EVEN HERE BEFORE WE GOT OUT UNDER THE HEALTH SERVICES WHERE WE'RE GOING BACK TO NOW. I WAS ONE OF THE MAIN PEOPLE TO PULL US OUT FROM UNDER MENTAL HEALTH. SO YOU NEED TO KNOW HISTORY AND YOU NEED TO KIND OF UNDERSTAND WHERE ALL THESE DIFFERENT FUNDINGS COME FROM AND WHO YOUR CHARGE IS BY LAW.

AND THAT'S ALL THE, YOU KNOW. THE PROBLEM IS THE MISUNDERSTANDING AND NOT UNDERSTANDING THE DIFFERENT PARTS. THIS IS JUST ONE SECTION OF, LIKE THE MILLIONAIRES GIVE US WHAT? 1% OF THEIR MONEY OVER A MILLION DOLLARS.

AND THAT'S WHY IT FLUCTUATES ON HOW MUCH WE GET, BECAUSE IT DEPENDS ON HOW MANY – THAT'S WHY IT FLUCTUATES BECAUSE IT DEPENDS ON HOW MANY MILLIONAIRES WE'VE GOT IN CALIFORNIA. OKAY, I'LL LET IT GO. BUT UNDERSTANDING IS ONE OF THE BEST THINGS IN THE WORLD.

>> DR. GASCO: THANK YOU VERY MUCH TO ALL OF YOU WHO ARE THE DIE HARDS THAT HAVE CONTINUED UP TO THIS POINT. WE ARE AT THE SAD MOMENT, WE HAVE TO SAY GOODBYE. BUT I WANTED TO JUST SORT OF TALK A LITTLE BIT MORE ABOUT THE NEXT STEPS.

NEXT STEPS WOULD BE ALL THE TESTIMONY THAT WAS PROVIDED TODAY. THIS WILL BE INCORPORATED INTO THE REPORT. I'M GOING TO REQUEST IF AT ALL FOR THE DEPARTMENT TO PROVIDE A WRITTEN STATEMENT TO THE MENTAL HEALTH COMMISSION BY OUR EXECUTIVE COMMITTEE MEETING. THAT MAY BE DIFFICULT TO DO, BUT AT LEAST SO WE CAN HAVE A REVIEW OF IT PRIOR TO THE FULL COMMISSION MEETING, WHICH WOULD BE MAY 26 AT WHICH TIME WE WILL VOTE SO WHETHER TO APPROVE OR NOT APPROVE THE MHSA PLAN.

I DO WANT TO THANK EVERYONE THAT ASKED QUESTIONS. SOME OF THEM WERE REALLY OUTSIDE OF THE BOUNDS OF MHSA. BUT THE FACT IS THAT YOU'RE HERE. AND IT'S IMPORTANT THAT WE HEAR THEM EVEN THOUGH IT'S, AGAIN, NOT SOMETHING THAT IS REALLY PERTINENT TO THIS PARTICULAR PLAN.

SO, AGAIN, I LIKE TO THANK DEBBIE IN PARTICULAR.

[APPLAUSE]

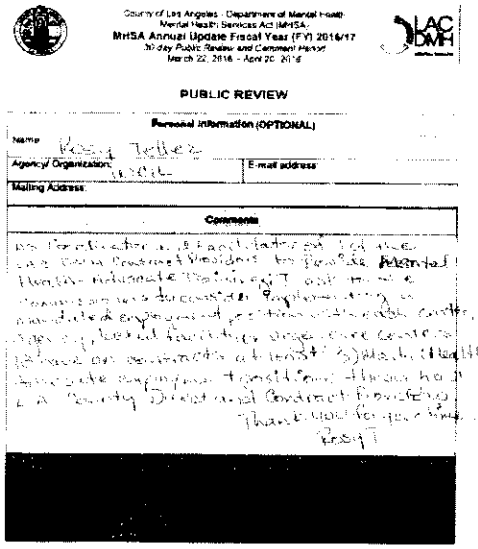
SHE HAS DONE AN OUTSTANDING JOB. AND SOME OF HER RESPONSES MAY NOT HAVE BEEN TOTALLY SATISFACTORY TO YOU, BUT THAT IS THE ANSWER. AND ONE OF THE THINGS THAT I CAN COMMEND DEBBIE FOR IS THAT, SHE'S VERY, VERY AGREEABLE AND ACCOMMODATES HERSELF TO A DEGREE THAT MOST PEOPLE DON'T, TO GO OUT AND ADDRESS COMMUNITY GROUPS. PRIOR TO THIS DATE, THIS IS SORT OF A LATE DATE. BUT THE FACT IS THAT YOU'RE HERE AND THAT'S GREAT.

SO PLEASE, IN THE FUTURE FOR THIS COMING YEAR, I'LL GET THE WORD OUT. YOU KNOW, THERE'S A LOT OF OPPORTUNITIES AND THE SERVICE AREA ADVISORY COMMITTEES AND MEETINGS AND DEPARTMENTS, ET CETERA, WHICH IS MORE THAN I CAN DETAIL TO YOU.

BUT IT'S REALLY IMPORTANT THAT PARTICIPATION AT THE EARLIEST STAGE POSSIBLE TO ENSURE THAT YOUR COMMENTS ARE REALLY INTEGRATED AS OPPOSED TO WHAT WE'RE GOING TO BE DOING NOW WHICH IS TO INCLUDED IN THE REPORT. IT WILL BE MORE OF AN ADDENDUM. IT'S A PLAN. BECAUSE IT'S A LITTLE LATE, BUT THAT DOESN'T TAKE AWAY FROM THE IMPORTANCE OF WHAT YOU HAVE TO SAY.

SO, AGAIN, BEFORE YOU COME UP AND GRAB THIS MIC THIS AWAY FROM ME, SO YOU CAN GO HOME, WE'RE NOW ADJOURNING THIS MEETING, AND THANK YOU VERY MUCH FOR BEING HERE.

[MEETING ADJOURNS AT 2:00 P.M.]



County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2016/17
30-day Public Review and Comment Period
March 22, 2016 - April 20, 2016

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Rosy Tellez
Agency/ Organization: LACDMH
E-mail address:
Mailing Address:

Comments

As Coordinator of Participation for the Los Rios Contract Providers to provide Mental Health Advocate Training I will be in charge of overseeing and coordinating employment positions with public centers, agencies, mental health agencies, drop-in centers, behavioral economics at least 5) Health Clinic. Appropriate supervision to assist them has a County Direct and Contract Providers.

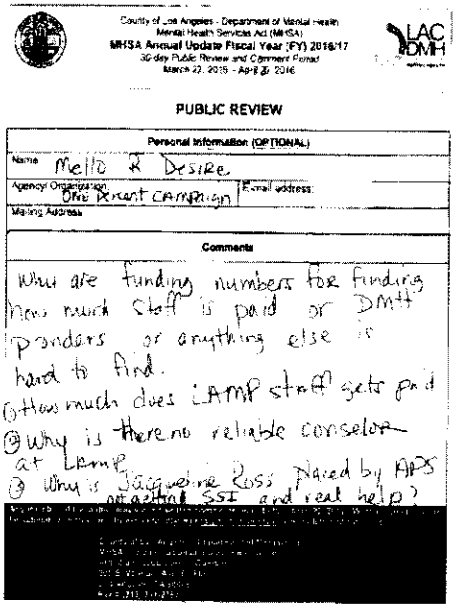
Thank you for your time.

Rosy T

"I would like [illegible] Contracts Division
[illegible] to Provide [illegible]
Participants to Provide Direct or Contract
Peer Staff to Provide Direct Contract
Providers -
1. Senior Peer Advocate
2. Community Worker
3. Mental Health Advocate
4. Case Manager Health Associate
5. Opportunities for Peer Internships"

(MHS)
Peers Individual Peer Support
Peer Case Management
"Life Coaches"?

(MHS)



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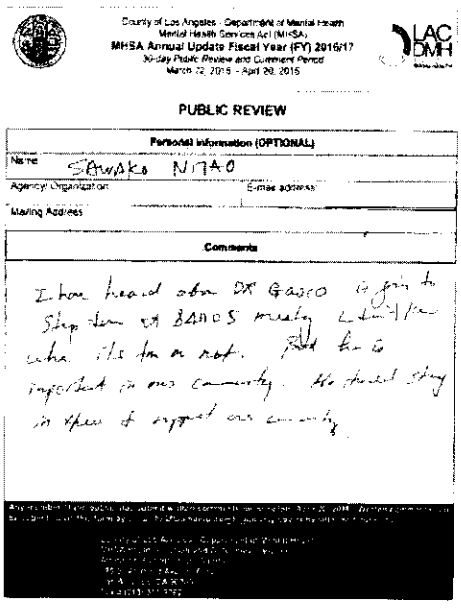
PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Mello R Desire
Agency/ Organization: One Breast Campaign
E-mail address:
Mailing Address:

Comments

What are funding numbers for funding
How much staff is paid or DMH
providers or anything else is
hard to find.
① How much does LAMP staff gets paid
② Why is there no reliable counselor
at LAMP
③ Why is Jaqueline Ross Placed by APS
on active SSI and real help?



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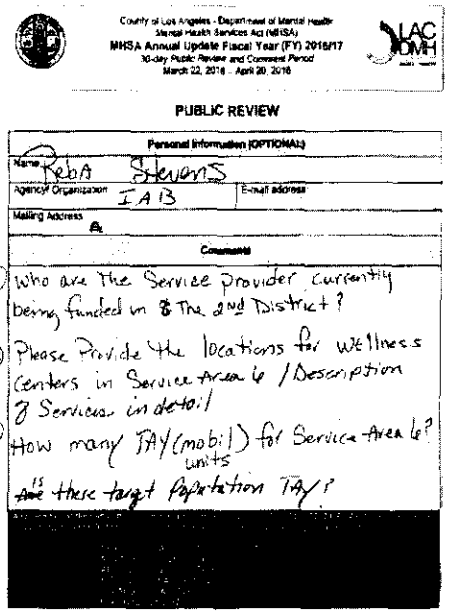
PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: SAWAKO NITAO
Agency/ Organization:
E-mail address:
Mailing Address:

Comments

I have heard about Dr Gasco is going to
Skid Row on BADOS mostly [illegible]
who [illegible] not. [illegible] for
important in our community. We should stay
in Skid Row support our community.



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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Reba Stevens

Agency/ Organization: IAB | E-mail address:

Mailing Address:

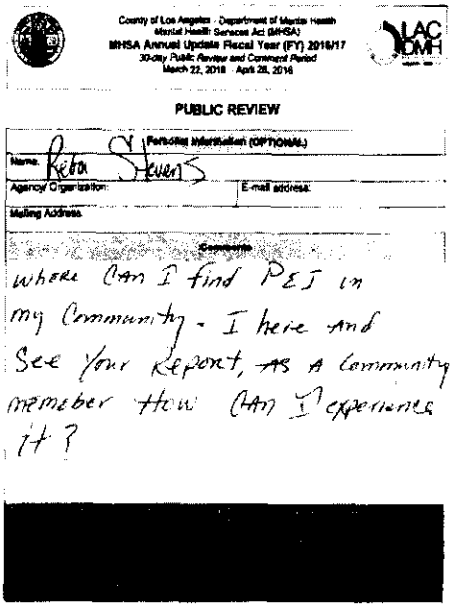
Comments

(1) Who are the Service provider currently being funded in the 2nd District?

(2) Please Provide the locations for Wellness Centers in Service Area 6 / Description of Services in detail

(3) How many TAY (mobil) units for Service Area 6?

Is there target population TAY?



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PUBLIC REVIEW

Personal Information (OPTIONAL)

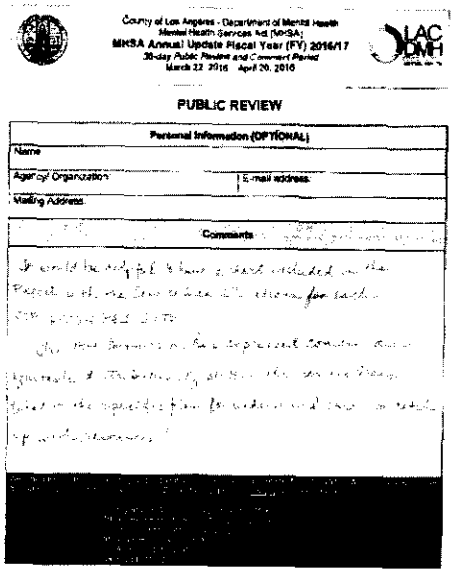
Name: Reba Stevens

Agency/ Organization: | E-mail address:

Mailing Address:

Comments

Where can I find PEI in my Community - I here and See your Report, as a Community memeber How can I experience it?



County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2016/17
30-day Public Review and Comment Period
March 22, 2016 - April 20, 2016

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name

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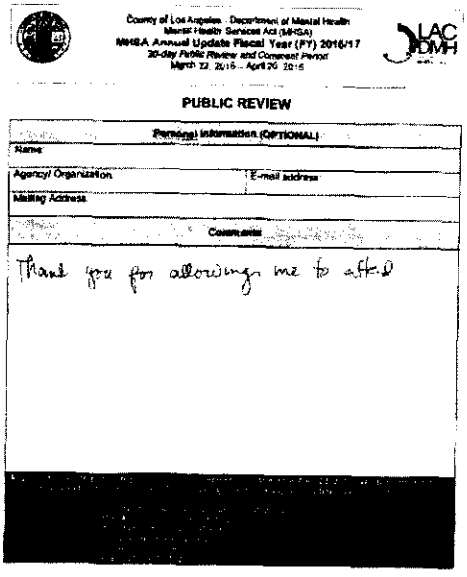
Comments



County of Los Angeles - Department of Mental Health
Mental Health Services Act (MHSA)
MHSA Annual Update Fiscal Year (FY) 2016/17
30-day Public Review and Comment Period
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PUBLIC REVIEW

Personal Information (OPTIONAL)

Name

Agency/ Organization | E-mail address

Mailing Address

Comments

Thank you for allowing me to attend

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU - MHSA IMPLEMENTATION AND OUTCOMES DIVISION

Summary of Written and Oral Public Comments-Fiscal Year 2016-17 Annual Update

1. Request for Service Area allocations for FSP, FCCS and PEI slots to ensure equitable distribution of slots in the Service Areas.

	Number of Clients Served				
Service Area	Prevention & Early Intervention	Field Capable Clinical Services			
		Child	TAY	Adult	Older Adult
1	3,420	303	52	97	29
2	9,105	1,359	633	2,091	505
3	10,157	1,926	511	1,588	167
4	7,516	1,270	305	2,020	947
5	1,896	271	319	352	294
6	8,749	1,353	741	935	124
7	6,675	977	342	1,088	275
8	8,619	1,762	378	355	263
Countywide	**55,094**	**9,135**	**2,766**	**8,504**	**2,581**

	Slot Allocation			
	Full Service Partnership			
Service Area	Child (7/10/2015)	TAY (6/30/2015)	Adult (6/26/2015)	Older Adult (6/30/2015)
1	50	43	155	54
2	265	156	586	108
3	252	165	503	134
4	248	219	608	101
5	27	59	232	28
6	362	258	735	40
7	245	153	390	82
8	314	238	1,069	118
Countywide	8	9	207	44
TOTAL	**1,771**	**1,300**	**4,485**	**709**

2. What is the plan for underserved areas to catch up with resources?
   The MHSA 3 Year Plan which will be initiated in September will review population data, service data and trends to address under-served areas of the County.

3. Unspecified concern about services at LAMP

4. Request for 5 peer staff at each directly operated or contracted peer provider:
   a. Senior community worker
   b. community worker
   c. Mental health advocate
   d. Co-Occurring Disorders Mental health advocate
   e. Opportunities for peer internships

5. Request for services providers in Service Area 6
   On-line provider directory link attached to transcript of public hearing

6. Wellness Center locations and description
   See attachment for locations of Wellness Centers and Client Run Centers. Note that there is an active solicitation for Client Run Centers in Service Areas 3 and 6.
   There are no TAY specific Wellness Centers. However, the TAY System of Care provides the Wellness Centers with consultation, linkage and resources through the TAY Navigation Team. For Fiscal Year 14-15, the Unique Client Count of TAY served in the Wellness Centers was 5,397. For Fiscal Year 15-16 the count is 5,209 TAY served.

7. How many TAY mobile units are there for Service Area 6?
   There are no TAY specific mobile units for any of the Service Areas (including SA 6). However, the TAY Navigation Team works closely with the SB82 teams and mobile response teams to provide age specific consultation, outreach, engagement, and linkage to needed resources for TAY youth. The TAY Navigation Team consists of Master's Level Clinicians and Bachelor's level Housing Specialists. Each of the 8 Service Areas has a TAY Navigation Team assigned. The primary role of the Navigation Team is to assist TAY youth by navigating them through the various human services systems in order to achieve effective linkages to needed mental health, housing, and other essential services.

8. What is the target population for TAY?

   The target population for TAY is youth 16 to 25 years of age who are Severely Emotionally Disturbed (SED) and/or Severely and Persistently Mentally Ill

(SPMI). The TAY System of Care has identified a number of priority TAY populations to receive these services; along with a specific emphasis on outreaching and engaging TAY who are currently unserved and underserved. These priority populations include the following:

1. TAY struggling with substance abuse disorders
2. TAY who are homeless or at-risk of homelessness
3. TAY aging out of the children's mental health, child welfare, or juvenile justice systems
4. TAY leaving long-term institutional care
5. TAY experiencing their first episode of major mental illness

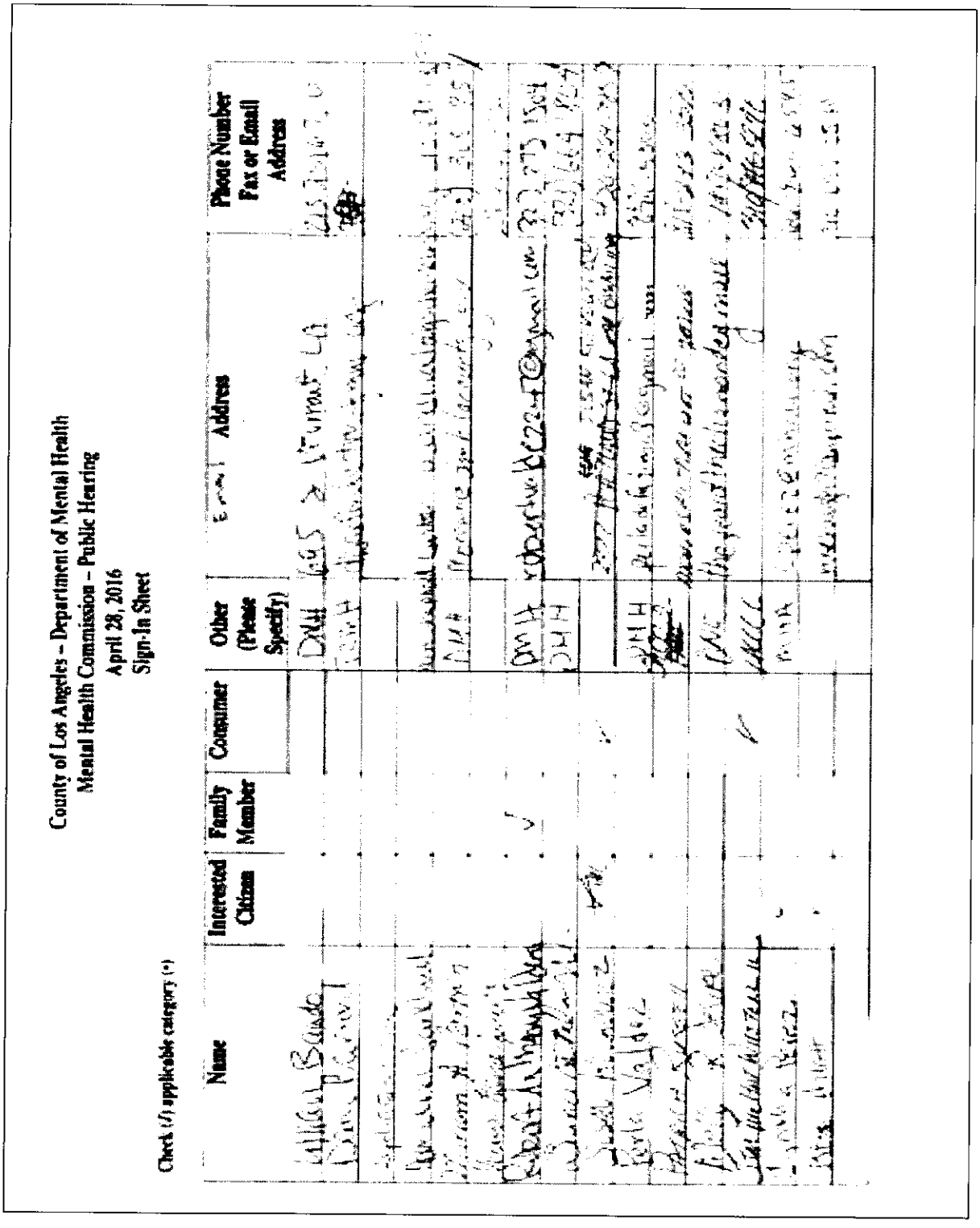
9. Where can I find PEI services in my community?
   We are going to add to the Annual Update website information on how to access our mental health service delivery system

10. Request for employment specialist positions to be placed in each program.

County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
April 28, 2016
Sign-In Sheet

Check (✓) applicable category (•)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Email Address	Phone Number Fax or Email Address
Carol Phillips	yes			LACDMH	DMH	
Iliana Navarro	yes			LACDMH	DMH	
[illegible]			✓	LACCS		
Phyllis Colo			✓	LACCS		
Carlos-Ludena	yes				celzco@[illegible].com	~~[illegible]~~
Andrew Keshk	yes					
Neil McGuffin				LTSC		[illegible]
Rosy Tellez				Contract Provider WCIL		[illegible]
Steve McNally	Y	Y	Y		stmcnally1@gmail.com	[illegible] 714-600-[illegible]
Susan Li	Y	Y	Y	JSN 721	susan.li@sou721.org	213 304-5792
Maria Tan					[illegible]@yahoo	
Dorothy Banks	~~[illegible]~~		X		dbanks0813@yahoo.com	
Eddie Lamon		X			Eddielamon@[illegible].com	
Alejandra Torres		X			[illegible]@gmail.com	[illegible]
[illegible]		X			[illegible]	



County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
April 28, 2016
Sign-In Sheet

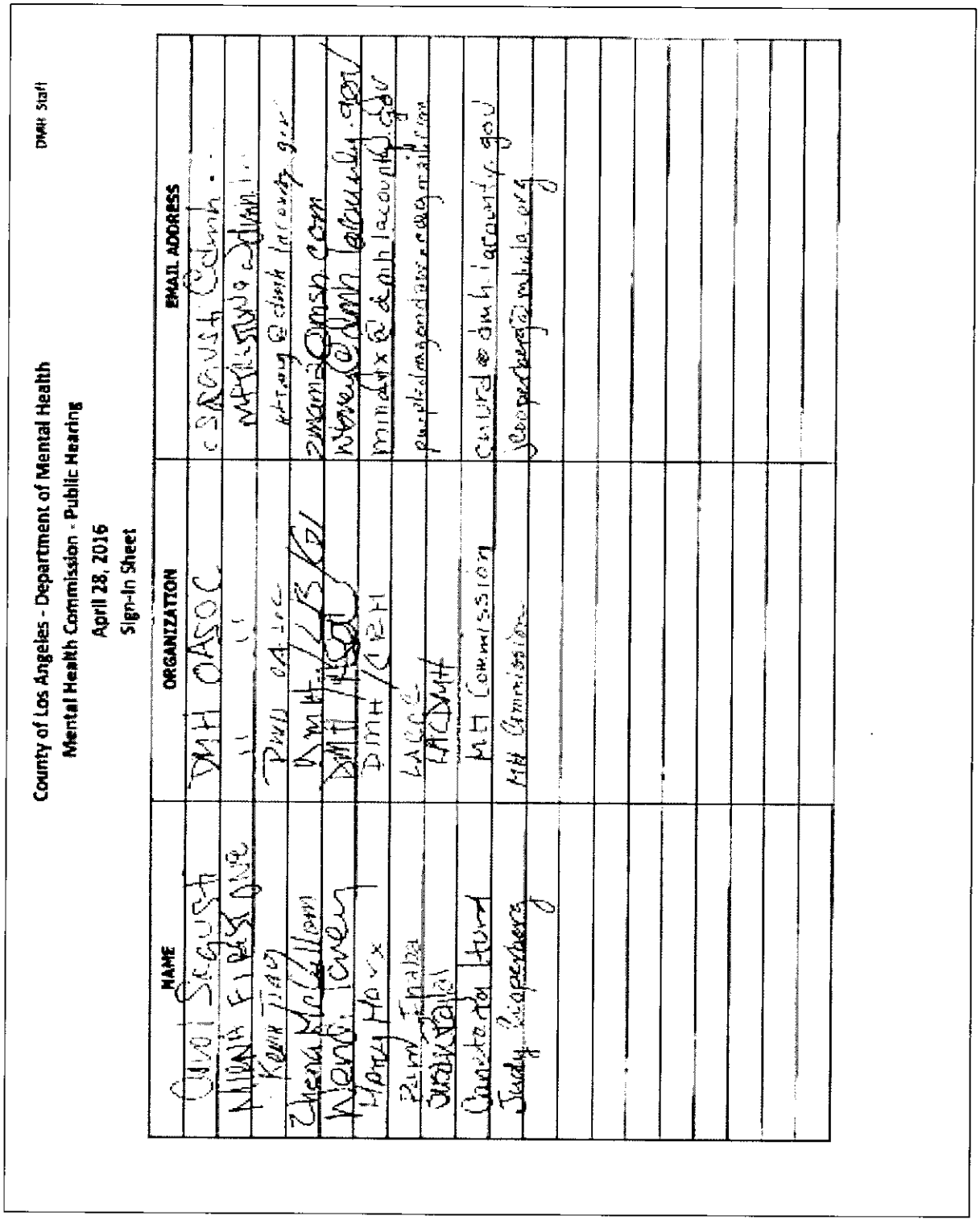
Check (√) applicable category (*)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Address	Phone Number Fax or Email Address
				DMH		
				DMH		
				DMH		
				DMH		

County of Los Angeles – Department of Mental Health
Mental Health Commission – Public Hearing
April 28, 2016
Sign-In Sheet

Check (✓) applicable category (•)

Name	Interested Citizen	Family Member	Consumer	Other (Please Specify)	Email Address	Phone Number Fax or Email Address
Raul Flores	yes					[illegible]
[illegible] Montan[illegible]	yes					(213) [illegible]-3719
[illegible]						
[illegible]	yes				5715 [illegible] AVE	(323) 541-7214
[illegible] Cohen	yes				jcohen@[illegible].org	
[illegible]	yes	yes	yes	[illegible]	[illegible] .com	562-507-9030
[illegible]					[illegible]	
Haydee Guevara	yes	yes			[illegible]@yahoo.com	818 939 48XX
[illegible]			✓		wellness[illegible]@[illegible].com	[illegible]



County of Los Angeles - Department of Mental Health

Mental Health Commission - Public Hearing

April 28, 2016

Sign-In Sheet

DMH Staff

NAME	ORGANIZATION	EMAIL ADDRESS
Carol Sagusti	DMH OASOC	csagusti@dmh...
Mirna Firestone	" "	mfirestone@dmh...
Kenn Tang	DMH OASOC	ktang@dmh.lacounty.gov
Zhena McCallom	DMH/LB/GI	zmam2@msn.com
Wendi Tovey	DMH/HSA	wtovey@dmh.lacounty.gov
Mary Marx	DMH/CRH	mmarx@dmh.lacounty.gov
Pam Enaba	LACCC	purpledragondaw...@gmail.com
Susan Rajal	LACDMH	
Canetaria Hurd	MH Commission	churd@dmh.lacounty.gov
Judy Cooperberg	MH Commission	jcooperberg@mhala.org

DMH Staff

County of Los Angeles - Department of Mental Health
Mental Health Commission - Public Hearing
April 28, 2016
Sign-In Sheet

NAME	PROGRAM	EMAIL ADDRESS
Kathleen Piche	DMH PIO	kpiche@dmh.lacounty.gov
Cindy Rubin	DMH	CRubin@dmh
Val Curtis	DMH	VCurtis@dmh
Phyllis Griddine	DMH	PGT@dmh
David Zippin	DMH	dzippin@dmh.lacounty.gov
Reina Turner	CHEERD	rturner@dmh.lacounty.gov
M.C. Harris	DMH-TAY	mcharris@dmh.lacounty.gov
Mary Romero	TAY	
[illegible]	DMH-ASOC	
[illegible]	DMH SAS Admin	[illegible]@dmh.lacounty.gov
Sandra Jackson	DMH	Sandra.Jackson@[illegible].com
[illegible]	DMH	[illegible]@dmh.lacounty.gov
Richard Espinosa	SUP. KNABE	RESPINOSA@LACBOS.ORG
Kara Tagudin	DMH MHA Imp	ktagudin@dmh
Alex Silva	" "	asilva@dmh

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

Service Area 1 **Adult Navigator - Angela Coleman (661) 223-3813**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Antelope Valley MHC 251 East Avenue K-6, Unit H Lancaster 93535 Tel. (661) 974-8400 Fax. (661) 729-2186	**7756A**	D/O	A. Christina Dedeaux, adedeaux@dmh.lacounty.gov Community Service Coulsel or Elizabeth Marsh emarsh@dmh.lacounty.gov	JoEllen Perkins, DC
Antelope Valley MHC 345-A East Avenue K-6 Lancaster 93535 Tel. (661) 723-4260	**1904**	D/O		JoEllen Perkins, DC
Palmdale MHC 1529 E. Palmdale Blvd, Ste. 150 Palmdale, 93550 Tel. (661) 575-1800 Fax. (661) 265-6025	**7386**	D/O	Mary Camacho-Fuentes	Mary Camacho-Fuentes, PH JoEllen Perkins, DC
Service Area 2 **Adult Navigator - Darrell Scholte (818) 610-6705**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
ACT Health & Wellness Outpatient 9003 Reseda Blvd., Suite 103 Northridge, 91324 Tel. (818) 465-9368	**7927**	LE	Greg Erdosi gerdosi@topangawest.com Michelle Logvinsky mlogvinsky@hotmail.com	Megan Mcdonald meganmcdonaldosyd@gmail.com
Didi Hirsch 1540 East Colorado Blvd., Glendale, 91205 Tel. (310) 751-5304 Fax. (818) 243-5431	**7812**	LE	Veronica Faiad vfaiad@didihirsch.org	Rachel Marks rmarks@didihirsch.org Program Director 310 751-5324
Hillview 12450 Van Nuys Blvd Pacoima, 91331 Tel. (818) 896-1161, ext., 271	**7068**	LE	Norma Franco nfranco@hillviewmhc.org	Aileen Garibyan, Prog. Director agaribyan@hillviewmhc.org
San Fernando MHC 10605 Balboa Blvd, Suite 100 Granada Hill, 91344 Tel. (818) 896-1161 ext. 292 Fax (818) 896-1462	**7760**	D/O	Maria Panduro-Morales mpanduromorales@dmh.lacounty.gov Tel. (818) 832-2400	Dina Duton, PH Lisa Wong, DC
San Fernando Wellness Center 10605 Balboa Blvd, Suite, 100 Granada Hill, 91344 Tel. (818) 832-2400 Fax. (818) 832-2567	**6840**	D/O	Carol Simpson CSimpson@dmh.lacounty.gov David Mcgreary Maria Panduro-Morales mpanduromorales@lacounty.gov	Lisa Wong, DC
San Fernando Valley CMHC (Victory Wellness Center) 14515 Hamlin Street, Suite 102 Van Nuys, 91411 Tel. (818) 989-7475 Fax. (818) 908-2434	**7235**	LE	Melissa Bratcher mbratcher@sfvcmhc.org Manar Danabren mdanabren@sfvcmhc.org	Melissa Argueta, Program Manager margueta@sfvcmhc.org

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

Santa Clarita MHC 23501 Cinema Drive, Suite 210 Valencia, 91355 Tel.: (661) 288-4800 Fax: (661) 254-3094	1905	D/O	Sabrina Barscheski	Michelle Majors, PH
Topanga West 22115 Roscoe Blvd Canoga Park, 91304 Tel.: (818) 884-8100 Fax: (818) 884-7808	7283	LE	Greg Erdosi gerdosi@topangawest.com Michelle Logvinsky mlogvinsky@hotmail.com	Megan Mcdonald meganmcdonaldosyd@gmail.com
West Valley MHC 7621 Canoga Avenue Canoga Park, 91304 Tel.: (818)598-6900 Fax: (818)595-6977	6841	D/O	Suzanne Holland	Jesus Romero, Jr.
Service Area 3 **Adult Navigator - Eugene Marquez (626) 471-6535**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Arcadia MHC 334 Live Oak Ave. Arcadia, 91006 Tel.: (626) 821-5858	1917	D/O	Elizabeth Gross	Elizabeth Gross, PH
Arcadia Wellness Center 301 E. Foothill Blvd., Suite 100 Arcadia, 91006 Tel.: (626) 821-5858 Fax:(626) 471-3575	7777A	D/O	Elizabeth Zimmerman ezimmerman@dmh.lacounty.gov	Elizabeth Gross, PH
Bridges 11927 Elliot Ave. El Monte, 91732 Tel.: (626) 350-3304 ext. 540 Fax: (626) 350-0756	7595	LE	Robyn Sheiniuk rsheiniuk@bridgesrehab.org	
ENIS 160 S. Seventh Ave. La Puente, 91744 Tel.: (626) 961-8971 Fax: (626) 961-6685	7173	LE	Adriana Medrano amedran@ehrs.com Caroline Alvarez calvare@ehrs.com	Fermin Muro, Program Director fmuro@ehrs.com Maria Carmichael-Regional Director mcarmic@ehrs.com
Pacific Clinics **Family Services** 66 Hurlbut St. Pasadena, 91105 Tel.: (626) 441-4221 ext. 310 Fax: (626) 799-1009	1974	LE	Audrey Read Brown abrown@pacificclinics.org Barbara Rappaport, Prog. Coord. brappapo@pacificclinics.org Christopher Lopez chlopez@pacificclinics.org	Laura Pancake LPancake@pacificclinics.org Connie Sun csun@pacificclinics.org

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

Pacific Clinics **Asian Pacific Family Center** 6353 E. Valley Blvd Rosemead, 91770 Tel. (626) 287-2988 Fax. (626) 287-1937	7101	LE	Hua Wen hwen@pacificclinics.org Winnie Hsien thsien@pacificclinics.org	Anne Wong awong@pacificclinics.org Joice Fong jfong@pacificclinics.org
Pacific Clinics **Sierra Family Center** 1160 South Grand Ave Glendora, 91740 Tel. (626) 335-5980 Fax. (626) 335-5989	7380	LE	Judy Grover jgrover@pacificclinics.org	
Prototypes' Wellness Center 2533 E. Colorado Blvd, Suite 100 Pasadena, 91107 Tel. (626) 792-2512	7370	LE	Rebecca Medina Snyder rsnyder@prototypes.org	James Heely jheely@prototypes.org (626) 577-2261
Social Model Recovery Systems 508 S. 2nd Ave. Covina, 91723 Tel. (626) 974-8133	7710	LE	Christopher Abernathy chrisa@socialmodel.com	Christopher Abernathy chrisa@socialmodel.com
Service Area 4 **Adult Navigator - Phyllis Moore-Hayes (213) 922-8129** **Supervisor Nancy Weiner (323) 671-2612**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Downtown MHC 529 S. Maple Ave Los Angeles, 90013 Tel. (213) 430-6700 Fax. (213) 895-6266	70578	D/O	Lynne Burroughs Lburroughs@dmh.acounty.gov Claudia Fierro cvfierro@dmh.acounty.gov	Naned Guirguis, PH
Gateways 433 N. Hoover St. Los Angeles, 90004 Tel. (323) 644-2026 ext. 261 Fax. (323) 644-2036	6757	LE	Bill Donnelly bdonnelly@gatewayshospital.org Linda Kaye lkaye@gatewayshospital.org	
Hollywood MHC 1224 N. Vine St. Los Angeles, 90038 Tel. (323) 769-6100	1909	D/O	Perla Garcia	Barbara Cienfuegos Engleman, PH
Hollywood Wellness Center 5000 Sunset Blvd. 6th F Los Angeles, 90027 Tel. (323) 671-2600 Fax. (323) 913-4045	7739	D/O	Karin Bonwitt Jessica Guzman	Barbara Cienfuegos Engleman, PH
LAMP 619 E. 5th St Los Angeles, 90013 Tel. (213) 537-0822 x 236 Fax. (213) 537-0827	7202	LE	Brooke Slusser BrookeS@lamcommunity.org	Francisco Carrillo FranciscoC@lamcommunity.org

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

Northeast MHC 5321 Via Marisol Los Angeles, 90042 Tel. (323) 478-8200	**1914**	D/O	Anthony Alvarado	Anthony Alvarado, PH
Northeast Wellness Center 5564 N. Figueroa St. Los Angeles, 90042 Tel. (323) 341-5100 Fax. (323) 254-3950	**7765A**	D/O	Carla Diaz	Anthony Alvarado, PH
Pacific Clinics-Portals 2500 Wilshire Blvd., Suite 704 Los Angeles, 90057 Tel. (213) 639-2660 Fax. (213) 388-4805	**7677**	LE	Cherie Harder charder@pacificclinics.org	
Special Services for Groups-APCTC 1310 Wilshire Blvd Los Angeles, 90017 Tel. (213) 483-3000	**7517A**	LE	A. Choi achoi@apcts.org Rebecca Yu rson@apcts.org	Elvia Sedeviia equineas@apcts.org
Service Area 5 **Adult Navigator - Geraldine Perkins (323) 482-6612**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Didi Hirsch 4760 S. Sepulveda Blvd. Culver City, 90230 Tel. (310) 390-6612 x 220 Fax. (310) 398-5690	**1973**	LE	Rachel Marks rmarks@didihirsch.org	Rachel Marks rmarks@didihirsch.org
Edmund D. Edelman MHC 11080 W. Olympic Blvd, 4th F Los Angeles, 90064 Tel. (310) 966-6500	**1906**	D/O	Dr. Nilsa Galindo, PH	Jacqueline Wilkinson, DC
Edmund D. Edelman **Westside MHC** 11303 W. Washington Blvd. Suite 200 Los Angeles, 90066 Tel. 310-481-3200 Fax. 310-915-8579	**7765**	D/O	Sherwood Brown	Dr. Nilsa Galindo, PH Jacqueline Wilkinson, DC
Service Area 6 **Adult Navigator - Margarita Cabrera (323) 788-2425**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Augustus Hawkins **Mental Health Center** 1720 E. 120th St. Los Angeles, 90059 Tel. (310) 668-4803 (310) 223-0712	**6864**	D/O	Lois Brooks 310-668-3965	Ann Marie Aviello, PH

Wellness & Client Run Centers

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

Compton MHC 921 E. Compton Blvd Compton, 90221 Tel. (310) 668-6800 Fax. (310) 223-0694	**1938Y**	D/O	Satoko Luce (Coco)	Angela Shields, acting PH
Exodus Recovery 8513 S. Vermont Ave Los Angeles, 90044 Tel. (323) 942-8475 Fax. (323) 967-0180	**7385**	LE	Pollyanne Hornbeck phornbeck@exodusrecovery.com	Danny Mallory dmallory@exodusrecovery.com
Kedren MHS 4211 S. Avalon Blvd Los Angeles, 90011 Tel. (323) 233-0425 ext. 265 Fax. (323) 432-3186	**7080**	LE	Berta E. Ortiz, Ph.D b_ortiz@kedrenmentalhealth.org Yoonie Lee Y_lee@kedren.org	Alann Salvador A_salvador@kedrenmentalhealth.org
Pacific Clinics **Portals Community Connection** 3881 S. Western Ave Los Angeles, 90062 Tel. (323) 290-4374 (323) 290-4349 Fax. (323) 293-8159	**7690**	LE	Marie Barros mbarros@pacificclinics.org	Shararen Ghedari sghedari@pacificclinics.org Tel. (323) 290-4374 Fax. (323) 293-8159
SCHARP 5201 S. Vermont Ave. Los Angeles, 90037 Tel. (310) 631-8004 Fax. (323) 731-2677	**7242**	LE	Julie Elder julie.elder@scharpca.org Dolly Allison dolly.allison@scharpca.org	Shawanda Crawford shawanda.crawford@scharpca.org 323-731-2677
Exodus Wellness Center 11905 Central Ave., 305 Los Angeles, 90059 Tel. (323) 312-0145 Fax. (323) 312-0188	**7774**	LE	Danny Mallory DMallory@exodusrecovery.com	
West Central MHC 3751 Stocker St Los Angeles, 90008 Tel. (818) 610-6700 Fax. (323) 292-0053	**1908**	D/O	Christina Auer	Ruth Burgner-Gibbons-PH Yolanda Whittington- DC
Service Area 7 **Adult Navigator - Alicia Ibarra (213) 738-6150**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
American Indian Counseling Center 17707 S. Studebaker Rd., Suite 208 Cerritos, 90703 Tel. (562) 402-0677	**7421**	D/O	Melanie Cain	Melanie Cain, PH Ana Suarez, DC
CA Hispanic Commission 10012 Norwalk Blvd., Suite 140 Santa Fe Springs, 90670 Tel. (562) 941-2537 Fax. (562) 946-6028	**7722c**	LE	Diana Soto dsoto@cncada.org	Germeen Dupleessis gdupleessis@cncada.org

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

ENKI 1436 Goodrich Blvd Commerce, 90022 Tel: (323) 201-3910 (323) 201-3911	**7253**	**LE**	Jeneve Nunez, Sub jnunez@enki.com	Lillian Morales, Prog. Director lmorales@enki.com Tel: (323) 725-1337
Pacific Clinics 1172 E Telegraph Rd, Bldg A Santa Fe Springs, 90670 Tel: (562) 948-8455 Fax: (562) 948-4807	**7421**	**LE**	Annette Clayton aclayton@pacificclinics.org	Mae Mikuscheminkus@pacificclinics.org
Rio Hondo MHC 17707 S. Studebaker Rd Cerritos, 90703 Tel: (562)-402-0688 Fax: (562) 402-3031	**1930**	**D/O**	Yucel Tat (Wendy) ytat@dmh.lacounty.gov	Adela Kaiso, PH
Rio Hondo De Bienestar 2677 Zoe Avenue, Suite 301, Huntington Park, 90255 Tel: (323) 826-8300 Fax: (323) 277-7862	**7813**	**D/O**	Elizabeth Cook Evelio Franco	Adela Kaiso, PH
Service Area 8 **Adult Navigator - Jenny Nguyen (562) 435-2257**				
Agency Name	**Prov. #**	**DO/LE**	**Primary Contact**	**Program Manager/Director**
Coastal Asian Pacific MHC 14112 S. Kingsley Dr. Gardena, 90249 Tel: (310) 217-7312 Fax: (310) 352-3111	**7064**	**D/O**	Helen Chang, PH	Youngsook Kim-Sasaki - DC
Didi Hirsch 323 N. Prairie Avenue, Suite 150 Inglewood, 90301 Tel: (310) 390-6612 x 2020 Fax: (310) 680-7062	**7208W**	**LE**	Rachel Marks PhD rmarks@didihirsch.org	Rachel Marks PhD rmarks@didihirsch.org
Exodus Recovery 923 South Catalina Ave. Redondo Beach, 90277 Tel: (310) 792-5454 Fax: (310) 792-5462	**7248**	**LE**	Kristi Knoerzer kknoerzer@exodusrecovery.org Cynthia Harbour charbour@exodusrecovery.org	Robert Duclos, Ph.D rduclos@exodusrecovery.com
Harbor-UCLA 1000 W. Carson St., Bldg D-5 Torrance, 90502 Tel: (310) 222-3151	**6859**	**D/O**	Stephen Jacobson	Sandra Kramer,PH Tel: (310) 222-3151
Harbor-UCLA 21730 Vermont Ave, Suite 210 Torrance, 90502 Tel: (310) 781-3403 (310) 781-3400	**7758**	**D/O**	Eva Mendoza	

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
WELLNESS CENTERS

HealthView 921 S. Beacon St. San Pedro, 90731 Tel. (310) 984-3065 ext. 3149	7092	LE	Maura Papazian maurap@hvi.com	
Long Beach MHC 1975 Long Beach Blvd Long Beach, 90806 Tel. (562) 599-9280 Fax. (562) 218-0402	1927	D/O	John Lewis jlewis@dmh.lacounty.gov Gwen Lewis-Reid glewisreid@dmh.lacounty.gov	Emilia Ramos, PH
Long Beach MHC 4510 E Pacific Coast Hwy Long Beach, 90804 Tel. (562) 346-1130 Fax. (562) 218-0402	7207	D/O	Julie Leevarinpanich	Derek Hsien, PH
Mental Health America 830 Atlantic Ave. LongBeach, 90813 Tel. (562) 285-0149 ext. 223	7576	LE	Brenda Hamamoto Bhamamoto@mhsla.org	
San Pedro MHC 150 W. 7th St. San Pedro, 90731 Tel. (310) 519-6100 Fax. (310) 732-5812	1928	D/O	Belen Williams	Kathrine Lundy, PH
South Bay MHC 2311 W. El Segundo Blvd. Hawthorne, 90250 Tel. (323) 241-6730	1935	D/O	Jennifer Bailey	Jennifer Bailey - PH
South Bay MHS Wellenss Center 1300 W. 155th St., Suite 103 Gardena, 90247 Tel. (310) 512-8100 Fax. (310) 324-2111	7758	D/O	Sung Hye Yu (Sunny)	Jennifer Bailey - PH

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
CLIENT RUN CENTERS

Service Area 1 **Adult Navigator - Angela Coleman (661) 223-3813**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
Discovery Resource Center 1609 E. Palmdale Blvd, Suite G Palmdale, 93550 Tel: (661) 726-2850 Fax: (661) 947-1595	7352	Con	Cynthia Perez cperez@mhsla.org (661) 947-1595	
Service Area 2 **Adult Navigator - Darrell Scholte (818) 610-6705**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
San Fernando Valley CMHC **(Victory Clubhouse)** 14515 Hamlin St, Suite 102 Van Nuys, 91411 Tel: (818) 989-7475	7235	Con	Melissa Argueta margueta@sfvcmhc.org	Roger Seward rseward@sfvcmhc.org
Service Area 4 **Adult Navigator - Phyllis Moore-Howes (323) 671-2624**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
SHARE! (Emotional Health Anonymous) 425 South Broadway, 2nd floor Los Angeles, 90013 Tel: (213) 213-0109 Fax (213) 213-0108	7773	Con	Patrick Chavez Patrick@shareselfhelp.org	
Special Services for Groups-BACUP 1730 W. Olympic Blvd, Suite 500 Los Angeles, 90115 Tel: (213) 368-1888 Fax: (213) 368-6588	7112	Con	Andy Posner aposner@bacup.net (Cell) 213-447-1841 Winston Tate wtate@bacup.net	

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH
ADULT SYSTEMS OF CARE
CLIENT RUN CENTERS

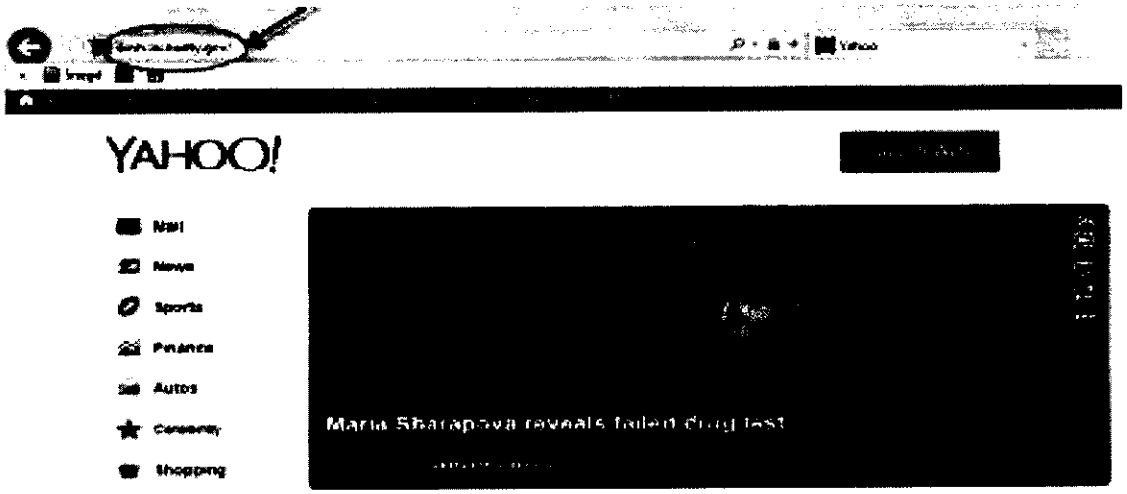
Service Area 5 **Adult Navigator - Geraldine Perkins (310) 482-6612** **Adriane Hughes (310) 482-6616**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
SHARE! 6666 Green Valley Circle Culver City, 90230 Tel: (310) 846-5270 Fax (310) 846-5278	7596	Con	Camille Dennis camille@shareselfhelp.org Jason Rodson jason@shareselfhelp.org	
Step Up On Second 1328 Second St Santa Monica, 90405 Tel: (310) 394-6889 Fax (310) 394-6838	7099	Con	Golena Aktah Golena@stepuponsecond.org Tel: (310) 394-6889 x 1653 Lance Moore lance@stepupatsecond.org	
Westside Center for Independent Living 12901 Venice Blvd Los Angeles, 90066 Tel: (310) 390-3611	7062	Con	Anastasia Badgalupo anastasia@wcil.org	
Service Area 7 **Adult Navigator - Alicia Ibarra (213) 739-6150**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
CA Hispanic Commission 10012 Norwalk Blvd, Suite 140 Santa Fe Springs, 90670 Tel: (562) 941-2537 Fax: (562) 946-6028	7722	Con	Diana Soto dsoto@chcada.org	
Project Return Peer Support 2677 1/2 Zoe Ave Huntington Park, 90255 Tel: (323) 312-0640 Fax: (323) 312-0643	7013	Con	Angelica Garcia agarcia@prpsn.org	P.A.I.T.H Center Sharon Doris
Pacific Clinics 11721 Telegraph Rd, Bldg. A Santa Fe Springs, 90670 Tel: (562) 949-8455 Fax: (562) 946-4807	7194	Con	Arnette Clayton aclayton@pacificclinics.org	
Service Area 8 **Adult Navigator - Jenny Nguyen (562) 435-2257**				
Agency Name	**Prov. #**	**DO/Con**	**Primary Contact**	**Program Manager/Director**
The One In Long Beach, Inc. 2017 E. 4th St. Long Beach, 90814 Tel: (562) 434-4455 Fax: (562) 522-7952	7737C	Con	Deena Abuyounes dabuyounes@centar3.org	

How to Locate
Los Angeles County Department of Mental Health Services

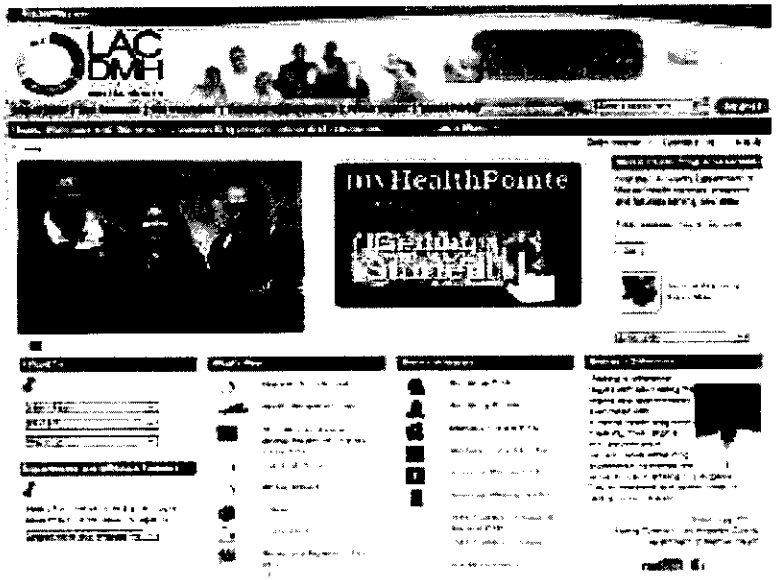
Listed are two ways to search for mental health services in the Los Angeles County provided by the Department of Mental Health:

Option I: This option will link the user directly to the DMH home page.

- **From your internet explorer type http://dmh.lacounty.gov in the address bar and hit enter.**



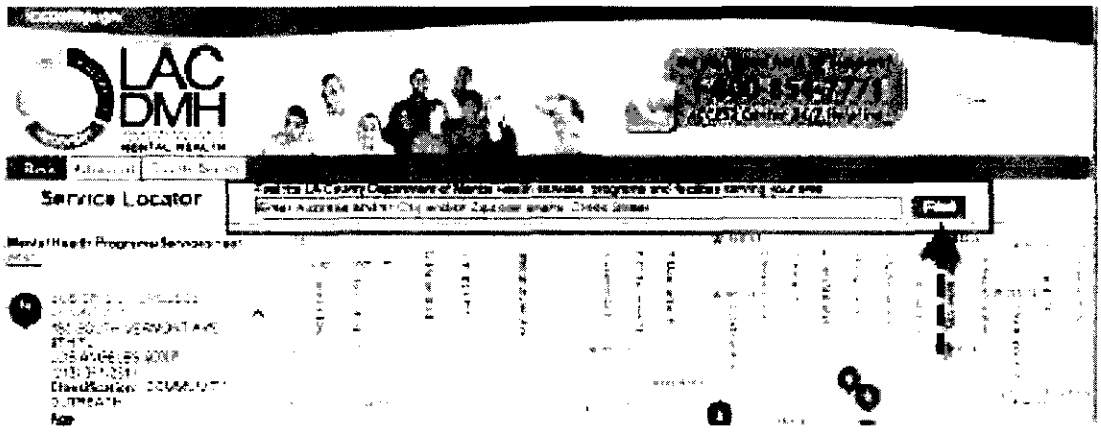
Home page



How to Locate Los Angeles County Department of Mental Health Services
Page 2

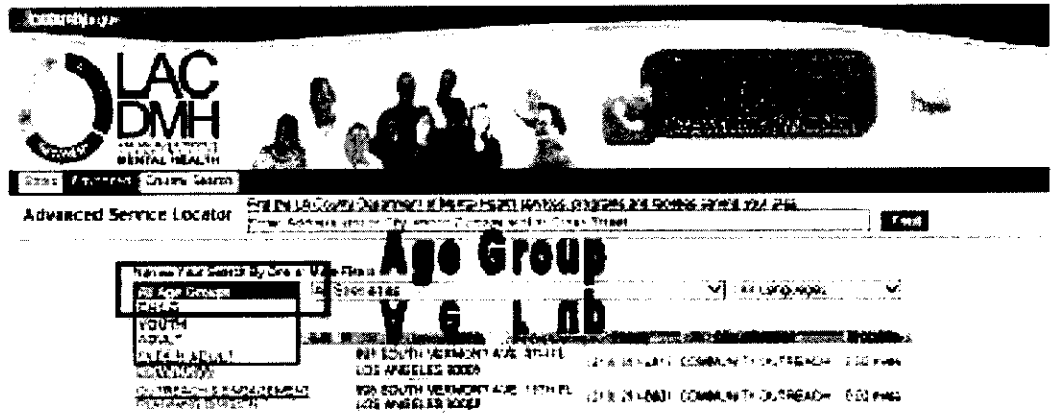
- Enter an address, city or zip code for services, programs and facilities and click "Go".
- If the user does not have an address, city or zip code, click "Go".

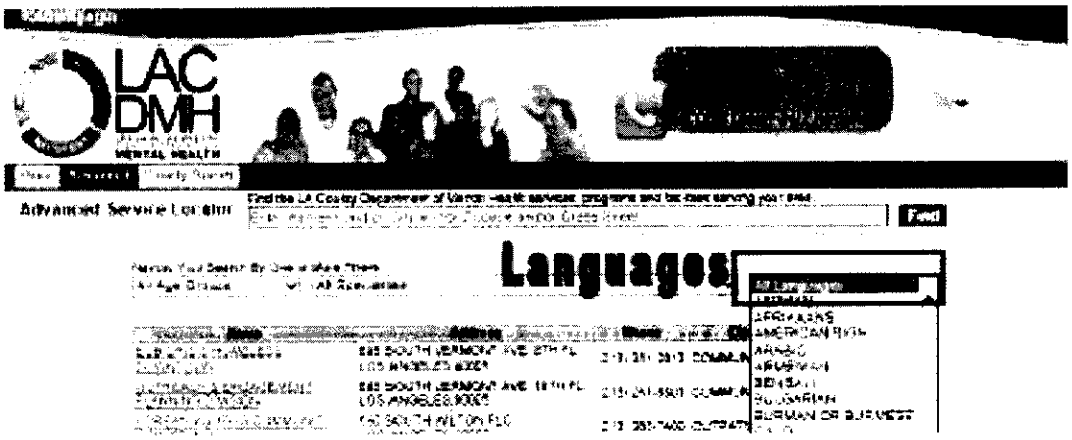
- The user will be directed to a page allowing the user to once again search by address, city, zip code and/or cross street.
- The user will enter the information and click find.



How to Locate Los Angeles County Department of Mental Health Services
Page 3

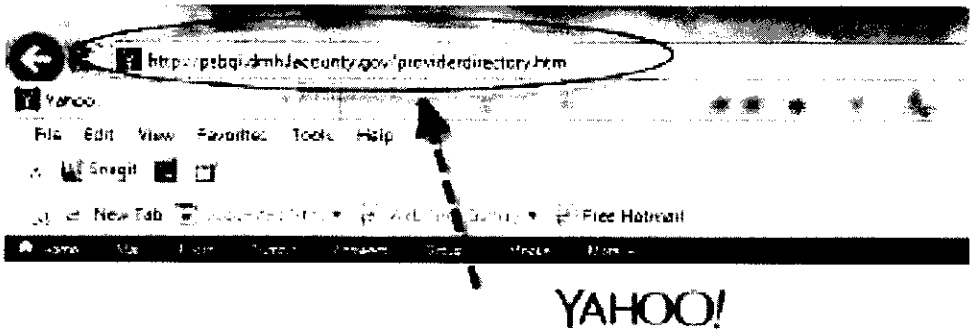
* **The user can conduct an advanced search by selecting a specific age group, program specialty or language.**





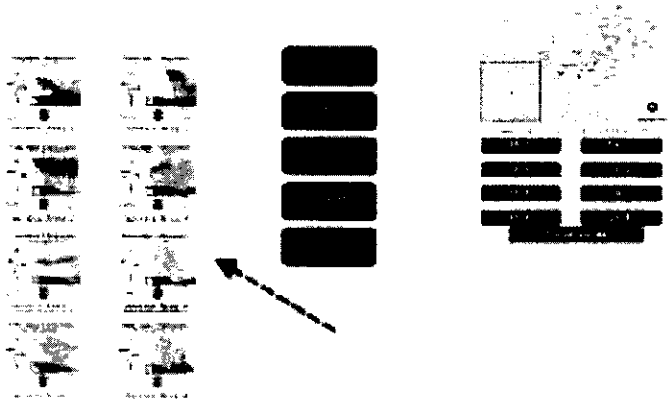
Option II: This option will link the user directly to the Provider Directory Site

* From your internet explorer type http://psbqi.dmh.lacounty.gov/providerdirectory.htm in the address bar and hit enter.

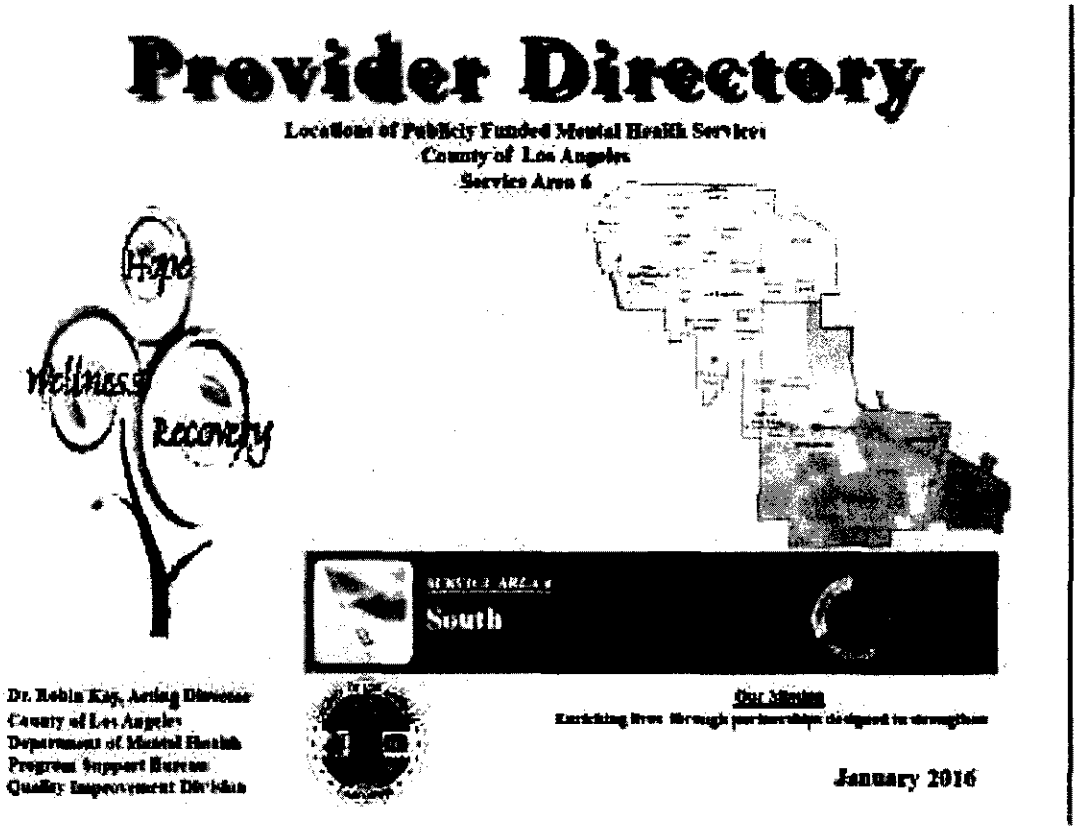


* The webpage will allow the user to click on a service area.

Provider Directory
By Service Areas



- Once the user selects a service area, the user will be directed to a provider directory for the service area.
- The provider directory can be saved as a pdf document.



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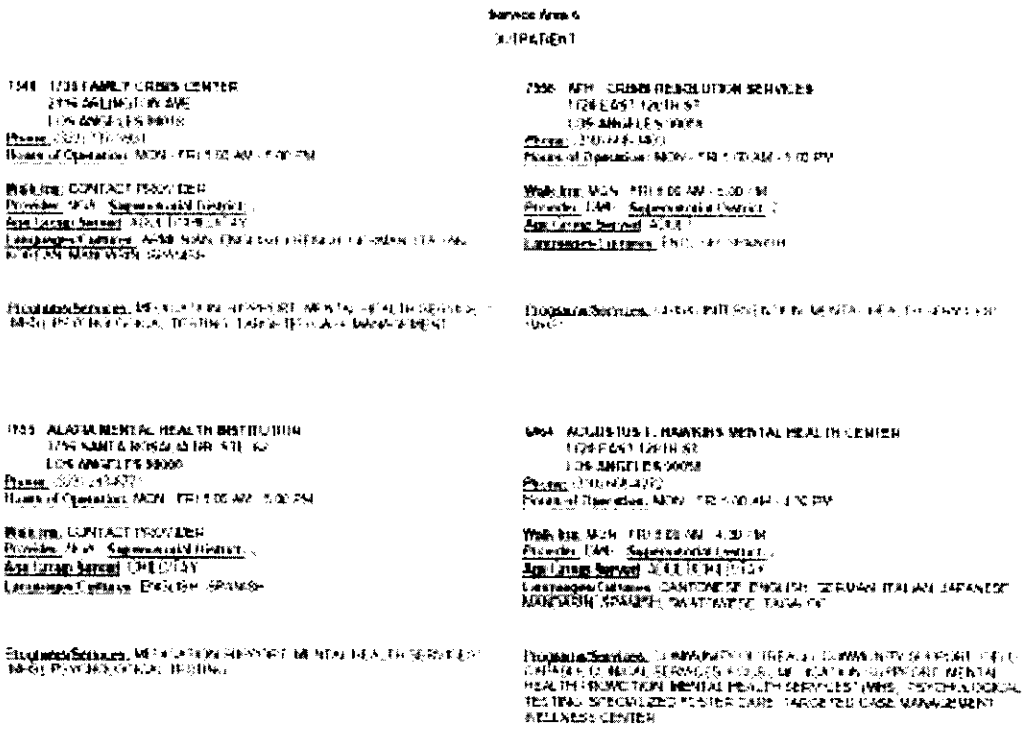
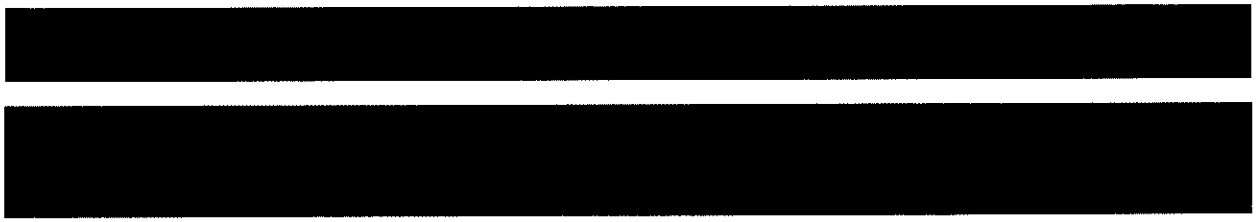
Page 6

- The provider directory is categorized by the type of service: 24 hour/residential, community outreach, crisis services, juvenile justice, and outpatient.