Los Angeles County: Data Notebook 2014

for California

Mental Health Boards and Commissions

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Prepared by California Mental Health Planning Council, in collaboration with: California Association of Mental Health Boards/Commissions, and APS Healthcare/EQRO

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Date: April 20, 2014

To: Chairpersons and/or Directors



Local Mental Health Boards and Commissions

From: California Mental Health Planning Council

Subject: **Instructions for Data Notebook 2014**

We ask that this report be prepared by the MH Board or Commission members. You are the most important resources for identifying program strengths and needs in your community.

On the first page, please fill in the requested information for your county websites:

* Department of Behavioral Health/ Mental Health
* Public reports about your county’s MH services.

Please send a copy of the filled-in first page to the Planning Council along with your final report which contains your answers to the questions in the Data Notebook. Please submit your report within 60 days by email to:

[DataNotebook@cmhpc.ca.gov](mailto:DataNotebook@cmhpc.ca.gov).

Or, you may mail a printed copy of your report to:

* Data Notebook Project
* California Mental Health Planning Council
* 1501 Capitol Avenue, MS 2706
* P.O. Box 997413 Sacramento, CA 95899-7413

Please examine the enclosed information, which will help you discuss the questions in the Data Notebook. We provide examples of recent mental health data for your county. In some figures, the term “MHP” is used to refer to your county’s Mental Health Plan.

Some data comes from APS Healthcare/EQRO, which gave permission to use their figures and tables, prepared for review of each county’s Medi-Cal Specialty Mental Health services. Data in this packet came from the following review cycle:

\_\_X\_\_ Fiscal Year 2013 -- 2014: <http://caeqro.com/webx/.ee85675/>

\_\_X\_\_ Fiscal Year 2012 -- 2013: <http://caeqro.com/webx/.ee851c3/>

For some questions, you will need to consult your local county Quality Improvement Coordinator, and/or Mental Health Director. If you are not able to address all of the questions, just answer the ones you can.

Thank you for your participation in the Data Notebook Project.

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County Name: **Los Angeles** Population (2013): 10,019,365

Website for County Department of Mental Health (MH) or Behavioral Health:

* Dmh.lacounty.gov

Website for Local County MH Data and Reports:

* Dmh.lacounty.gov, click on “About DMH”, click on the Mental Health Services Act (MHSA) tab, then select the “Implementation and Outcomes Division” link.

Website for local MH Board/Commission Meeting Announcements and Reports:

* http://dmh.lacounty.gov/wps/portal/dmh/about\_dmh/mhc

Specialty MH Data from review Year 2013-2014: <http://caeqro.com/webx/.ee85ab0/>

Total number of persons receiving Medi-Cal in your county (2012): 2,984,424

Average number Medi-Cal eligible persons per month: 2,510,108

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 45.6 %

Adults, ages 18-59: 37.8 %

Adults, Ages 60 and Over: 16.6 %

Total persons with SMI[[1]](#footnote-1) or SED[[2]](#footnote-2) who received Specialty MH services (2012): 155,845

Percent of Specialty MH service recipients who were:

Children 0-17: 47.7 %

Adults 18-59: 43.1 %

Adults 60 and Over: 9.2 %

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INTRODUCTION: Purpose, Goals, and Data Resources

This Data Notebook has been developed for the use by the local mental health (MH) boards and commissions by a yearlong workgroup comprised of members from:

* California Mental Health Planning Council (CMHPC)
* California Association of Local Mental Health Boards and Commissions (CALMHB/C)
* APS Healthcare/ EQRO (External Quality Review Organization)

Our plan is for the Data Notebook to meet these goals:

* assist local boards to meet their mandates to review the local county mental health systems, identify unmet needs, and recommend improvements.
* provide a professional format for submitting reports to their local Board of Supervisors, and/or their county Director of Mental Health Services.
* function as an educational tool for local boards, whose members have varying levels of skills, frequent turnover, and need ‘refresher’ training about using data.
* help the CMHPC fulfill its mandates to review and report on the public mental health system in California, which also helps provide evidence for advocacy.

Data reporting drives policy, and policy drives funding for programs. But the data must be both recent and available to the public, or else it is not useful. So, the CMHPC will provide examples of local data from current public reports. We focus on two broad areas: (1) evaluation of program performance, and (2) indicators of client outcomes.

We recognize that each county has a unique population, resources, strengths, and needs. Thus, there is no single perfect data source to answer all the important questions one might ask about mental health services. However, the following data resources will help board members answer questions in this Data Notebook:

* experience and opinions of the local mental health board members
* recent reports about county MH programs from APS Healthcare/EQRO
* data you request from your county QI Coordinator and/or Mental Health Director (because CMHPC does not have that data, and it’s not in other public reports)
* client outcomes data provided by California Institute of Mental Health (CiMH) in their analysis of the most recent Consumer Perception Survey.

Some of our data comes from APS Healthcare/EQRO, which kindly gave permission to use their figures and tables, prepared for review of each county’s Medi-Cal Specialty Mental Health services. Those reviews are at: [www.CAEQRO.com](http://www.CAEQRO.com). You may find the full-length EQRO reports helpful because they summarize key programs and quality improvement efforts for each county. They also describe strengths, opportunities for improvement, and changes in mental health programs since the last year.

Understanding changes in local programs can help consumers because of the massive re-organization of mental health services statewide. Some changes have been confusing to clients. The old state Department of Mental Health was eliminated in 2012 and many functions were moved to the Department of Health Care Services. Other changes due to federal health care reform and the Affordable Care Act affect how mental health services are provided, funded, and linked to primary health care or substance use treatment. Also, local counties have adjusted to major challenges.

Remember, this report is about your community, and what you and your stakeholders choose to discuss. Examining the data can indeed “Tell a Human Story.” But quantitative data (numbers) provides only part of the picture, for example:

* measures of whether the quality of program services improve over time
* whether more people from different groups are receiving services
* how many clients got physical healthcare or needed substance use treatment.

The other part of the story gives human context to the numbers. Such qualitative data (narrative, descriptions, or stories) tells more of the story, because we can:

* describe special programs targeted for outreach to specific groups
* examine how the programs are actually implementing their goals
* list concrete steps that are taken to improve services, and
* tell what is being done to increase client engagement with continued treatment.

We hope this project contributes to ongoing quality improvement (QI) in mental health services. We seek constant improvement in our approach to quality because:

* needs change over time,
* all human endeavors are by nature imperfect,
* creativity gives rise to new ideas, and
* we can share examples of successful programs to help other communities.

One question is whether local boards are permitted to provide additional information, besides that requested in this Notebook. We always welcome supplemental reports about successful projects, or which the county administration uses to inform the public. Any additional reports may be attached in an “Appendix,” with the website address (if available). However, we emphasize such extra reports are not required.

Thank you for participating in this project. We hope this Data Notebook serves as a springboard for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

TREATING THE WHOLE PERSON:

Integrating Behavioral and Physical Health Care

Studies have shown that individuals with serious mental illness die, on average, 25 years earlier than the general population.  This information makes improving the physical health of clients of great importance and should be a goal of county mental health departments along with providing effective and appropriate mental health services.  Coordination of care for mental health, substance abuse and physical health is one way of accomplishing the goal.

The California Mental Health Planning Council does not have any data to provide to show how your county’s programs connect clients of mental health services with necessary physical health care. We ask that the local mental health board request information from your county mental health department for any data on numbers (or percent) of total mental health clients who are referred to, or connected with, physical health providers to assess, treat and monitor physical health issues.

If your county has data on numbers or percentages of clients who are also receiving physical health care, please include it in your Data Notebook you submit to the Council.

\_\_\_ Check here if your county does not have such data or information.

**1)  Please describe any efforts in your county to improve the physical health of clients.**

**(Answered by the Innovation Perspective)**

The County of Los Angeles Department of Mental Health has implemented four MHSA Innovation funded program models that integrate mental health, physical health, and substance abuse services. The evaluation of the Integrated Clinic Model (ICM), Integrated Mobile Health Team (IMHT), Integrated Service Management (ISM) and the Peer Run Models will inform future practice and improved integrated care outcomes for Los Angeles County Department of Mental Health Consumers.

**(Answered by Children’s Systems of Care)**

 Children and families enrolled in Child Full Service Partnership (FSP) programs have access to Client Support Services (CSS) funds that provide an opportunity for FSP teams to assist clients with their pursuit of recovery and resiliency goals using approaches designed to balance supportive services with client self-sufficiency. Children’s Systems of Care (CSOC) Administration has worked collaboratively with our Provider Network over the past several years to change practices related to using healthier food options, when using CSS funds. We have diligently supported the use of flex funds to purchase gym memberships, pay enrollment fees for sports and other physical activity related programs, and to cover the cost of educational opportunities such as Diabetes Camp.

CSOC has encouraged our Child FSP programs to collaborate with children’s pediatricians for the purpose of addressing issues related to physical health.

**(Answered by Transition Age Youth Division)**

Full Service Partnerships (FSP) provide an array of services and supports to help individuals make progress on their particular paths to recovery and wellness. Referrals and linkages to appropriate physical health care are provided to clients enrolled with FSP programs. Physical health referrals and information is also provided at Transition Age Youth (TAY) Drop-In Centers to assist youth link with physical health resources.

The Department has also focused on the integration of mental health, physical health, and substance abuse treatment through its Mental Health Services Act (MHSA) Innovations projects.

**(Answered by Adult Systems of Care)**

Los Angeles County Department of mental Health has made tremendous efforts in connecting individuals with Health Home to these entities to ensure health issues are being addressed as well as their mental health issues. Long Beach MHC created a program called the “Care Clinic”, which sees each client who comes in for psychiatry services, not only are the clients seen prior to their psychiatrist appointments by a case manager, but are also provided with basic health screenings upon intake and as needed (i.e. Weight, blood pressure, BMI, etc.). The Care Clinic has been piloted at five (5) directly operated clinics since December 2013 and is currently expanding to the remaining sixteen (16) adult directly operated programs. Each client is also screened for benefits establishment and a hard linkage to their health care provider is made with client present and health appointments are attended with clients when needed. Labs are efficiently ordered and reviewed in the Care Clinic as well, ensuring health issues are identified early and appropriate referrals are made.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

The DMH/DHS Collaboration Program has small teams of mental health staff stationed on a full-time basis within Department of Health Services (DHS) Comprehensive Health Centers (CHC) and Multi-service Ambulatory Care Clinics (MACC). There are currently 7 programs in DHS with plans to open an 8th program this year. The intent of this program is to provide short-term early intervention mental health services in a non-stigmatizing location where many people are comfortable receiving care. Treating common mental health symptoms seen in primary care, specifically depression and anxiety, will improve one’s mental health as well as health status and will facilitate care coordination among providers.

**2)  How does your county address wellness programs to engage and motivate clients to take charge of improving their physical health?**

Examples:

* Exercise
* Nutrition
* Healthy cooking
* Stress management
* Quitting smoking
* Managing chronic disease
* Maintaining social connectedness

**(Answered by the Innovation Perspective)**

Health status improvement is a key indicator of success for Innovation Model programs. Each of the 4 Innovation Models target a specific focal population, wellness strategies have been implemented to engage and motivate individuals to take charge of improving their physical health based on the unique needs of that population. Examples from each model include, but are not limited to the following: An ICM program provides ongoing nutrition and health eating groups to clients to provide tools for clients to maintain a healthy BMI. The IMHT model programs are staffed by a multidisciplinary Assertive Community Treatment (ACT) team that includes a physical health provider to provide street outreach and engage individuals who are homeless and vulnerable due to mental illness, untreated health care need, and/or substance use issue. The ISM Model services are grounded in ethnic communities and have a strong foundation of community based and non-traditional services such as inclusion of faith leaders in outreach to the Cambodian community and the facilitation of Healing Circles for the American Indian community to promote emotional health and wellness. One of the Peer Run Program Model programs has provided an area in their Client Run Center where individuals can measure their weight and blood pressure, and trained Health Navigators are available to help coach and empower individuals with Health related goals.

**(Answered by Children’s Systems of Care)**

As previously stated CSOC Administration promotes healthier habits for children and families. CCS funds have been authorized for the following:

* Funding family gym memberships
* Funding summer camps which promote physical activity and healthier lifestyle choices (dance, diabetes camp, kickboxing, karate, etc.)
* Promoting healthier food choices through nutritional education

**(Answered by Transition Age Youth Division)**

Our TAY Drop-In Centers provide wellness programs that encourage and promote healthy life skills. Groups and resources regarding individual wellness and improving physical health are provided to the youth. The various TAY housing programs also provide psychoeducational groups and referrals focused on improving physical health.

**(Answered by Adult Systems of Care)**

LAC DMH has initiated many “healthy living and wellness recovery oriented” services into the service array available to clients. The Wellness Centers have smoking cessation groups/programs, mindfulness and meditation groups, healthy eating/cooking/shopping, exercise such as yoga and walking, nutrition, meetings with doctors to ask questions about medications and/or medical issues. There has also been assistance in community reintegration and connecting our consumers to their community resources which increases social supports and opportunity to become involved in activities at many levels.

#### NEW CLIENTS: One Measure of Access

One way to evaluate the quality of mental health services outreach is to measure how many clients receive services who have never been part of the service system before (“brand new” clients). Another measure is how many clients return for services after a period of time with no services (“new” clients).

The California Mental Health Planning Council is exploring how each county mental health department defines “new” clients, and how a client is labelled when they return for additional services. This information is important in determining whether your county has a “revolving door,” that is, clients who are in and out of mental health services repeatedly. This data is one indicator of the success of your county’s programs in closing cases appropriately and providing adequate discharge planning to clients.

This data is not currently reported by the counties to the state. The Council does not have data to provide to you. This information should be requested from your county mental health department.

\_\_\_\_ Check here if your county does not have this information.

**3. How does your county define 'new' client for those individuals who have previously received services, but who have not received services for a while? (e.g., 6 months, 12 months, 2 years?)**

**(Answered by QI and Data/GIS Unit)**

We generally don’t run routine client statistics for new clients. In previous years we did something along these lines with Paul Arns and the general consensus was “aged-out” clients = no service in past 120 days. It’s hard to define new unless we look at historical records and match by Name and Client ID to see if they’ve ever been in our system. We don’t have such a table right now but could run it, if needed.

**4.  Please provide any data your county has on the number of 'new' clients last year.  And if you have it, how many of those new clients were brand new clients?  You may need to ask your county mental health department for this data.**

# new children/youth  (0-17 yrs)  \_\_\_\_\_

of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

# new adults (18-59 yrs) \_\_\_\_\_

of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

# new older adults  (60+ yrs)\_\_\_\_\_

of these, how many (or %) are ‘brand new’ clients \_\_\_\_\_

**(Answered by QI and Data/GIS Unit)**

Last FY (12-13) we saw a big surge in clients by nearly 10,000 partly due to conversion of Healthy Way LA clients into MCE. We have never seen this big surge in clients in the past 8 years of TY data. Overall, the increase of new clients between subsequent each FY has been 5,000 or less…generally speaking.

**(Answered by The Older Adult System of Care Bureau)**

The Older Adult System of Care Bureau continues to serve and meet the needs of a growing and diverse population of older adults throughout Los Angeles County. The growth in mental health services and resources for older adults has been modest and the number of older adults served throughout the Los Angeles County Department of Mental Health, continues to increase. During fiscal year (FY) 12/13, 15,637 older adults (unique clients) were served through outpatient Short-Doyle/Medi-Cal facilities. This was a six percent (6%) increase over the previous fiscal year. REDUCING RE-HOSPITALIZATION: Access to Follow-up Care

Sometimes, an individual experiences acute symptoms of mental illness or substance abuse which can result in a brief stay in an acute care hospital.  Receiving follow-up services after discharge from a short-term (3-14 day) hospitalization can be critical to preventing a return to the hospital.

The chart below shows the percentage of people discharged in your county who received at least one service within 7 days of discharge. Also shown is the percentage of those same people who were readmitted to the hospital.  The chart also shows the same information for receiving services and being readmitted to the hospital within 30 days.  Red indicates the numbers for your county and the blue indicates the percentage for the state of California.

**Los Angeles County**:



**6.  Looking at the chart, is your county doing better or worse than the state?  Discuss why (e.g., your county has programming available that specifically ensures a warm handoff for follow-up services).**

**(Answered by QI and Data/GIS Unit)**

The chart shows that LA is doing the same or worse than the State, especially for readmission rate. Our data shows that although we have declined slightly in our 7 day measure of outpatient visit after an inpatient discharge, we have seen overall improvement in number of clients/discharges seen in an outpatient facility after an inpatient discharge. Just the sheer number is a challenge. We have approximately 20,437 annual inpatient discharges for about 16,000 unique clients. The 7 day outpatient visit and 30 day hospitalization measures vary widely by geographic region and age group. In LA County, generally children and youth inpatient measures are a lot better than for adults. For example, 17% youth are readmitted in 30 days as compared with 20% or higher for adults. Given the size of LA County and the complexity of measuring inpatient discharges and readmission, this data should be examined separately for adults versus children.

**7. Do you have any suggestions on how your county can improve follow-up and reduce re-hospitalizations?**

* Reduce inappropriate hospitalizations
* Improve access to effective outpatient follow-up with guaranteed availability of medication assessment at first visit
* Robust patient reminders

**8. What are the three most significant barriers to service access? Examples:**

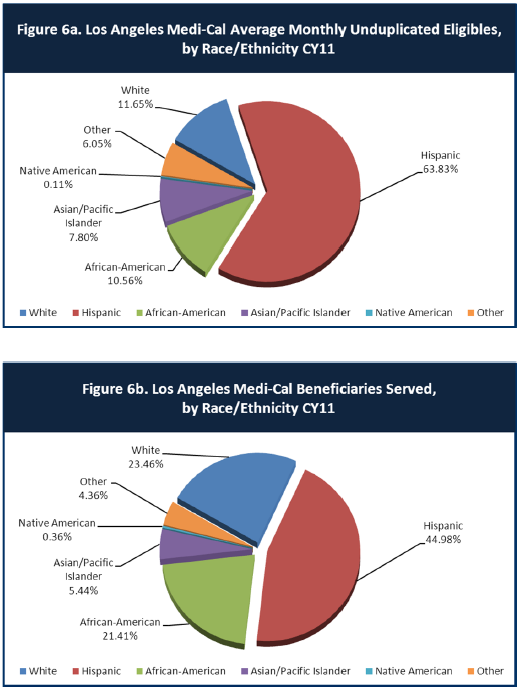
* Transportation
* Specific cultural issues
* Lack of psychiatrists or tele-psychiatry services

##### ACCESS BY UNSERVED AND UNDER-SERVED COMMUNITIES

One goal of the Mental Health Services Act (MHSA) is to reach unserved and underserved communities, especially communities of color. The MHSA promotes outreach to engage these communities in services. If individuals and families in these communities are not accessing services, then we may need to explore new ways of reaching them. Or, we may need to change our programs to meet their mental health needs in ways that better complement their culture.

From data the counties report to the state, we can see how many individuals living in your county are eligible for Medi-Cal, and of those individuals, how many received mental health services. Are you serving the Medi-Cal clients who need your services?

**Los Angeles County**:



**9. Is there a big difference between the race/ethnicity breakdown on the two charts? Do you feel that the group(s) that need services in your county are receiving services?**

**(Answered by Quality Improvement Division, Cultural Competency Unit)**

Yes, there are significant differences between the race/ethnicity breakdown on the two charts. The charts particularly highlight disparities for the Asian/Pacific Islander and Latino populations.

As a means to assess disparities within our system of care, LACDMH monitors and tracks penetration and retention rates based on ethnicity, age group and gender using demographic data specific to each Service Area. Estimates of unmet needs are derived by using penetration rates by Service Area for populations with estimated Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) enrolled in Medi-Cal using CHIS prevalence rates.

The following are specific populations by ethnicity and age with estimated unmet needs by:

* Service Area

SA 1: Latino, Children, Transitional Age Youth (TAY) and Older Adults.

SA 2: Asian Pacific Islanders (API), Latinos, White, Children, TAY, Older Adults.

SA 3: API, Latinos, Children, TAY, Older Adults.

SA 4: Children, TAY, and Older Adults.

SA 5: TAY and Older Adults.

SA 6: Latinos, Children, TAY, Older Adults.

SA 7: API, Latinos, Children, TAY, Older Adults.

SA 8: Latinos, Children, TAY, and Older Adults.

* Ethnicity

APIs are estimated to be underserved in Service Areas 2, 3, and 7. Latinos are

estimated to be underserved in all Service Areas except Service Areas 4 and 5.

* Age Group

Older Adults are estimated to be underserved in all Service Areas. Children are

estimated to be underserved in all Service Areas except SA 5. TAY are estimated to be underserved in all Service Areas.

*Source: 2013 Quality Improvement Work Plan Evaluation Report, LACDMH, Program Support Bureau, Quality Improvement Division*

While these ethnic and age groups are receiving mental health services, our data indicates that their rate of service utilization is not proportionate to population size or levels of unmet need. To set our commitment to reduce disparities into motion, a variety of outreach projects have been developed to specifically target underserved, unserved, and inappropriately served populations. Nonetheless, our quest to reduce disparities continues due to multiple factors associated with the large size and culturally diverse nature of the County of Los Angeles. These factors include ethnic population growth, immigration rates, social determinants and culturally engrained issues (e.g. stigma, lack of information, fear of governmental agencies, etc.) that keep underserved populations from utilizing mental health services.

**10. What outreach efforts are being made to reach minority groups in your community?**

**(Answered by Quality Improvement Division, Cultural Competency Unit)**

LACDMH considers Outreach and Engagement (O&E) to be a critical venue to help us achieve our vision of hope, wellness and recovery in a culturally relevant manner. Our Cultural Competency Plan identifies the following 19 strategies to reduce disparities, especially those due to race, ethnicity and culture. O&E is the first strategy on the list and collectively, these 19 strategies serve to organize our efforts to outreach to underserved populations; reduce disparities; combat stigma; promote hope, wellness, recovery and resiliency; and serve our communities with quality care.

1. Outreach and Engagement

2. Community education to increase mental health awareness and decrease stigma

3. Multi-lingual/multicultural materials

4. Collaboration with faith-based and other trusted community entities/groups

5. School-based services

6. Field-based services

7. Programs that target specific ethnic and language groups

8. Designating and tracking ethnic targets for Full Service Partnerships (FSP)

9. Flexibility in FSP enrollment such as allowing “those living with family” to qualify as

“at-risk of homelessness”

10. Countywide FSP Networks to increase linguistic/cultural access

11. Integrated Supportive Services

12. Co-location with other county departments (Department of Children and Family

Services (DCFS), Department of Public Social Services (DPSS), and Department of

Health Services (DHS)

13. Interagency Collaboration

14. Consultation to gatekeepers

15. Trainings/ case consultation

16. Provider communication and support

17. Multi-lingual/multi-cultural staff development and support

18. Evidence-Based Practices/ Community-Defined Practices for ethnic populations

19. Investments in learning such as the MHSA Innovation Plan

Our goal is for all O&E activities to create an infrastructure that supports all levels of a health neighborhood, as well as the development of partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations, and other County Departments to achieve an integrated mental health system.

At present, there are eleven Under-Represented Ethnic Populations(UREP) Projects that target five underserved, unserved and inappropriately served populations using culture-specific O&E strategies. The five ethnic groups include African/African American, American Indian/Alaskan Native, Asian/Pacific Islander, Eastern European/Middle Eastern, and Latino.

Additionally, LACDMH has implemented the Community-Designed Integrated Management Model (ISM) for these five ethnic groups. One of the core values of the ISM is to integrate community-specific outreach, engagement and education for underserved, unserved and inappropriately served populations.

In addition to the UREP and ISM Projects, which provide culturally relevant and targeted O&E, there are other LACDMH programs that conduct O&E activities. Some examples include:

* Full Service Partnerships (FSP) for Children, TAY, Adults and Older Adults
* CalWorks
* Katie A.
* Field Capable Clinical Services (FCCS)
* Service Area-based O&E teams

Under the direct guidance of the Service Area District Chiefs, O&E coordinators

promote mental health awareness, decrease stigma, and link underserved

communities to the services they need.

* Workforce, Education and Training Division (WET)

**(Answered by the Emergency Outreach Bureau, Field Response Operations)**

Psychiatric Mobile Response Teams (PMRT)

Psychiatric Mobile Response Teams (PMRT) consist of DMH clinicians designated per Welfare and Institutions Code 5150/ 5585 to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder.

Law Enforcement Teams (LET)

This co-response model pairs a DMH clinician with a law enforcement officer. The primary mission is to respond to 911 or patrol officer requests for assistance on calls involving mentally ill, homeless, or high risk individuals. LET and PMRT support one another as resources permit. Current programs:

1. Alhambra Police Department Mental Evaluation Team (AMET)
2. Santa Monica Police Department Homeless Liaison Program (HLP)
3. Burbank Police Department Mental Health Evaluation Team (BMHET)
4. Los Angeles County Sheriff's Department Mental Evaluation Team (MET)
5. Long Beach Police Department Mental Evaluation Team (Long Beach MET)
6. Los Angeles County Metropolitan Transit Authority Crisis Response Unit (CRU)
7. Pasadena Police Department Homeless Outreach Psychiatric Evaluations (HOPE)
8. Los Angeles Police Department Case Assessment and Management Program (CAMP)
9. Los Angeles Police Department Systemwide Mental Assessment Response Team (SMART)

School Threat Assessment Response Team (START)

START provides training and consultation, assessment and intervention, and case management and monitoring to students at risk for targeted school violence. START collaborates with educational institutions, law enforcement agencies, mental health providers, and parents to mitigate or eliminate threats.

Special Prevention Unit (SPU)

SPU is a countywide program collaborating with local, state, and federal law enforcement agencies, corporate, and executive protection firms in managing individuals of concern who are mentally ill and have either made a threat or pose a threat but have not crossed the threshold for criminal prosecution or psychiatric detention. Targets are typically high profile individuals, government officials, or public or private institutions.

Homeless Outreach Mobile Engagement (HOME)

HOME provides countywide field based outreach and engagement services and intensive case management to under-served or disengaged homeless persons who are mentally ill, living in homeless encampments, or frequenting locations where outreach is not readily available or provided in a focused manner.

Mental Health Alert Team (MHAT)

MHAT provides the mental health response to barricade and hostage situations in partnership with local and federal law enforcement agencies. The goal is to facilitate a negotiated rather than tactical solution.

Emergency Response Teams (ERT)

Emergency Response Teams (ERT) are comprised of DMH staff that provide field response to critical incidents such as school violence, earthquakes, or acts of terror. ERT provides on-scene consultation and crisis intervention to survivors, their families, first responders, and the community. ERT collaborates with the LA County Office of Emergency Management and the LA City Office of Emergency Management.

Homeless Outreach Teams (HOT)

Homeless Outreach Teams (HOT) are comprised of PMRT staff providing outreach and engagement to mentally ill homeless persons. HOT increases the likelihood of effective outcomes for this population in situations when they are at risk of involuntary hospitalization.

Psychiatric Emergency Teams (PET)

Psychiatric Emergency Teams (PET) are mobile teams operated by psychiatric hospitals approved by the Department of Mental Health to provide 5150 and 5585 evaluations. Team members are licensed mental health clinicians. PET operates similar to PMRT and provides additional resources in specific geographical regions.

**(Answered by The Older Adult System of Care Bureau)**

Older Adult Anti-Stigma and Discrimination Team

Summary

The Older Adult Anti-Stigma and Discrimination Team (OA ASD) is currently comprised of one Community Services Counselor, and in May of 2014 a Service Extender was added. Occasionally, other older adult systems of care staff provide assistance. The OA ASD Team participated in a total of 166 events during the fiscal year 2013-2014, outreaching to more than 2,516 Los Angeles County residents. These events included countywide educational presentation, community events and collaboration with various agencies.

Highlights of OA ASD’s accomplishments include:

* Provided over 166 workshops for seniors throughout the county
* Participated in 3 Health Fairs throughout the county
* Increased number of workshops to 5 in areas of SA1
* Identified locations for workshops in the Antelope Valley.
* Rolling out The Mental Health First Aid training for non-clinical staff, volunteers, and people in the community.
* Adding a Service Extender to provide presentation in the Spanish language.

OA Full Service Partnership

The OASOC’s FSP program is designed to provide a wide array of services for Older Adults age 60 and older who reside in Los Angeles County and who have been diagnosed with a severe and persistent mental illness.

Summary

OA FSP is a countywide program comprised of one directly operated clinic and eleven contracted agencies. The FSP program goes beyond the traditional outpatient services in that they provide services both inside and outside of client’s home. FSP programs provide specialty mental health services designed to meet the unique bio-psycho-social needs of Older Adults. OA FSP provides intensive services to those individuals who have experienced the following:

* Homelessness or at risk of homelessness;
* Incarceration or have frequent contact with the criminal justice system;
* Frequent psychiatric hospitalization or psychiatric emergency services;
* At risk of abuse, neglect, harm or placement in a higher level of care, such as a skilled nursing facility;
* Co-occurring medical or substance abuse disorders;
* Individuals who have aged up in the system and require services specifically for Older Adults.

Partners in Suicide Prevention Team:

The Partners in Suicide Prevention (PSP) Team for Children, Transition Age Youth (TAY), Adults, and Older Adults (OA) is funded by Proposition 63, the Mental Health Services Act (MHSA). This innovative program offered by the Los Angeles County Department of Mental Health is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The PSP Team offers community education and provides best-practice training models in suicide prevention, and provides linkage and referrals to age appropriate services.

PSP is comprised of one Psychiatric Social Worker and one Medical Case Worker for each of the four age groups. Training is also augmented by staffs from various programs that support suicide prevention. See Appendix for list of active trainers.

Summary:

PSP Team members participated in a total of 173 suicide prevention events during Fiscal Year 2013-2014, outreaching to more than 4,700 Los Angeles County residents. These events included countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners.

**11. Do you have suggestions for improving outreach to and/or programs for underserved groups?**

**(Answered by Quality Improvement Division, Cultural Competency Unit)**

Additional outreach suggestions for underserved groups include:

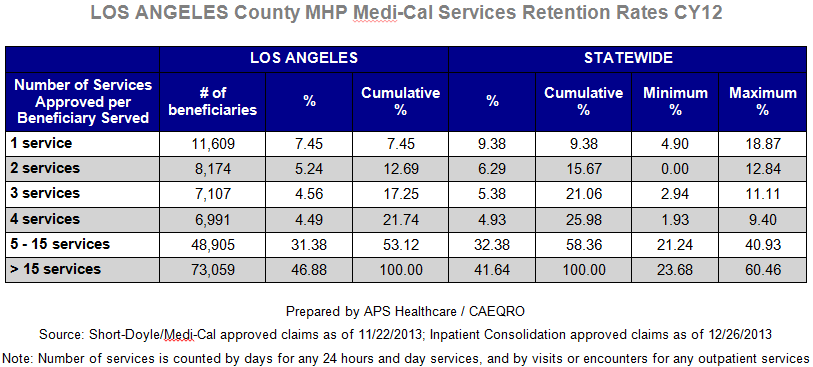
* Outreach, educate and raise awareness of LGBTQ issues
* Promote reduction of homophobia and stigmatization of LGBTQ individuals
* Include mental health education in school curriculum
* Promote peer-to-peer support and family-to-family outreach and education

CLIENT ENGAGEMENT IN SERVICES

One MHSA goal is to connect individuals to services they need to be successful. Clients who stop services too soon may not achieve much improvement, nor is it likely to last. So it is important to measure not only who comes in for treatment, but also how long they stay in services. Here we are considering individuals with high service needs, not someone who just needs a ‘tune-up.’ Although not every individual needs the same amount of services, research shows that when someone with severe mental illness continues to receive services over time, their chances of recovery increase.

Engagement in services, also called ‘retention rate’, is important to review. If individuals come in, receive only one or two services and never come back, it may mean the services were not appropriate, or that the individual did not feel welcome, or some other reason that should be explored. Again, we recognize that some individuals only need minimal services, but here we are looking at those with severe mental illness. Ultimately, the goal is to ensure they are getting needed services and are on the road to recovery. But we would not know that unless we look at how many services individuals received over time.

The chart below shows the number of Medi-Cal beneficiaries in your county who received 1, or 2, or 3, or 4, or 5, or more than15 mental health services during the year. For individuals experiencing severe mental illness, the more engaged they are in services, the greater the chance for lasting improvements in mental health.



**12. Do you think your county is doing a good job at keeping clients engaged in services? If yes, how? If not, why?**

**(Answered by the Innovation Perspective)**

The implementation of Mental Health Services Act (MHSA) funded Community Services and Support programs such as Full Service Partnership Programs (FSP) and Field Capable Clinical Services (FCCS) has improved the capacity of Los Angeles County to engage those individuals who are not receiving services or not connected to the appropriate services. The implementation and current evaluation of Innovation Programs is providing valuable learning that will continue to improve engagement of those who individuals and communities that have been the most difficult to reach. Examples of this learning include strategies for engaging chronically homeless individuals and strategies for engaging racial and ethnic communities where barriers to engagement in services exist.

**(Answered by Children’s Systems of Care)**

Yes, Children’s Systems of Care (CSOC) Administration believes that our Child Full Service Partnership (FSP) programs have done a good job at engaging and maintaining children and their families in treatment. One of the guiding principles of FSP is the inclusion of consumers in the treatment team, including Parent Partners/Advocates (PP/A). The personal experience that PP/A have gained from navigating their own family through the mental health system is invaluable, and their contributions to the child and family’s wellbeing, many. Parent Partners are also available to connect with families that are considering dropping out of treatment. CSOC Administration, when reviewing disenrollment documents for child/families requests outreach to families by PP/A to reengage them in treatment.

**(Answered by Transition Age Youth Division)**

In Los Angeles County, multiple strategies are utilized to keep clients engaged in services and treatment. For the TAY population, TAY System Navigators and Housing Specialists outreach and engage youth to link them with ongoing mental health services and supports. They TAY Housing Ambassador also provides outreach and engagement for youth residing in permanent supportive housing.

**(Answered by Adult Systems of Care)**

I believe staff are doing the best they can to engage clients, yet we cannot always meet the demand of the client to serve them to meet all of their expectations. The programs are doing their best to create new and innovative group processes to support clients in between their individual appointments. The Department is attempting to be proactive in encouraging our clients to integrate into their communities and provide them with support they can engage in outside of the mental health system, but still receive the needed supports. The manner in which we are doing a tremendous job in engaging clients is through the consumer advisory boards (CAB) which provides them with a voice and input into the necessary programming and supports to make available in our clinics. There have also been many peer provided services which has shown staff clients the power and recovery and the resiliency of our consumers.

LACDMH’S EFFORTS TO ENGAGE THE FAITH COMMUNITY

(Clergy Outreach)

A Brief Summary

In 2002, the Los Angeles County Department of Mental Health (LACDMH) hosted a Clergy Breakfast with the goal of fighting stigma and discrimination toward mental illness, and toward people with mental illness, to help improve access to services especially for underserved populations. The strategy was to educate clergy about mental illness, the availability of effective treatment, and the possibility of recovery, and then encourage them to convey the message to their congregations and surrounding communities as a means to reduce stigma and improve access. Hence the event featured speakers who were experts on mental illness and those who were successful in their mental health recovery. Invitations were distributed to a purchased mailing list of close to 6,000 religious institutions in Los Angeles County. Close to 150 clergy and lay faith leaders attended. Additional 75 attendees included clinicians, family members and people in recovery who were specifically invited to emphasize the message in conversations with clergy at each table. Considered a success, there was immediate expectation from attendees for the dialogue to continue.

Since then LACDMH has hosted an annual educational event, which over the years has developed into a one-day conference on “mental health and spirituality.” However, the goal expanded too. It was no longer just about reducing stigma and discrimination and thereby improving access to services with the help of the faith community. It was also about enhancing the cultural competency of recovery-oriented mental health services and supports by considering the whole person including the person’s spiritual interests. This emphasis was supported by studies that showed a strong association between spirituality and religion and people’s well-being. It was strengthened by a survey in California that indicated an overwhelming interest from people receiving mental health services and family members to have their spirituality considered and included as part of their care. Funded by Mental Health Services Act (MHSA) money and approved each year by the Board of Supervisors, the one-day conference is now attended by close to 500 clergy, lay faith leaders, mental health staff, people in recovery and family members combined. Nominal registration fees apply. Clergy are offered a discounted rate. A limited number of people in recovery and family members receive scholarships. It has become so well-known that neighboring counties send people to attend. The conference presents two keynote addresses and six to eight workshops in a single day. In addition to addressing stigma and discrimination, the curriculum now also includes topics that help providers integrate spiritual considerations with mental health services and help those in recovery learn of spiritual practices and factors that aid mental health recovery.

Initially funding proved difficult, limited and last-minute for the annual conference. Without any dedicated staffing, the planning and execution was accomplished with staff from multiple divisions when they had time to spare. Hence there were consistency and coordination issues. It began to flourish only when MHSA provided a strong rationale for funding it, staff were permanently assigned to the event, and a dedicated committee was created to plan and execute it.

Another staple of the LACDMH’s outreach to faith community is its Clergy Advisory Committee. It was launched in 2005 based on the realization that the time between annual conferences was too long to sustain an ongoing relationship with the faith community,. The Committee was formed primarily to advise LACDMH on how best to engage the faith community to continue the fight against stigma and discrimination. In its first three years of monthly meetings, the Committee also helped plan the annual conference and advocated for collaboration between faith community and mental health on communal issues such as homelessness. Although clergy participation in the Committee fluctuated over the years, the Committee continued because of growing interest for local outreach in some of the eight Service Areas (Service Planning Areas). Staffing was an issue. But with dedicated staff assigned to it beginning in 2008, the Committee grew into its current role of being a catalyst for:

* collaboration in each Service Area to address mental health disparities,
* educating staff on supporting the spiritual interests of people in recovery, and
* educating/training clergy on first responder roles and prevention.

Today the Committee has about 30 clergy and lay leaders from the faith community with about 20+ in attendance at each meeting. The Committee meeting also draws outreach and engagement staff from each Service Area. The Committee has become the central guiding force in advising LACDMH on its strategy (#6 under LACDMH Strategic Plan Goal 3) to “develop partnerships with faith-based organizations to enhance opportunities for clients to utilize their spiritual choices in support of their recovery goals.” Some of its accomplishments include:

1. Provided guidance on LACDMH “Parameters for Spiritual Support.”
2. Promoted the introduction of LACDMH and Clergy Roundtable in each service planning area.
3. Supported the planning and execution of the annual conference.
4. Promoted an interfaith approach to addressing mental health issues in each community.
5. Advocated for collaboration with faith community on prevention and social inclusion.
6. Served as ambassadors for underserved communities on mental health issues.

As a result of centralized activities, all eight Service Areas have begun periodic meetings with their regional faith communities. Some have included faith leaders in their Service Area Advisory Committee, which is the established mental health stakeholder planning body for each Service Area. However, these were administrative outreach to the faith community. No formal means were available to establish working relationships between clergy and service delivery staff. Therefore in 2010, LACDMH launched a pilot Clergy and Mental Health Roundtable program in Service Areas 6 and 7. The success of the pilot allowed its expansion to Service Areas 2 and 4 in 2013. Roundtables are set to operate in all service areas by 2016. Based on a model that facilitated clergy and mental health staff learning directly from each other about collaboratively supporting persons in recovery, each Roundtable brought together 6-7 mental health staff with 6-7 clergy for an hour-and-a- half long monthly meeting. Implementations difficulties included limited funding, staffing and space, unforeseen difficulties recruiting clergy, and competing priorities in each Service Area. Having proven successful despite barriers and now with three years of MHSA funding in hand, plans are under way to expand it to the remaining four Service Areas. The importance of the Roundtable Program is that it creates local, working relationships between the mental health system and the faith community to facilitate collaborative professional and community support for recovery.

Efforts are also underway to create programs that can expand the capacity of faith community in their role as early, and usually first, responders to underlying mental health issues and often for people in crisis. One such effort under development is the implementation of the Clergy Academy program that offers a training and education curriculum to enhance the mental health competency of clergy and lay leaders. With a menu of 23 topics and a faculty of DMH staff and volunteers, the program is currently operational in four locations and set to start in additional sites.

Another effort already in progress is using qualified faith community organizations to provide outreach, engagement and prevention education to underserved communities using MHSA funding. These organizations have to go through a pre-qualification process before becoming eligible to respond to the LACDMH’s proposal requests.

**13. For those clients receiving less than 5 services, what is your county doing to follow-up and re-engage those individuals for further mental health services?**

**(Answered by the Innovation Perspective)**

The programs addressed above employ numerous community based outreach strategies to build report on an individual level as well as to ensure communities are informed that services exist,. Engagement strategies for those hard to reach individuals include street outreach for homeless individuals, providing a continuum of care that offers consumers numerous entry points into service, and using person centered approaches to engagement that involves engaging individuals with assistance to achieve goals that the consumer defines.

**(Answered by Children’s Systems of Care)**

CSOC Administration has a protocol in place which inquiries into the circumstances leading to families disenrolling from services after 5 or less contacts. Some of the factors reviewed include efforts made by FSP staff in engaging the family; presenting problems; barriers to access; as well as services provided and level of intensity. Based on this review, we make recommendations for further outreach efforts.

**(Answered by Transition Age Youth Division)**

DMH provides outreach to follow-up with clients and re-engage these individuals with mental health services. Youth who have emancipated from the child welfare system and were identified as needing mental health services are being followed by our TAY Navigators. The TAY Navigators make contact with these youth several months after emancipation to follow up with the youth regarding their mental health needs. The youth are re-engaged and re-referred and linked to appropriate mental health services and supports.

**(Answered by Adult Systems of Care)**

All clients in the adult system of care are provided with reminder calls for all appointments at the mental health clinic, regardless of type of appointment. When and if a client does not come to their scheduled appointments, a follow-up call is made to ensure the client is okay and an appointment is rescheduled for the clients at that time. If the impression of the clinician is disconcerting at any level when communicating with clients over the phone, or if they are unable to make contact; staff from the clinic, an emergency outreach team and/or the police go out to see the client and assure their safety and put forth their best effort to engage/re-engage the client to supportive services. Should a client be hospitalized the staff are quick to follow-up with clients when they are in the hospital and to ensure an appointment is scheduled within five (5) days of their discharge. In the event staff are unable to make face to face contact with a client, a letter is sent to reach out to them at their residence on file. When and if the staff are unable to make contact with a client and have concern for their safety and have consulted with their clinical supervisor, emergency contacts may be contacted in order to ensure the safety of a client in assumed grave danger.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

In the context of DMH/DHS Collaboration Program, we routinely make several phone-based attempts to re-contact anyone who is not following up with services. Additionally, we contact them by mail in an attempt to re-engage and provide options should they wish to pursue mental health treatment at a later time.

**14. Looking at the previous chart of who is being served by race/ethnicity in your county, do you have any thoughts or ideas to share regarding your county’s engagement of underserved communities?**

**(Answered by Quality Improvement Division, Cultural Competency Unit)**

The large size and cultural diversity of the County of Los Angeles present several challenges for the delivery of equitable and culturally appropriate services. Nonetheless, LACDMH continues to strive for the reduction of mental health disparities and a more culturally competent system of care.

LACDMH believes that the engagement of underserved, unserved and inappropriately served communities in our system of care requires a multipronged approach that involves O&E strategies from different Programs /Units. Below is a summary of engagement efforts for populations shown to have disparities in access to mental health services:

I. Engagement for ethnic underserved populations

African/African American

* UREP capacity building project (Resource mapping project, cultural

relevant brochures and The Ethiopian Community Mental Health Training

and Education Project)

* Community-Designed Integrated Management Model (ISM)

Asian Pacific Islanders

* Adult and Child Full Service Partnership (FSP) programs
* UREP capacity building project for APIs (e.g. The API Consumer Leadership Council and API UREP Consumer Employment Training Program)
* ISM

Eastern-European/Middle-Eastern

* UREP capacity building project (e.g. Mental health brochures in Armenian, Russian, Farsi and Arabic, and multi-media outreach campaign via public service announcements)
* ISM

Latinos

* All FSP programs (including the Transitional Age Youth (TAY) and Infant FSP – Young Mothers and Babies/ Mamás y Bebés)
* UREP capacity building project for Latinos (e.g. Promotores de Salud Model as a promising practice)
* ISM

American Indian/Alaskan Native (AI/AN)

* UREP capacity building project (e.g. AI/AN Mental Health Conference and

Community spirit wellness project)

* ISM

II. Engagement for age groups

Children

* Full Service Partnership program
* Field Capable Clinical Services
* Katie A.

Transitional Age Youth

* TAY FSP program
* TAY and Infant FSP program – Young Mothers and Babies/ Mamás y Bebés
* Housing Ambassador Project
* TAY Mobile Library
* Anti-Stigma and Discrimination Project
* “Seeking Safety” Evidence-based Practice

Older Adults

* Older Adult FSP Program
* FCCS (Field Capable Clinical Services)
* Service Extenders

IV. Engagement for Women

* All FSP Programs (including the TAY and Infant FSP program - Young Mothers and Babies/ Mamás y Bebés)
* CalWORKs

V. Engagement for Limited English Proficient (LEP) consumers

Language Assistance Services:

* Language translation and interpretation services (including American Sign Language)
* Translation of LACDMH consent forms and brochures

VI. Engagement related to Workforce, Education and Training

Culturally and linguistically diverse workforce development:

* Public Mental Health Workforce Immersion into MHSA Program
* Licensure Preparation Program
* Health Navigator Skill Development Program
* Recovery Oriented Supervision Training and Consultation Services
* Interpreter Training Programs
* Community College Partnering Projects
* Clergy/Mental Health Staff Roundtable Pilot Project
* Mental Health Rehabilitation Specialist Training
* Peer Advocate Training
* Parent Advocates/Parent Partners Training Program
* College Faculty Immersion to MHSA
* Stipend Program for Master of Social Work and Master of Family Therapy

Students

Specialized trainings for LACDMH staff based on:

* Cultural diversity
* Cultural competency for effective service delivery to ethnic groups and

other cultural populations

* Clinical skill development, conceptualization and formulation of mental

health conditions

* Language interpreters
* Ethnic-specific conferences
* Military culture
* HIV/AIDS culture
* Client culture
* Age groups (children, TAY, adult and older adult)
* Physical disability
* Spirituality
* Sexual identity/sexual orientation

Trainings for consumers, peers, peer advocates and parent advocates

* + Hope and Recovery Conferences (English and Spanish)
  + Wellness Recovery Action Plan
  + Client Congress Forum

VII. Prevention and Early Intervention (PEI) Division

* School Mental Health Project
* Stigma and Discrimination Reduction Project
* Suicide Prevention Project
* School-based Services Project
* Family Education and Support Project
* At-Risk Family Services Project
* Trauma and Recovery Services Project
* Primary Care and Behavioral Health Project
* Early Support and Care for Transitional Age Youth Project
* Juvenile Justice Services Project
* Early Care and Supports for Older Adults Project
* Improving Access for Underserved Populations Project
* American Indian Project
* Over fifty Evidence-Based Practices (EBPs) for PEI populations with

identified target age groups and ethnic groups

VIII. Office of Family Engagement

* Outreach and engagement
* Trainings

While the list presented above is not exhaustive of all our efforts, it demonstrates that LACDMH is actively seeking to attend to the needs of underserved, unserved and inappropriately served ethnic communities and other cultural groups. Our efforts focus not only on Programs and projects to engage our consumers but also on building the cultural competency of staff to work effectively with them.

CLIENT OUTCOMES: Consumer Perception Survey (August 2013)

Ultimately, the reason we provide mental health services is to help individuals manage their mental illness and to lead productive lives. We have selected two questions from the Consumer Perception Survey which capture this intention. One question is geared toward adults of any age, and the other is for children and youth under 18.

Below are the data for responses by clients in your county to these two questions.

For general comparison, statewide reference data for various sized counties are shown in the tables on page 19.

The total numbers of surveys completed for Adults or Children/Youth in your county are shown separately in the tables below, under the heading “**Total**.”

Q1. Adults. As a direct result of the services I received, I deal more effectively with daily problems.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total |
| Number of Responses | 48 | 147 | 711 | 1750 | 1759 | 4415 |
| Percent of Responses | 1.1 % | 3.3 % | 16.1 % | 39.6 % | 39.8 % | 100.0 % |

Q2. Children/Youth. As a result of services my child and/or family received, my child is better at handling daily life.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree | Total |
| Number of Responses | 98 | 183 | 898 | 2598 | 1409 | 5186 |
| Percent of Responses | 1.9% | 3.5 % | 17.3 % | 50.1 % | 27.2 % | 100.0 % |

**15. Are the data consistent with your perception of the effectiveness of mental health services in your county?**

**(Answered by the Innovation Perspective)**

Those who engaged in services would be the most likely to be filling out the survey. For those individuals the data is consistent that mental health services provided to consumers is generally effective.

**(Answered by Children’s Systems of Care)**

The data above is consistent with the data that CSOC Administration collects regarding client satisfaction and perception of improvement as a result of Child FSP services. The Department of Mental Health is dedicated to ensuring that families are truly happy with the services provided. Data gathered through Customer Satisfaction Surveys over a four year span reflect that the implementation of Child FSP programs throughout Los Angeles County has been a great success; 80% of families reported that their child was happier, better able to cope with daily life, and had better relationships with their caregivers and siblings after meeting their FSP treatment goals. Overall satisfaction has increased from 75% to 88% over a four year span.

**(Answered by Transition Age Youth Division)**

The data is consistent with our perception of the effectiveness of mental health services in Los Angeles County. Los Angeles County is able to provide an array of mental health services and supports to address the complex needs of our population. Los Angeles County utilizes data and service outcomes to assist in improving service delivery and in planning new programs and services to meet the changing needs of our clients.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

Clinical outcomes are measured on a session-to-session basis in the DMH/DHS Collaboration programs. We use the PHQ-9 to measure symptoms of depression, the GAD-7 to measure anxiety and the PCL-C to measure trauma. We track progress session-to-session in order to know timely if the client is having favorable response to treatment or if we need to make any adjustments in treatment. For reporting outcomes, we look at the initial screener score and compare it to the last screener score to determine if there have been any positive or negative changes in scores across treatment.

For data collected in FY 12-13, we have the following outcomes for those clients who have completed treatment (completed treatment is identified as the completion of a relapse prevention plan prior to the end of treatment):

52.33% positive change (lessening of symptoms) in depression over an average of 7.72 sessions

47.59% positive change (lessening of symptoms) in anxiety over an average of 7.3 sessions

**16. Do you have any recommendations for improving effectiveness of services?**

**(Answered by the Innovation Perspective)**

Emphasis on care coordination, ensuring consumers have access to an array of services beyond mental health treatment including healthcare, substance abuse treatment, permanent housing, and the opportunity to support and participate in meaningful activities that are naturally occurring in our communities such as school, employment, and/or volunteer work.

**(Answered by Children’s System of Care)**

Children’s System of Care Administration is dedicated to ensuring the quality of child FSP services and is always striving to improve services. As an ongoing effort, CSOC Administration assesses the quality of services through analyzing data, conducting site visits, satisfaction surveys, and family focus groups. These efforts assist to monitor the quality of services and make improvements.

**(Answered by Transition Age Youth Division)**

Improving the effectiveness of mental health services and supports is important to address the changing needs of our target population. Los Angeles County must be aware of arising issues within the community and be able to adapt and adopt strategies to deliver effective services to address these issues.

Outcomes should assist in developing plans to improve the effectiveness of services. In our TAY Division, we utilize data in our various programs to assist in our monitoring process to ensure services are effective and are delivered appropriately.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

Within the DMH/DHS Collaboration Programs, the endorsement of the mental health providers as part of the treatment team is an important ingredient in clients accepting services. Also, a shared medical records system would facilitate timely access to information and improve care coordination.

**17. Many counties experience very low numbers of surveys completed. Do you have suggestions to increase the response rate?**

**(Answered by the Innovation Perspective)**

Incentives for consumers to complete the survey, such as gift cards.

**(Answered by Children’s Systems of Care)**

In an effort to ensure that the Child FSP client contact information is current, Children’s Systems of Care Administration developed a disenrollment checklist. The disenrollment checklist requires the FSP service provider to provide the most up to date contact information when children are disenrolling from FSP services. Using current contact information when we are conducting surveys increases our response rates.

**(Answered by Transition Age Youth Division)**

Utilizing multiple approaches in collecting the surveys (i.e., online, telephonic, mail) may potentially reach more individuals to respond to the survey. Incentives for completing surveys may also lead to an increased response rate.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

While not a survey per se in the traditional sense, I think that it has been very helpful to have the screeners as an integral part of the service delivery model.

**18. Lastly, but perhaps most important overall, with respect to delivery of services, do you have suggestions regarding any of the following:**

1. **Specific unmet needs or gaps in services**

**(Answered by the Innovation Perspective)**

Though a number of approaches are being funded, there continues to be an identified challenge to engage ethnic communities and link to mental health services, despite the resources that exist. This is certainly due to the vast diversity in Los Angeles County. PEI approaches are being explored to help better engage and serve communities including the Asian Pacific Islander, Armenian, African American, Ethiopian/African Immigrant, American Indian, and other communities that have traditionally been inappropriately served. Strategies to better engage the Lesbian, Gay, Bisexual, Transgender communities are being explored as well.

**(Answered by Children’s System of Care)**

On Tuesday July 15th, 2014 LA County Board of Supervisors approved the Department of Mental Health (DMH) Mental Health Services Act (MHSA) Three Year Program and Expenditure (3YRPE) Plan. The resulting plan reflects the Department’s efforts to address the identified gaps in services. For Children’s Programs, the main gap in services is the lack of services for children and families that complete Prevention and Early Intervention Services but continue to need treatment and do not meet criteria for intensive mental health treatment. The expansion of Child Field Capable Clinical Services, will address this unmet need.

1. **Improvements to, or better coordination of, existing services**

**(Answered by the Innovation Perspective)**

The move towards integrated treatment planning provides an opportunity to improve the coordination of care for all mental health consumers. Often health care and substance abuse interventions are limited to consumers due to the complexity of navigating systems that are not structured to communicate with each other. Better training and integration of Peer Support providers will further improve the coordination of existing services.

**(Answered by Children’s System of Care)**

With the implementation of the Affordable Care Act, DMH has been tasked with improving the integration and coordination of care and services across physical, mental health and substance abuse through the development and implementation of Health Neighborhoods.

**(Answered by Department of Mental Health/Department of Health Services Collaboration Program)**

1. Medical Records
2. Ongoing education of various providers so they are aware of why it might be helpful
3. Method to reimburse health providers for taking the time to coordinate care
4. **New programs that need to be implemented to serve individuals in your county**

**(Answered by Transition Age Youth Division)**

In an effort to address unmet needs and gaps in services, Los Angeles County adopted the MHSA Three-Year Plan. The Department of Mental Health, the Systems Leadership Team, and various community representatives participated in the planning process to address unmet needs/gaps in services in the current mental health system. Planning processes such as these, which involve the service providers, service receivers, and other community representatives continue to be needed to evaluate the delivery of services to ensure that effective services are provided within Los Angeles County.

**(Answered by Children’s System of Care)**

With the MHSA 3YRPE Plan, the new Children’s programs that will be implemented include: Mental Health Promoters, a Family Wellness/Resource Center and Respite Care Services.

**<END>**

REFERENCE DATA: for general comparison with your county MHP results





**County Mental Health Plan Size:** Categories are based upon DHCS definitions by county population.

o Small‐Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity

o Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne

o Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo

o Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura

o Los Angeles’ statistics are excluded from size comparisons, but are included in statewide data.

Total Values (in Tables above) = include all statewide data received by CiMH for these survey items.

**REMINDER:**

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for the following year. We welcome your input.

**Please submit your Data Notebook report by email to:**

[**DataNotebook@CMHPC.CA.GOV**](mailto:DataNotebook@CMHPC.CA.GOV)

**Or, you may submit a printed copy by postal mail to:**

* **Data Notebook Project**
* **California Mental Health Planning Council**
* **1501 Capitol Avenue, MS 2706**
* **P.O. Box 997413**
* **Sacramento, CA 95899-7413**

For information, you may contact either email address above, or telephone:

(916) 449-5249, or

(916) 323-4501



1. Serious Mental Disorder, term used for adults 18 and older. [↑](#footnote-ref-1)
2. Severe Emotional Disorder, term used for children 17 and under. [↑](#footnote-ref-2)