COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING

Wednesday, December 21, 2016 from 9:30 AM to 12:30 PM

St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Receive DMH Update from the Director on county priorities
2. Receive presentation of the MHSA 3-year Plan Program and Expenditure Plan and vote to endorse the plan.

MEETING NOTES

Department of Mental Health Update	***Jonathan Sherin, M.D., Ph.D.,* Director, County of Los Angeles, Department of Mental Health** *Introduction of Richard Espinoza*, who was a Deputy in District 4 for Supervisor Knabe. He will be helping Dr. Sherin and Dr. Kay liaison with Board offices. *The concept of home*: We have a mission of taking care of those who are challenged by suffering with mental conditions, who don't have an extended definition of "home." Home is a special word; it does not have a lot satisfactory synonyms in the English language. Home is a place where it is a safe and nurturing place to live, but it is also much more than that. It is a connection to a human network. Those that are suffering from mental illness and who don't have a "home" are the individuals we need to focus on engaging. We have a responsibility as stewards to use our resources in a humanitarian way. Besides it being the right thing to do, it is also very clear that it's the Board's priority. Populations of focus are those in the streets, those in a transitional, temporary type of housing/shelter, those in the justice system, those experiencing domestic violence, children between placements, and those in and out of hospitals, emergency rooms, or placements. The term placement in itself, by definition… if you are being placed, you aren't really going home. We want to bring people home. We want people to have a place that they can live that is dignified and they have support and a human connection and can develop purpose and belonging. Independence is the recovery piece and the purpose and belonging is the reintegration piece. One of the things that really binds these groups of people, this population, is trauma. Those who are experiencing trauma, have experience of trauma, been affected by trauma, may or may not have what we might formally diagnosed as a mental illness, those are the people who we are focused on helping the most. These are the populations that are the focus. I am trying to figure out ways where we can sharpen our focus in certain areas, where we can develop a means through the SLT, through the SAACS, through the coalitions, through the commission to develop a set of partnerships that's growing in the same direction, where we as a group identify priorities, given the constraints of the highest level of direction that we get from the board.

Discussion, Q&A

- Q: In the list of people that you just listed that you wanted to work with, I didn't hear the family members, and I am sure it was an oversight on your part, so are you interested in including family members in NAMI, in what is going on?
    - A: Yes, it is a good point for you to raise, and when I talk about home, I am talking about a place to live that is safe, secure and nurturing and a family so that involves that whole unit. I talked about it before here and I talk about it all the time, you really cannot provide care for individuals, if we are going to look for the basic unit, it is going to be the household, we have to be thinking about that. Also a big problem of teaching younger clinicians, and psychiatrists, in particular, who get too focused on what medications, what combinations, what dosage for an individual to deal with the symptoms and signs that are showing up in the office but what is happening in the rest of the world, what is happening in the household, what are things that you can do to help support that household to create a home for that individual. In many cases, it is more important than which molecule you are prescribing.
- Q: Speaking of Medication: I have read that you are in favor of decreasing medication as much as possible, and I was wondering if you might want to share a little about that because I think it is a good idea to do that.
    - A: It relates back to what I was just saying, when you focus on only a part of your clinical resources, you are going to over-express the use of that resource as opposed to looking at other things, whether its family integrity, education training, employment, opportunity. It is through that approach, emotional, physical and intellectual health, which are important for an individual to become independent. I think about faith, family, society, and the cosmos, some will say spirituality, as the basic building blocks of belonging and purpose which is connectedness so independent and entirely connected. If we are looking at those things and not focusing on medication we're going to bring medication doses down.
- Q: My question is in regards to the synonym "home" and you used the word trauma. Speaking as a First Nations person, home and homeless, not to minimize the homeless but Native Americans as a whole, we feel that we have no home in general, we have reservations, but it is equivalent to concentration camps, so as our 5th generation grows I see in them, there is no purpose, our sense of belonging in society or main stream so the overall question is how can DMH help Native Americans as a group that comes to the table, sit down, talk and come to a solution, that we come out of this. I don't know if it is going to happen right away but it's been going on for so many years.
    - A: That is a big, big question, we could make an argument and be an advocacy entity to help articulate at a higher level, which would be a population model. What it means to be on a reservation vs. to be in a community and part of a community. You are expanding beyond the Department of Mental Health, except that we can be advocates, and we can base it on the issue of trauma, isolation, the issue of loss of independence on some levels. As a group, DMH would be able in a position to advocate the appropriate relationship with First Nations.
- Q: In this room, there are subject experts that have been working together for many years and your predecessors have been really open to having discussions with all of us without them making decisions without us knowing and allowing us to participate as stakeholders, I am hoping that it will be the same with you. There is a wealth of information in this room and many of these people have been together since Mental Health Services Acts began, so we are supporting the department, we are hoping you will listen to us and support us as well

	o A: I am thrilled to come to a system that is set up. I didn't really know much about how MHSA, I knew about the proposition, but beyond that the infrastructure that was built to ensure stakeholder input. I didn't know about this group, and I am glad that it is here, glad that it had a chance to form, glad that it has a relationship to SAACs and other stakeholder portals and that is has a relationship to the commission and to the Department. I think it is built in such a way, it has a very profound and strong voice. The sacred interface between the providers and the clients and that's where the gold is, where information is and where we get our understanding about what the needs are so that we can drive the deployment of our resources. • Q: Many of us support your focus already; this body has supported homeless and those that need housing a lot. Since this program and this funding has been generated because we understand the need out in the community, my question to you is what is your focus or interest relevant to the cultural relevancy and competencies of services generated to the underserve communities and the second part of that is when you don't have family, are you interested in providing a community support system to those that don't have family to create a community home and so those are the two questions I have. o A: I have spent a fair amount of my career in recent years in trying to push those things in terms of putting together programs and also pushing legislation. I talk about peers and the importance of peers and I talked to the Board a lot when they interviewed me, many time. What do you need if you are isolated and you are homeless? Well you need a place to live and a surrogate family. The peer who has a shared experience, who is going to organically be more trusted and has the same type of language provides what I call a surrogate family function. That includes taking individuals helping them navigate life. Are we doing the right thing with certain populations if we are creating scattered site housing, or if we are doing project-based housing? If it doesn't offer what you're talking about, which is community. Along with the CEO's office right now, we are scouring the County asking where are there properties, where are there buildings unused or being repurposed. We all need a hometown, a place where you belong and have a purpose, that is the fundamental theme. No inventory in LA. We have build it new. We have to invest in stuff to take care of those who don't have the extended definition of home so we can design it on the front side. Of course there is Healthcare, Mental Health care, maybe on site, there's education training, employment opportunities, maybe entrepreneur opportunities, recreational activities, family support, place to gather and socialize, all the things everyone needs and those who are lucky enough to have a home in a community enjoy and benefit from every day. That becomes the attractor, I don't want to live on the street, although living on the streets for some is a place where they prefer rather than be isolated in an apartment because they have family there. The attraction of a campus like that is not that because it's a constraint and restricted environment if it is some might consider a threat. The attractor is that it is a great place to be. Why does it not stick when you go to a scatter-site apartment, or why do you not want to be in a locked facility? Those are ways we think about keeping people and constraining and treating them as opposed to creating magnetic attractive places where they would want to be and where they will benefit and ultimately a platform of well-being. • Q: With the development of MHSA, we focused a lot on cultural relevance to the services provided and trying to find cultural relevant practices to help the community address their needs and issues, so are you still on that vein as well?

	o A: Yesterday we had our weekly meeting, the issue of how we are thinking about was how to use funding. There are 13 threshold languages in LA County, so my question to the team is let's find out where there is a barrier to access, that is a problem. Whether it's cultural competency, language, we need to do everything we can to create, to take out access barriers. I am trying to take a really disciplined systematic look at what we do across this county and the different populations because there are a lot of different barriers for a lot of different populations. • Q: I understand what you were talking about the home, what I don't know and my question is what about parents living in the home with their families that are isolated from their own families. Those that are sitting in a family home with children going wild because one child. Is that something that is including in this? Many families don't want someone else coming into their homes telling them what to do. So how would you it? o A: Same way as you construct an environment that would be comfortable and dignified to live in, you need to also have the family be built in functional. Families that are having really difficult problems, which can lead to into someone entering the streets or getting into problems otherwise, or worse arenas. Those families need to get help with their process, the whole enterprise of group therapy and family therapy in the context of individuals getting care is based on that problem, you need to have a strong family fabric, and the right environment to have a home. • Q: Ok, I understand that, but I don't think I am saying my question right because I am not talking specifically therapy, I am talking about the actual family trying to live as a whole with a child or two with disabilities and one more questions and that is it. We were talking about the homeless and how would you work or help homeless people that really don't want to live in a home? I have seen/heard, "I like it here" Is there a plan that might help them, campground, something? Isn't it a liability to have people sleeping in the streets? o A: I was trying to address the question from a different angle, and my comments earlier about intention communities, people have sense of belonging and opportunities to heal as individuals as well because in theory that would be somewhere that is attractive and those folks who don't want to accept what is available now might be interested in accepting that. Those people that are very reluctant to engage with in and accept the types of resources that we have and get a taste of something like that and say hey, this is different and I want to be here. I don't want to be in the street with family which keeps me there, and a routine that I am used to but I want to be there, I want to be there because I am part of a community where I am not judged where there are resources there and available to help me. That is a magnet for people as opposed to some of the other resources in the ways we use resources traditionally. Compare them to being on the street, some people will take the street. We need to create resources that people will want to take those resources and not choose the street. • Q: Sounds like your emphasis is more on homelessness and trauma. LA is fully of cultural populations who have went through a lot of trauma, I was wondering whether you are going to be emphasizing trauma related to homelessness only or are you going to be also relating to other kinds of trauma like immigration, all kinds of different kinds of traumas? o A: There is a little bit of chicken/egg thing here. Folks who don't have homes, the broad definition of home, largely have been traumatized; they have suffered trauma, and that trauma can happen in utero. What I am saying is trauma leads to, and trauma is not a one-time thing, and it can be a vicious cycle for certain folks, which we obviously want to stop, but trauma really in addition to being a risk factor for

	mental illness is what populating these different areas of not having a home. We want to go to those areas where people don't have a home and we also want people to stop entering that non-home arena, and stop people from returning once they get out of that area. Populations that I am describing have a tremendous trauma burden, and also have a tremendous risk for repeated trauma. That is our responsibility to intervene. • Q: Homelessness is not the only trauma that we have those cultural populations that are living in Los Angeles. o A: Maybe you can give me an example, when I am talking about homelessness, I am not talking about people living on the streets. I am talking about much more than that, that is why I listed the large arenas that people live in. • Q: My thinking is a little different… I am thinking of trauma that a lot of populations have gone through, like Native Americans, Armenians, intergenerational traumas that we do have, immigration, those immigrants that have come from war torn countries, we have a lot of different kinds of trauma. o A: First of all, being homeless or being on the streets is traumatizing and the reason people end up on the streets is because they experienced trauma. We need to be thinking proactively about the fact that the people who immigrated here are at great risk for entering these areas that are so problematic. How do we deal with the trauma load? In a perfect world we can go into every nook and cranny where there is trauma and deal with it. The more efficient we are, the more effective with the work that we do the more that we drive our work on how it impacts people and we evaluate it the further out we can get from the center cork of the dartboard.
MHSA 3-year Program and Expenditure Plan	Debbie addressed Emma's comments and questions. • MHSA has 5 key vehicles and one of those vehicles is innovation. Innovation 2 Project, which the Finance dept. signed off yesterday, means it will go to County Council and hopefully move forward shortly. Innovation 2 focuses on community capacity building and trauma. One strategy in particular addresses multi-family trauma across generations so think about that in context of what Dr. Sherin was saying. • Housing and concept of home – will see reduction in homelessness FSP, and increases in independent living. Look at sustainability of housing – maybe that is the next step of this concept of home. Debbie made acknowledgement of those persons that made this Plan possible. MHSA stipulates that every 3 years a County develops a 3-year plan and updates it annually. • Plan requires a 30-day public comment period and a public hearing. • Public comment will commence somewhere around Jan 15th or 20th. • Public hearing is Feb. 23, 2017. • MH Director and County Auditor Controller certify it to make sure it is in compliance with laws and regulations. • Last Quarter of the fiscal year we work on Board of Supervisor adoption and engaging in a number of contract amendments and other activities to make this effective July 1st. Timeline is tight, as actions require a lot of administrative work in short amount of time.

Presentation of the 3-Year Plan

Contents of Three Year Program and Expenditure Plan

- Executive Summary
- Community Services and Supports (CSS) plan programs
  - Unique clients served, their ethnicity, their language
  - Average cost per client
  - Program outcomes
  - CSS work plan consolidation
- Prevention and Early Intervention (PEI) programs
- Innovation
- WET
- Budget for next 3 fiscal years.

CSS Plan

- Last fiscal year we served 119,277 unique clients. Increase from last fiscal year but consistent with prior fiscal years.
- Ethnicity: .22% Pacific Islanders, 5% Asian.
- Language: 76% English, 17% Spanish
- Comparisons to prior Fiscal Years.
- Service Areas: Service Area 4 has the most # of clients seen, followed by Service Area 6, followed by Service Area 8.

Full Service Plan (FSP)

- Distinction of Child and Child Wraparound and TAY and TAY Wraparound? What adds to the cost of that?
  - Services are more intensive, higher cost and requirements with working with child and family teams. ICC IHBS services, which cost a little more when working with DCFS involvement.
- How are allocations determined, equity of distribution, whether is it by age group and service areas?
  - Initial allocation by age group for FSP when we put the bid out. CSS plan in general, delegates agreed to. Over time, depending on board priorities or other priorities relative percentages may have changed a little bit, including service area allocations.
  - In 2006, the Department issued solicitations for all services that were contracted out. Allocations first started with our State requirements for FSP for example, 51% of CSS dollars have to go to FSP programs and then we started drilling down in terms of what went out to bid based on at that time what we estimated the needs were by service areas. Over time we had to see the folks that were coming in for services so even though we had ethnic specific slots allocated, to some extent those folks were served, but also folks that were homeless, out of jail, and folks that had more need. They all meet the FSP criteria. Overall we have a QI annual report shows by service area, by age group, Medi-Cal, non Medi-Cal populations, who's being served.

	o Estimated needs were, looking at poverty rates, where services were, penetration rate, etc. Everything is documented in terms of history. • What is the allocated slots in comparison to the needs overall and how are the decisions being made? Looking at that and difference between slots allocated and clients served all of them, are more folks served in most of the categories except for the adults and I was curious why that was? o We will have to take a look that and see why. They were just starting out that fiscal year. If slots were added, especially with the assisted outpatient treatment, we had some struggle filling those slots so that could explain that. • Percentage of clients that disenrolled because they have met their goals. o Child is increasing in this area, 59% of their clients disenrolled because they met their goals. o 38% for TAY, 35% for Adults and 50% for older adults. o We want these percentages to increase. We want people to leave of FSP not because they drop out or the services don't meet their needs but because their goals have been met. • FSP Disenrollment across fiscal years • FSP Disenrollment with met goals. o Shows 4 fiscal years, in Older Adults it was 26% of clients disenrolled because they met their goals in fiscal year 2014-2015, last year up to 50%. 2 reasons for this one could be that they started to pay more attention to how they were coding the disenrollment, and/or they providing the interventions and the services and supports that then disenrolls somebody and moves them on in their recovery. Well done Older Adults. • FSP outcome methodology – Metrics are measured the year before a client enters a FSP program, living arrangements, hospitalizations, incarcerations, independent living, out of home placement for kids, etc. As changes occur in those statuses, that information is recorded in the Department's OMA database through a Key Event Change. Children (0-15) in FSP spend fewer days hospitalized and in juvenile hall post partnership, 29% reduction in days hospitalized after enrolling in FSP, and 12% reduction in days in juvenile hall post partnership. o Clients- 38% reduction in children who were hospitalized after enrolling but 140% increase in children involved in juvenile justice system after enrollment. o Difference between days and clients- more kids in juvenile justice system but less days. We know there is something happening, there are more kids going into the juvenile justice system, and we can make a lot of assumptions but our first order of business is to talk with the providers and look as these cases and find out what is different. We have some work to do, to access and address this issue and come up with some good strategies to address it. This is their area of focus for this year. • FSP TAY- 24% reduction that were homeless, 45% reduction with those hospitalized, 31% increase in the number of clients living independently—and that is up compared to prior years--More TAY youth are living more independently in FSP. 61% reduction in juvenile justice system post partnership. o Can we pull out ethnicity, school outcomes/performance, and juvenile hall involvement for Child and TAY. Should pull out age as well. • FSP TAY Employment-all have increased • FSP Adult Living Arrangements—spent fewer days homeless, hospitalization, and in jail and more days living independently post-partnerships.

- CSS Work Plan consolidation- 24-25 CSS Work plans consolidated into 6 major categories. POE-Planning Outreach and Engagement. FSP-Full Service Partnership Programs- which starting in July will include some parts of FCSS. ACS-Alternative Crisis Services. CIRRS-Community Integrated Recovery & Resiliency Services (Non-FSP) Linkage programs. Housing.

- Implications: Administrative efficiency- DMH will do fewer contract amendments which means services get to the clients faster, allow a range of services provided, will meet needs much better, benefits clients and families and support a more seamless system of care.

- CSS Work Group Tasks—met by age group (child, TAY, Adult, Older Adults). Full Service Partnership Services- reviewed FSP criteria from CSS Regulations. Operationally defined "at risk of," expanding focal population criteria. Discussed methodologies to determine levels of care. Community Integrated Recovery & Resiliency Service (Non-Full Service Partnership Services). Developed service expectations.

- Child FSP-Focal Population—current regulations – any child that meet SED criteria could be enrolled in a FSP program, you have a choice—PEI, FSP, what is the right need and set of services?

- TAY FSP-Focal Population—Current criteria: TAY must have SED and/or SPMI. Operationalizing at Risk/Expansion of Focal Population Criteria: At risk of homelessness: unstable, sporadic housing/multiple placements or currently involved Commercial Sexual Exploitation of Children Youth (CSECY) or youth with a history of CSEC involvement.

- Adult FSP-Focal Population—Current criteria: homeless, jail, living with family members without whose support the individual should be at imminent risk of homelessness, jail or institutionalization. State criteria: must meet the criteria in either (1) or (2): Unserved and one of the following: homeless or at risk of becoming homeless, involved in the criminal justice system, frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. (2)- underserved and at risk of one of the following: homelessness, involvement in the criminal justice system, institutionalization. Operationalizing At Risk/ Expansion of Focal Population Criteria—Homelessness, Criminal Justice System, and Psychiatric Hospitalization.

- Older Adult FSP-Focal Population—Current Criteria: reasons for referral of an older adult with Serious Mental Illness. Operationalizing at risk/Expansion of Focal Population Criteria- Hospitalization, Institutionalization, Out of Home placement, Incarceration.

- Methodology to Determine Levels of Care:
    - Children: The needs of children and families change rapidly and children's services should be as broad and flexible as possible. Workgroup members recommend avoiding the creation of levels of care within FSP and instead focus on meeting the unique needs of individual children and families.
    - TAY: Milestones of Recovery Scale (MORS) and specific determinant of youth level care.

- Adult: Milestones of Recovery Scale (MORS) and determinants of care.
- Older Adults: Milestones of Recovery Scale (MORS) and determinants of care.

- Continuum of Care by Age Group—Look at it as a continuum and not everything is listed.
  - All the work plans that have been in our plan will continue, we are looking at how they serve as a continuum.
- Are we addressing the continuum of care across age groups? How are we addressing that? When we address independence and see recovery as independence are we covering that in some way and the reintegration back into the community so that we cover the continuum of care all the way from the access point. Here we are talking about delivering services but how are we making sure the discharge is appropriate and that they are going to be reintegrated back into the community and not have them keep coming back to us.
  - As we use the levels of care system we will be able to track a clients' progression in terms of moving through the system and then once they leave the system there are options that we may be able to employ in terms of sampling and looking at where and what happens to a clients after they leave.
- Are we going to be tracking the cultural relevance and effectiveness of this continuum of care system as it relates to the communities that are being served and the clients that are being served because that should be the underserved continuity all along that is consistent with MHSA?
  - Encourage the underserved cultural community groups to help us figure out. Unserved and Underserved are in a way a proxy for what you are talking about and so the work that the USCC groups do and the leadership committee could help inform that. We can look at data to see are these things making a difference.
- The cultural competency committee has advocated for the intergenerational treatment to really see the family as a whole, and when we look at continuum of care by age groups, families have intergenerational age groups within the family so the other thing is how are we addressing that issue? Really looking at the family as a whole and treating them.
  - Are the age groups getting the budget and services that they need? As we move towards the 6 work plans as opposed to the 24 or 25, we are not going to have "Child" FSP as a billing plan. We will look at the age of the client in the FSP, which means some children will be served in the TAY FSP. Age of the client instead of the program that they are in. The other thing is there will be an interest in the age groups coming together to say how do we support the whole family and those sorts of transitions.

Prevention & Early Intervention (PEI)

- In fiscal year '15-'16 we served 45,288 clients, that is a 10,000 client reduction from years '14-'15 which was lower than fiscal year '13'-'14.
  - 65% of the 45,288 were Latino or Hispanic, 14% were African Americans and still have a small percentage of Asians and Pacific Islanders.
  - Symptom improvement exceeded 40% after completion of an evidence-based, promising or community-defined evidence practice for several practices including Trauma, Severe Behaviors/Conduct Disorders: Brief Strategic Family Therapy, Anxiety and Depression, and Parenting difficulties: Parent-Child Interaction Therapy.
- PEI: Trauma Focused- Cognitive Behavioral Therapy (TF-CBT) and PEI: Alternative for Families Cognitive

Behavioral Therapy (AF-CBT) have significant improvements
- PEI-Suicide Prevention- reviewed data for suicide prevention hotline.

Summary- Revised PEI Plan
- 7 PEI Plan Programs- the way we report our services to the state. We reorganized them and they are not reduced.
- Total of 79 L.A. DMH PEI programs/projects
- 32 Prevention Programs
- 38 Early Intervention Programs
- 16 Evidence-Based Programs
- 13 Promising Practices
- 9 Community-Defined Evidence Practices
- 11 Cross-cutting Programs and Strategies

PEI-01: Suicide Prevention-will remain pretty much the same.
- 24/7 Crisis Hotline-we do a lot of training.
- Applied Suicide Intervention Skills (ASIST) Training
- Assessing and Managing Suicide Risk (AMSR) Training
- Latina Youth Program
- Partners in Suicide (PSP) Team for Children, TAY, Adults and Older Adults
- Question, Persuade and Refer (QPR) Training
- Recognizing and Responding to Suicide Risk (RRSR) Training

PEI-02: Stigma and Discrimination Reduction - we have expanded a number of these programs.
- Children's Stigma and Discrimination Reduction Project
- Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination.
- Mental Health First Aid (MHFA)
- Mental Health Promoters/Promotores Program—expanding that to serve Latino populations.
- Older Adults Mental Health Wellness Project
- Profiles of Hope Project

PEI-03: Strengthening Family Functioning
- Prevention Programs
    - Asian American Family Enrichment Network (AAFEN)
    - Making Parenting a Pleasure (MPAP)
    - Second Step- school-based program. Student and parent focused and it is already in the PEI resource guide

- Early Intervention Programs
    - Alternatives for Families-Cognitive Behavioral Therapy (AF_CBT)

- Brief Strategic Family Therapy (BSFT)
- Caring for Our Families (CFOF)
- Family Connections (FC)
- Incredible Years (IY)
- Loving Intervention Family Enrichment Program (LIFE)
- Mindful Parenting Groups (MP)
- Parent-Child Interaction Therapy (PCIT)
- Reflective Parenting Program (RPP)
- Positive Parenting Program (Triple P)- Prevention & Early Intervention
- UCLA Ties Transition Model

PEI-04: Trauma Recovery Services

- These will remain the same. This program is heavily utilized services in LA County.

PEI-05: Individuals and Families Under Stress
Prevention Programs

- Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors)
- Mindful Schools
- Nurse Family Partnership (NFP)
- School, Community, and Law Enforcement (SCALE) Program
- Senior Reach

Early Intervention Programs

- Crisis Oriented Recovery Services (CORS)
- Depression Treatment Quality Improvement (DTQI)
- Dialectical Behavioral Therapy (DBT)
- Families OverComing Under Stress (FOCUS)
- Group Cognitive Behavioral Therapy (CBT)
- Group Individual Psychotherapy (Group IPT)
- Individual Cognitive Behavioral Therapy (Ind CBT)
- Individual Psychotherapy (IPT)
- Managing and Adapting Practice (MAP)
- Mental Health Integration Program (MHIP)
- Problem Solving Therapy (PST)
- Program to Encourage Active Rewarding Lives for Seniors (PEARLS)
- Providing Alternative Thinking Strategies (Paths)
- The Mothers and Babies Course, Mamas y Bebes

PEI-06: At-Risk Youth
Prevention Programs

- American Indian Life Skills (AILS)
- Boys and Girls Club Project (LEARN)
- Early Identification and Prevention of Psychosis Outreach
- Olweus Bullying Prevention Program
- Positive Action
- Safe School Ambassadors
- School Threat Assessment and Response Team (START)
- TAY Drop-in Center Targeted Outreach & Engagement Strategies-Peer Lead Support, Painted Brain, Drumming for Your Life
- Why Try Program

Early Intervention Program

- Aggression Replacement Training (ART)
- Center for the Assessment and Prevention of Prodromal States (CAPPS)
- Coordinated Specialty Care Model for Early Psychosis (CSC-EP)
- Functional Family Therapy (FFT)
- Multidimensional Family Therapy (MDFT)
- Multisystemic Therapy (MST)
- Strengthening Families Program (SFP)

PEI-07: Vulnerable Communities
Prevention Programs

- Commercial Sexual Exploitation of Children and Youth (CSECY) Training for CSECY
- Domestic Violence and Intimate Partner Violence Services
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and 2-Spririt (LGBTQI2) Services
- PEI Supportive Housing Services
- Veterans Community Colleges Outreach and Case Management Services
- Veterans Mental Health Services
- Veterans Service Navigators

Cross-Cutting Programs and Strategies
Programs

- Building Resilience for Vulnerable Children and Families
- Commercially Sexually Exploited Children and Youth (CSECY) Programs
- County Department of Health Services (DHS)-DMH Co-Located Programs.
- Domestic and Intimate Partner Violence
- Early Education, Head Start and Preschool Programs

- Federally Qualified Health Center (FQHC) Programs
- Juvenile Justice After Care Program
- School-Based and School-Linked Programs
- Training for Community, Consumers, and Providers
- Unaccompanied Minors
- Services for co-occuring Physical Impairments and Mental Health (Blind/Visually Impaired and Deaf/Hearing Impaired)

Dennis Murata presentation

There are reasons for why numbers are dropping in PEI, one is that many clients come to our doors do not meet the PI populations. The emphasis this year is to do more things out in the community. Outreach and have other prevention programs and hopefully it won't result in a flood of folks coming to our services but we also know that as result of outreach and education people will be connected to services.

- The ongoing budget for PEI is $103 million for ongoing programs. Kim has asked us to maintain current funding level for the 3-year plan. However, we also have about $40 million of one-time that we are going to allocate in addition to $103 million dollars for a 3-year period. A lot of these initiatives are going to require additional funds but we also know our current PEI programs as budgeted are not spending their allocations.
- Working on ability for our agencies to bill for most of the outcome data collections.
- Community based organizations that do not have a contract with us will be allowed to be subcontracted with the legal entities to provide some of these services. Most efficient and effective way to get these things going.
- All these programs are wonderful, but they require a huge effort in contracting and we are trying to streamline ways to get the programs up and running.
- There are a tremendous number of uninsured kids in our program. What percentages of them really do fit for early intervention type services.
- PEI for the homeless and for housing—we need to develop more in terms of what specific prevention and early intervention program that fit that population because we tend to see that as CSS type of population but it is not.
- Focus on prevention- of the $40 million one time in the next 3-years about $25 million of that will go to new initiatives that will be part of the 3-year plan and about $15 Million of that will go to the variety of the things we are expanding that are in the current PEI plan. The estimate is $30 Million annually, we are budgeting for $15 million because we also have to look at because we are not spending our PEI allocations, some of those dollars can be shifted to these efforts.
    - Comment - Some concerns of the prevention programs are that the age groups really need to be reduced if you are going to prevent. For instance, CSECY in TAY, it's too late, they have already been exploited.
- State requires that 51% of PI funds go to children in TAY. Locally we agreed it would be 65%. However, when we take a look at what is being done out there in our current programs, 75-80% of that is for children in TAY. So some of the things you are looking at is targeted to Adult and Older Adult population trying to balance out the allocations that we have and the services that we have for those age groups.

Budget - Mary Marx

Department issued two RFPs for SB 82, which funded Urgent Care Centers as well as crisis residential treatment programs. We completed that process and have selected 4 providers. Three of those UCC's will be funded with MHSA dollars for operational costs, 1 UCC will be funded by the office of diversion and re-entry. The Department has selected Telecare for Service Area 3 San Gabriel Valley for and Urgent Care near Pomona. Exodus Recovery for the Harbor UCLA Urgent Care. Starview for the Long Beach Urgent Care and we've done a sole source for Starview in the Antelope Valley. In terms of the Crisis Residential programs we issued an RFP and had 11 agencies respond. We have 21 proposals for Crisis Residential Programs across the county. These programs will provide short term intensive residential care with approximately 10-14 day stay and partner with the Urgent Care centers to provide flow. We are moving forward with the award letters to award those contracts. The cost of the 3 CHFA funded UCC's including the 1 time cost will not exceed $1.4 Million for capital development and start-up cost. The annual operational cost for UCCs Crisis Stabilization services for the 3 UCC is approx. 5.4 million dollars per UCC. Those programs will be funded by MHSA Assembly bill AB109 post release community supervision FFP, Medi-Cal, and some 2011 re-alignment UPSTD. Estimated cost for MSHA component for each UCC is 2.3 million dollars, or an annual cost of 6.9 million. The annual cost for the crisis residential programs is approximately 2.2 million dollars in MHSA funding per crisis residential program. The total annual estimate cost of the UCCs and the 21 Crisis Residential programs is almost 28 million dollars.

- Q: How many clients can you serve in the facilities?
  - A: Most of them are between 14-16 beds with an average length of stay of 10-14 days.
  - A: Part of the UCC have a crisis transition specialists funded by SB82 OAC Grant. Discharge planning is part of their package of services that they deliver.

Workforce Education and Training component

- It is a draft, we still have some work that needs to be done on it. It only shows 2 of the 3 fiscals years that we are planning for.
- WET is a 1 time allocations given to the counties that could be spent over a 10-year period. The 10 year ends June 30th 2018, anything that we need to fund beyond that must come from your MHSA allocations.
- $5.7 million is an estimate but DMH is not currently requesting at this moment to continue funding WET. A proposal will be made to the SLT at a later point, through a mid-year adjustment or next year's Annual Update.

Fiscal Year 2016-17

- In August 2016-every county found out that there were state admin funds being held at the state that was then released to the counties.
  - $121.6 million for LA County. We attributed 80% to CSS, 20% to PEI, and take 5% off of each of those for Innovation.
  - Divided a 1 time allocation into 3 years and hopefully by the end of fiscal year '18-'19 we will be able to sustain this.
  - Allocating $30.8 million to CSS, $7.7 million to PEI, and $2.03 million to INN for the next 3 years.
  - Breakdown of the CSS allocation by services:
    - Allocate $25.3 Million for FSP—support service dollars for Whole Person Care, which we aren't

	funded for, Measure HHH, and No Place Like Home. This would fund all of those Board priorities including re-entry- people coming from out of jail, people that are homeless, and people who are intensive service recipients. ▪ $5.5 Million for CIRS (non-FSP) o Budget: CSS Programs ▪ FSP- $120 Million ▪ CIRS (non-FSP)-$166 Million ▪ Alternative Crisis Service-$80.4 Million ▪ Linkage-$16.9 Million ▪ Housing-$12.5 Million ▪ POE-$15 Million ▪ CSS Administration-$33 Million ▪ Totals are consistent ’17-’18 through ’19-’20 so far the projections that fiscal consultant gave us there isn’t much difference in ’17-’18 and ’18-’19. He hasn’t given us projections for ’19-’20 yet and his best advice is to use ’18-’19 as a proxy for ’19-’20. That’s why you see similar budget projections. In March, we will know the annual adjustment and that will help us understand better what our budget will be in ’17-’18, and if it goes up or down dramatically you will know about. We will convene a budget workgroup. ▪ These are net dollars, they do not include any federal dollars that we draw down from EPSDT, Medi-Cal or the state general fund portion of it. o FSP Slot Increase (Estimate)--Total Slot increase all age groups: 5,826 ▪ Child- 1,564 ▪ TAY-635 ▪ Adult-527 ▪ Older Adult-263 ▪ Total-2,989 Plan consolidation ▪ One Time allocation estimated slots-- will not fund Child slots because its not the focal population. • TAY (18yrs+) & Adult-2,571 • Older Adults-266 o Budget: INN, WET, & CFTN ▪ Roughly about $23 Million/yr for INN ▪ 5.7 Million in WET—disregard for now—working on a better more aligned plan

Public Comment and Announcements	• Comment: Reba -Thank you for presentation. I live in Service area 6. Where is the growth in the community per this presentation? I see numbers increasing but you continue to receive funds, health care in my community is declining. So the concern that I have in Service Area 6 is once again, I am not seeing it, feeling it, and I cannot taste it. I would like to highlight, since you haven't voted and I think it is important to recognize that Service Area 6, South Los Angeles is in dire need of funding and we need to actually experience the funding. I think it is totally unfair to look at numbers and not take a look at needs. How many of you recognize the needs of Service Area 6? Take that into consideration when you look at a breakdown of numbers. Thank you. • Question: In PEI-Strategy 2 - With the Promotores program…It didn't consider the African American population, what about the African Population? • Question: My observation and question is pertaining to the children in the TAY population. We talked about the EPSDT, outreaching to the schools, prevention and early intervention pieces and only if the families have Medi-Cal are accessible and I know things have changed and we have a lot of families that do not have any type of insurance because they themselves are either unserved or underserved. Dennis, I want to remind you to please consider my population which is the working poor, I still have children that receive services under TAY and I have private insurance. I can tell you it is very difficult to have services for my children and other parents that I know who are having difficulty because they have insurance and private insurance to access service. Remember that population and those children who are not receiving services or even if they are counted because they have private insurance. **DMH response: The MHSA prohibits the use of MHSA funds for clients with private insurance where the insurer refuses to pay for the county MH MHSA service** • Question: Pam Inaba - When are the Peer and family stakeholders are going to get some kind of review after the vote because we don't know what is going on. We have some in the SLT but the rest of us not in the SLT we don't know what's going on and we want to know. We would like an overview or a place we can talk about it and see the numbers and some of the other information because we don't get to see all that. Yes, some of the consumers and family reps can spread some of the information out but it doesn't go everywhere and we really need to get more of that out there so the rest of us know what's going on and we would appreciate that. • Question: Bruce - Nothing was talked about with the $5.5 Million for non-FSP is allocated for, unless I missed something. We heard for the $25.3, those three priorities but what about the 5.5 Million? o A: $5.5 will be in the Non-FSP category and that will be for that continuum of services for the different age groups. (Child, TAY, Adult, Older Adult.) • Q: Bruce- For what services? o A: Debbie - For CIRS • Q: Bruce- that comprising a lot of other things so how are the allocated in the sub categories? When you look at CIRS-there are a lot of elements in CIRS, like we talked about wellness centers, etc. o A: Debbie - the $5.5 could be used for that or field base service or other- • Q: Bruce- so we aren't making a determination on what that is used for at this point? o A: Debbie - It would be up to the provider. • Q: Ruth - I'm glad that Romalis feels heard and that his programs are included. I am surprised that the Adult PEI

programs are not showing up on here, in particular, the Critical time intervention for housing for people who are going through their first break. Which I think is totally a prevention and early intervention program and I am not seeing it there. The other question that I have is what is happening with the programs that were in the last 3-year plan such as the client run center in service area 6 and the client run center in service area 3 that still have not come out and also the stigma from the Inside-Out proposal that was part of the last fiscal plan and was supposed to be one of the first things that was implemented with new money. We got new money and it was never implemented.

  - A: Debbie - Not sure about the last one, but the intention of every annual update, certainly in the 3-year plan is in the narrative we would report on every work plan, we don't necessarily report on a particular peer-run center or client run center of FSP program but we report on the aggregate. And if something wasn't implemented we would certainly note that as well.

- Q: Ruth-are they going to be implemented in the new 3-year plan? What is going to happen in the programs that have not yet been implemented in the last 3-year plan?
  - A: Debbie - If something wasn't implemented you will see that in the new plan. This is a high level summary of a very large document.
- Q: David -Trying to understand the different allocations in the budget and how they tie to the master one here. For instance slide 56 has CSS overall budget has $444.4 million and the summary has $401 Million so I am not understanding.
  - A: Debbie - the disconnect may be that slide 56 does not include the one time allocation. Discrepancy you are talking about is $401.1 million which was what the projection that Mike Guy's projection. We have some unspent funds that will help cover the different cost of it.

Vote to endorse going forward to post the plan in Jan, present it to the Mental Health Commission and have a Public hearing.

A-fully agree
B-agree, minor concerns
C-neutral
D-disagree, but will go with group
E-Block.

If you vote E, you have to create an alternative proposal. Create an alternative proposal and that gets voted on and if there is not a majority then original proposal goes forward.

Question-What if we don't vote today?

The downside to that is the contract actions, which are complex, may not be completed by July 1st, and if that is the case, then we are unable to do CSS workplan consolidation and there are a number of issues and that is why this had been a truncated process.

Announcement- Colleagues- we are going to have the African American Mental Health Conference on Feb 9th. Conference brochure and handout on the table- please take it back to your community and groups ad share it, everyone is welcome to the Conference.

	4 E's- There were 4 people who blocked this. Only 1 SLT member acknowledged blocking the vote, stating I am willing to go to a neutral on this but I want to be clear that I don't want to ever see this happen ever again. This is not a satisfactory process, and I feel and I think a lot of people feel left out of this process even though I have put hours and hours into making it happen. **Debbie-** We have enough to move forward. We have 32 A's and B's so we have a majority. Thank you very much, you have voted then to move forward this Plan to the Mental Health Commission.