Welcome!

2016 EBP Symposium Plenary

Real World Implementation: Challenges and Solutions at the County Level
• **Lillian Bando, JD, MSW**  
  District Chief, PEI Administration Division, Los Angeles County  
  – Implementation of EBPs for MHSA PEI programs

• **Cindy Guz, MFT**  
  Deputy Director, Youth & Young Adult Services, Imperial County Behavioral Health.  
  – Implementation of EBPs for Imperial County

• **Amanda Pyper, MPA, MFT**  
  Behavioral Health Manager: Oxnard Adult Region, Ventura County Behavioral Health  
  – Implementation of CBT/EBPs for Ventura County

Plenary Presenters
Common Challenges In Implementing EBPs

- Selection of EBPs
- Training
- Use of Outcome Measures
- Staff Commitment
- Billing and Claiming
- Outreach, recruitment, referrals
- Staff Turnover
- Infrastructure
- Cultural Challenges
CHALLENGES AND SOLUTIONS IN IMPLEMENTING PEI EBPs in LA County

- Number of Evidence-Based Practices, Promising Practices, and Community-Defined Evidence Practices: 33
- Number of clients served in Fiscal Year 2014-15: 44,544
- Race/Ethnicity:
  - 68% Hispanic/Latino
  - 16% African/African-American
  - 10% White
  - 2% Asian/Pacific Islander
  - <1% American Native
- Number of Site Visits conducted 2012-13: 122
- Number of Site Visit conducted 2014-16: 134
• List of 33 PEI EBPs
• 2. PEI Program Implementation Matrix (Benchmarks and Stages)
• 3. Challenges and Responsive Actions PEI Implementation
• 4. Program Implementation, EBP Fidelity, and Sustainability Checklist
<table>
<thead>
<tr>
<th>No.</th>
<th>Practice Name</th>
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<tbody>
<tr>
<td>1.</td>
<td>Aggression Replacement Training (ART)</td>
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<td>2.</td>
<td>Alternatives for Families- AF-CBT</td>
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<td>3.</td>
<td>Brief Strategic Family therapy (BSFT)</td>
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<td>4.</td>
<td>Caring for Our Families (CFOF)</td>
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<td>5.</td>
<td>Center for Assessment and Prevention of Prodromal States (CAPPS)</td>
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<td>6.</td>
<td>Child Parent Psychotherapy (CPP)</td>
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<td>7.</td>
<td>Cognitive Behavioral Intervention for Trauma in Schools (CBITS)</td>
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<td>8.</td>
<td>Crisis Oriented Recovery Services (CORS)</td>
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<td>9.</td>
<td>Depression Treatment Quality Improvement (DTQI)</td>
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<td>10.</td>
<td>Dialectical Behavior Therapy (DBT)</td>
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<td>11.</td>
<td>Families Over Coming Under Stress (FOCUS)</td>
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<td>12.</td>
<td>Functional Family Therapy (FFT)</td>
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<td>13.</td>
<td>Group CBT for Major Depression (Group CBT)</td>
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<td>14.</td>
<td>Incredible Years (IY)</td>
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<td>15.</td>
<td>Individual CBT (Ind DBT)</td>
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<td>16.</td>
<td>Interpersonal Psychotherapy for Depression (IPT)</td>
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<td>17.</td>
<td>Loving Intervention Family Enrichment Program (LIFE)</td>
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<td>18.</td>
<td>Managing and Adapting Practice (MAP)</td>
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<td>19.</td>
<td>Mental Health Integration Program (MHIP)</td>
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<td>20.</td>
<td>Mindful Parenting Groups (MP)</td>
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<td>21.</td>
<td>Multidimensional Family Therapy (MDFT)</td>
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<td>22.</td>
<td>Multisystemic Therapy (MST)</td>
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<td>23.</td>
<td>Parent-Child Interaction Therapy (PCIT)</td>
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<td>24.</td>
<td>Problem Solving Therapy (PST)</td>
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<td>25.</td>
<td>Program to Encourage Active Rewarding Lives for Seniors (PEARLS)</td>
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<tr>
<td>26.</td>
<td>Prolonged Exposure – PTSD (PE-PTSD)</td>
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<td>27.</td>
<td>Providing Alternative Thinking Strategies (PATHS)</td>
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<td>28.</td>
<td>Reflective Parenting Program (RPP)</td>
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<td>29.</td>
<td>Seeking Safety (SS)</td>
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<td>30.</td>
<td>Strengthening Families Program (SFP)</td>
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<td>31.</td>
<td>Trauma Focused CBT (TF-CBT)</td>
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<td>32.</td>
<td>Positive Parenting Program (Triple P)</td>
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<td>33.</td>
<td>UCLA Ties Transition Model (UCLA TTM)</td>
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Phase I

**Exploration and Adoption** focuses on the tasks of examining and selecting PEI Practices most congruent with agency and target population needs (Year 1)

<table>
<thead>
<tr>
<th>Benchmark (activities/tasks to accomplish)</th>
<th>Please insert an “X” below the column header which best describes the agency’s status for each benchmark listed.</th>
<th>List accomplishments or challenges for each benchmark.</th>
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<tbody>
<tr>
<td>Met</td>
<td>Accomplishments</td>
<td>Challenges Rationale</td>
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<tr>
<td>Partly Met</td>
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<td>Not Met</td>
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1. Establish team to oversee PEI Practices selection and implementation

2. Develop PEI Program strategic plan (e.g. goals, objectives, activities, work plan, timelines, and staffing, etc.)

3. Develop communication plan/education between staff, stakeholders, leadership and clients

4. Conduct needs assessment to identify resources, gaps, and readiness for PEI Program

5. Consult with LACDMH, developers, community experts, researchers, etc.

6. Research/review PEI Practices for adoption

7. Identify PEI Practices for adoption by agency
### Phase II:

The Initial Implementation Phase focuses on preparation and provision of PEI services at the agency level (Years 2-4)

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<tr>
<th>Benchmark (activities/tasks to accomplish)</th>
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<tr>
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<td>Not Met</td>
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<tr>
<td>Accomplishments</td>
<td></td>
<td>Challenges Rationale</td>
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</tbody>
</table>
1. Implement changes in organizational infrastructure* in preparation for PEI Practice

2. Implement strategies to build staff support for PEI Program implementation

3. Identify key staff for oversight and implementation of PEI Program and Practice(s)

4. Implement system to track administration, scoring, data entry, and analysis of PEI Practice Outcome Measures

5. Outcome Measures Application (OMA) & CIBHS (MAP, TF-CBT, Triple P) Compliance rate for Outcomes (based on OMA data) is a minimum of 50%

6. OMA Completion rate for PEI clients is a minimum of 60%

7. Dropout rate for PEI clients does not exceed 50%

8. Implement internal program evaluation procedures and begin data collection

9. Implement tracking system to monitor completion of training protocol
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<tr>
<td>10.</td>
<td>Schedule PEI Practice trainings and staff complete initial trainings</td>
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<tr>
<td>11.</td>
<td>Implement claiming for PEI practices in accordance with PEI Guidelines</td>
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<tr>
<td>12.</td>
<td>Schedule PEI Practice Training and supervisors complete initial training</td>
</tr>
<tr>
<td>13.</td>
<td>Group/individual supervision implemented for PEI Program/Practices</td>
</tr>
<tr>
<td>14.</td>
<td>PEI practice fidelity monitoring framework implemented</td>
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<td>15.</td>
<td>Utilize PEI specific outreach/engagement to increase appropriate client referrals to PEI</td>
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<tr>
<td>16.</td>
<td>Implement PEI Program triage to support placement of clients in the appropriate PEI Practice</td>
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<td>17.</td>
<td>Implement Quality Assurance/Improvement procedures to address PEI Program/Practice(s)</td>
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Phase III:

Full Implementation reflects the successful integration and fully operational implementation of the PEI Programs and delivery of PEI Services within the agency’s infrastructure (Years 4-5)

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<td>Not Met</td>
</tr>
<tr>
<td>Accomplishments</td>
<td>Challenges Rationale</td>
<td></td>
</tr>
</tbody>
</table>
1. PEI Program infrastructure* is well established and supports effective delivery of PEI Practices to meet PEI population need

2. Staff demonstrates increased support, improved attitude, and enhanced skill development for PEI Program/Practice(s)

3. Key PEI Program staff have documented responsibilities, demonstrate proficiency in their role, and are knowledgeable about PEI Practices and outcome protocol

4. Outcome measure data utilized clinically with client

5. Outcome measure data utilized for data driven program decisions

6. OMA & CIBHS (MAP, TF-CBT, Triple P) Compliance rate for Outcomes is a minimum of 90%

7. OMA Completion rate for PEI clients is a minimum of 85%

8. OMA Dropout rate for PEI clients does not exceed 30%

9. Internal program evaluation conducted and results utilized for program decisions, and dissemination of results to inform stakeholders, partners and staff
10. Tracking system, to monitor completion of training protocol, is consistently updated by designated staff member and accurately reflects training status of each PEI Program supervisor/clinician

11. PEI Practice training protocol(s) completed by staff

12. Claiming for PEI practices is proceeding in accordance with DMH PEI Guidelines

13. The agency utilizes a minimum of 80% of the PEI allocation

14. PEI Practice training protocol(s) completed by supervisors

15. PEI Practice-specific supervision supports clinicians’ mastery and utilization of skills

16. Clinicians utilize fidelity monitoring tools and delivers PEI Practices with adherence to model components

17. Continued PEI-specific outreach/engagement supports appropriate client referrals and utilization of PEI Practices
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<tr>
<td>18.</td>
<td>Clients, referred for PEI services, complete the appropriate outcome measures in accordance with practice guidelines as a result of established triage protocol</td>
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<tr>
<td>19.</td>
<td>Initiate sustainability planning (e.g. timelines, train-the-trainer model, funding support, etc.)</td>
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<td>20.</td>
<td>Agency develops collaborative partnerships and identifies additional funding streams to support program sustainability</td>
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<tr>
<td>21.</td>
<td>PEI Program meets population need and PEI services become normative treatment modality for client population</td>
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<td>22.</td>
<td>Agency provides on-going training for new staff and additional training to expand existing practices</td>
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Phase IV:
The Fidelity and Sustainability Phase is focused on supporting the provision of PEI Practices with fidelity and sustaining the PEI Program/Practices over time (Years 5+).

<table>
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<tr>
<th>Benchmark (activities/tasks to accomplish)</th>
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<tr>
<td>1</td>
<td>Clinicians demonstrate competent delivery of PEI Practices and are fully trained in the models they deliver</td>
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<td>2</td>
<td>Outreach and engagement strategies in place with a well-developed triage system to funnel appropriate clients (meeting PEI criteria) to PEI services</td>
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<td>3</td>
<td>Agency utilizes PEI Practice champions, supervisors, and train-the-trainer model to support sustainability</td>
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<td>4</td>
<td>Outcome monitoring, internal program evaluation, and tracking of training systems are well established and consistently utilized for clinical and programmatic data-driven decisions</td>
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<td>5</td>
<td>The agency maintains a high staff retention rate contributing to sustainability</td>
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<td>6</td>
<td>Agency maintains and utilizes a diverse menu of PEI Practices to appropriately address client needs</td>
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<td>7</td>
<td>Agency’s PEI Program’s internal processes are aligned with DMH guidelines and procedures</td>
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<td>8</td>
<td>Agency is utilizing a minimum of 97% of PEI allocations</td>
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<td>9</td>
<td>Agency has other sources of funding to support sustainability of PEI Program/Practices</td>
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<td>Description</td>
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<td>10.</td>
<td>Adaption of PEI Practices occurs with consultation from the developer/experts and data is collected to support efficacy for the target population.</td>
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<td>11.</td>
<td>Agency strongly utilizes collaborative partnerships allowing for resource sharing and leveraging to support program sustainability.</td>
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<td>12.</td>
<td>PEI Program demonstrates efficient service delivery and cost containment contributing to practice sustainability.</td>
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<td>13.</td>
<td>Agency has an infrastructure to provide ongoing training for new staff and additional training to expand existing practices.</td>
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TOP 10 CHALLENGES AND RESPONSIVE ACTIONS IN PEI IMPLEMENTATION

In the PEI pre-site visit questionnaires, providers were asked “What challenges has your staff experienced during their on-going implementation of PEI practice(s)? How has your agency attempted to overcome these challenges?” Then at the site visit itself a discussion was held about the challenges and how they were impacting the agency’s PEI program. This dialogue allowed for sharing of an agency’s strategies, tactics, or actions in dealing with these challenges. As the site visits progressed, DMH staff were able to share with providers the actions undertaken by previous agencies for similar challenges. The table below summarizes the challenges most often mentioned, with the different nuances indicated under each challenge and the types

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>AGENCY RESPONSIVE ACTIONS</th>
<th>LACDMH ACTIONS</th>
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<tbody>
<tr>
<td>1. SELECTION OF EBPS</td>
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<tr>
<td>2. TRAINING</td>
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<td>3. STAFFING</td>
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<td>4. FIDELITY TO THE MODEL</td>
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<td>5. TARGET POPULATION</td>
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<td>6. OUTREACH AND REFERRALS</td>
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<td>7. OUTCOME MEASURES</td>
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<td>8. BILLING AND CLAIMING</td>
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<td>9. INFRASTRUCTURE</td>
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<td>10. SUSTAINABILITY</td>
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Imperial County Behavioral Health Services

Evidence-Based Programs Implementation
Cindy Guz, MFT, Deputy Director
Imperial County Behavioral Health Services

- Imperial County Population 180,672 (2014)
- Total client caseload: 4,393
- Number of employees 447
  - Total Clinicians: 42
    - Employed Interns: 31
    - Employed Practicums/Trainees: 6
    - Volunteer Practicum Students/Trainees: 5
Challenges

- Identification of the most effective EBPs per population
- Getting staff’s “Buy in”
- Ensuring fidelity to the model
- Tracking outcomes
- Staff turnover
Solutions

Identification of the most effective EBPs

- 2008 consulted with CIMH county assessment and target populations
  - Included partner agencies
  - Recommendations for specific models were provided
- Separated the clinical divisions by age and diagnosis
  - Children and Adolescent Outpatient Services (CAOS)
  - Youth and Young Adult Services (YAYA)
  - Adult and Older Adult Services (AOAS)
    - Services in each division target unique challenges and needs for the particular target population
    - Lead staff attended symposiums/conferences on emerging EBPs
    - Researched online
Children and Adolescent Outpatient Services (CAOS)

- Target Population: Children and youth ages birth to 13 diagnosed with a Serious Emotional Disturbance (SED) and youth up to the age of 18 diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)
- Caseload: 1,450
  - Mental Health Outpatient Clinics
  - MHSA Prevention and Early Intervention Program (community-based)
  - Innovation Program (school-based)
CAOS Evidence-Based Practices

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Depression Treatment Quality Improvement (DTQI)
- Functional Family Therapy (FFT)
- Coping Cat for Anxiety
- Incredible Years
- Aggression Replacement Training (ART)
Youth and Young Adult Services (YAYA)

- Target population (Mental Health): Individuals 12 to 25 diagnosed with a Serious Emotional Disturbance (SED) or Severe Mental Illness (SMI)
  - Current Caseload: 871
  - Anxiety and Depression Clinics
  - MHSA Full Service Partnership Programs
- Target population (Alcohol and Drug Services): Individuals 12 to 18 who are diagnosed primarily with a substance use disorder
  - Current Caseload: 126
  - Adolescent Outpatient Drug Free Program (O.P. and school-based)
  - Prevention Program (school-based)
- YAYA Total Caseload: 997
YAYA Evidence-Based Practices

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Cognitive Processing Therapy (CPT)
- Functional Family Therapy (FFT)
- Depression Treatment Quality Improvement (DTQI)
- Anger Replacement Training (ART)
- Portland Identification and Early Referral (PIER)
- Moral Reconation Therapy (MRT)
- Too Good For Drugs
Adult and Older Adult Services (AOAS)

- Target Population: Adults ages 26 and older who are diagnosed with a Severe Mental Illness (SMI) which may include co-occurring disorders.
  - Client Caseload: 1,946
  - Anxiety and Depression Clinics
  - MHSA Full Service Partnership Programs
  - MHSA Recovery Center Programs
AOAS EBPs

- Cognitive Processing Therapy
- Cognitive Therapy for Depression
- Moral Reconation Therapy
- Portland Identification and Early Referral (PIER)
Solutions (continued)

Getting Staffs’ “Buy In”

- First trained only lead clinicians, supervisors, managers
- Initially implemented EBP with only those lead staff
- Lead clinicians were able to spread the word by talking about their positive outcomes/success stories, experience with the model
- Combat misconceptions with research during meetings/division retreats
Ensuring Fidelity to the Models

- Contracted with CIBHS/CIMH or developers of the model to include:
  - Initial training, consultation calls, advanced/booster training, site visits
- Identified “Champions” to continue meetings on each model to monitor fidelity
- Internal Quality Improvement Review Committees
- Recent contract with consultant to develop electronic fidelity indicators
Solutions (continued)

**Tracking outcomes**

- Worked closely with Information Technology staff
  - Cross training on IT system, data collection, outcome tools
  - Assigned lead clinician to pilot EBP electronic data entry
- Recent contract with consultant in outcome measurements
  - Data collection in electronic system to report findings on individual, program, division, and target population level
Solutions (continued)

Staff Turnover
- Contract with local colleges for practicum students, trainees, and interns to obtain their hours
  - Currently 11 MFT Practicum Students/MSW Trainees
- Train the trainers for some models
- Addressing staff burnout
  - Developed system to assign amount and type of EBPs to staff
    - Point values based on EBP difficulty
  - Increased appointment times as necessary to administer and score tools, etc.
Cultural Competency

- Spanish is the threshold language for Imperial County
- 82% of total clinicians are Hispanic/Latino
- 70% of total clinicians speak Spanish
  - Non-direct staff certified as interpreters to assist as needed
- Outcome tools provided in Spanish
- If needed, staff communicated questions to EBP consultants and some adaptations were allowed within the model
Assessment Resource

- OUTCOME MEASUREMENT ASSESSMENT TOOLS MATRIX

- Matrix by service age type (Child, youth/young adult, Adult/older adult)

- Age, Area of measurement, Type of Tool/Disorder, Completion time, Staff responsible, Completion frequency

- Tool to assist in assessment selection
VENTURA COUNTY
BEHAVIORAL HEALTH

Amanda Pyper, MPA, MFT
Behavioral Health Manager: Oxnard Adult Region
Ventura County Demographics

- Population: 846,178
- Median Household Income: $76,544
- Language spoken in home: 38% other than English
- Housing: 282,231 units
- Owner 65%, Renter 35% Half of Renters pay over 35% Household Income
- 18% under 18, 12% over 65
- 9.4% over 200K, 11.1% below poverty level
- 62% English, 30% Spanish, 8% Other
- Half of Renters pay over 35% Household Income
VCBH Consumer Characteristics

Race
- 59% Caucasian
- 30% Other
- 5% African American
- 6% Multiple Race

Demographics
- 46% Latino Ethnicity
- 13% Spanish Language
- 51% Male

Age
- 6% 0 to 5
- 35% 6 to 18
- 9% 19 to 24
- 49% 25 to 64
- 4% 65+

Court Status
- 5% Foster Youth
- 4% Juvenile Offender
- 1% Involuntary Commitment

Location
- 44% Oxnard Plains
- 18% Ventura
- 12% Simi Valley
- 10% Conejo Valley
- 8% Santa Clara Valley
VCBH Services Data

**FY14-15**
- 14,960 Clients
- 461,314 Contacts
- 23,280,388 Units
VCBH Clinical Data

Diagnosis by Division

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<tr>
<th>Condition</th>
<th>Y&amp;F</th>
<th>Adults</th>
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<tr>
<td>Mood</td>
<td>23%</td>
<td>31%</td>
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<tr>
<td>Co-Occurring</td>
<td>10%</td>
<td>26%</td>
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<tr>
<td>Psychosis</td>
<td>1%</td>
<td>29%</td>
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<tr>
<td>Disruptive</td>
<td>29%</td>
<td>0%</td>
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<tr>
<td>Anxiety</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>5%</td>
<td>16%</td>
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<tr>
<td>Adjustment</td>
<td>14%</td>
<td>4%</td>
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Challenges & Solutions

1) Sustainability: Staff turnover; cost of training; rigidity of many EBP’s. Solution: select widely applicable model (CBT) – basis for most EBP’s – allows for flexibility in application; train in application for individual, group & family therapy

2) Staff buy-in: Resistance to change. Solution: Peer model; continuous training; senior level support

3) Fidelity: More paperwork! Solution: CTRS

4) Measuring outcomes: More paperwork; staff resistance; how to record. Solution: start w/ low-hanging fruits (depression & anxiety); use cheap and easy measures (GAD 7, PHQ 9). Record scores in EHR.
• Lillian Bando, LA County
  – LBando@dmh.lacounty.gov
• Cindy Guz, Imperial County
  – CindyGuz@co.imperial.ca.us
• Ventura County:
  *Please Contact Angela Riddle
  – angela.riddle@ventura.org