COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING

Wednesday, March 15, 2017 from 9:30 AM to 12:30 PM

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

REASONS FOR MEETING

1. Provide an update on behalf of the County of Los Angeles Department of Mental Health.
2. Share information on State legislative and budget items.
3. Endorsement from SLT Budget Work Group.
4. Discuss MHSA 3 Year Plan.
5. Veterans service needs through Prevention and Early Intervention.

MEETING NOTES

Department of Mental Health Update	***Jonathan Sherin, M.D., Ph.D.,* Director, County of Los Angeles, Department of Mental Health** **DMH Website** - Dr. Sherin looked at the website and found that it was not sufficient and very problematic. The turnaround time was very quick and a lot of work has been done, however, we are nowhere near where we need to be. There is still work to be done and we need input from everyone. It is now connected to real information and has more functionality. Please provide input through the website's feedback portal, that is up on the website. This portal will allow people to share ideas and also to report inaccuracies on the website. Dr. Sherin gave an example of functionality talking about Virtual Cognitive Behavioral Treatment. He hopes to be able to provide a link to get set up with virtual treatment at no charge. This will help avoid stigma, especially with the younger folk. The website is pretty good for the quick turnaround. **SAAC Tour** - Dr. Sherin has gone to 3 SAACs so far, with a lot more to do. He is pleased by the attendance, with the level of the dialogue, by the focus on identifying problems, offering solutions, and the interest in trying to help the department help more people more directly. **Peer** - Dr. Sherin's interest is in the work of peers. The role of peers is important, in addition to peers being able to play different roles. The model of peers that he wants to bring to the table is a little different. If you take a look at folks who suffer from mental illness and don't have a home or the extended version of home, the vast majority don't have a quality consistent place to live, no adequate resources, or lack of contact with family or kinship. Housing is a healthcare need. Kin-less-ness is a core deficit in the most vulnerable population. We need to set up the proper systems, leveraging peers who have shared experiences who are trained/certified/paid; they can provide the missing element. This isn't about being a part of a FSP program or a clinical team; it is about being a part of that person's life. Only when the individual as reconnected with their family of origin in a meaningful healthy strong way, would there be a handoff back to kin. For those that don't have a family of origin, the handoff can be when they have developed their own healthy strong

Department of Mental Health Update (Cont.)	kin relations in their life. Families don't hand people off. The communities, peer organizations, and families have a lot of power. We will lead that charge in Sacramento, it is important for that work to be recognized as a core need and for us to be able to support it with reimbursement. We will push and develop peer enterprise as a core piece of our redesign. I ask for your support in that. It is as important as having access to resources and a place to live. **Discussion, Q&A** • **Ruth Hollman** - I love what you are saying about peers, I have said for years that every consumer in the department should be a provider. Every consumer should be introduced to self-help support groups. In those self-help support groups they become a provider to every other consumer in terms of this family makeup. I agree with the employment piece but we need to take it a step forward. By using research-based practices of self-help support groups to reduce hospitalization by 50%, reduce the amount of medications that psychiatrist prescribe, reduce criminalization by 2/3's and to improve outcomes. • **Eugenie Lewis** - Can you expand on how the treatment team interacts with the family? Do you see the need to have specialty peers, such as substance abuse, domestic violence, etc.? o **Dr. Sherin** - I want to be intentional about developing a division that leverages peers and peers through shared experiences. The most powerful connection is shared experience. The experience and life that creates the connection and the trust. Peers also include family as well, not just the person with the illness. We need to leverage that. • **Karen Macedonia** - Regarding Salutogenesis, as you use peers, I ask that you consider the prevention and community power. Some kind of model where it is not about us and them, it is about a shared life experience so that we are doing all the things we talked about to help people who are almost vulnerable but we are also interrupting the pattern. o **Dr. Sherin** - Salutogenesis is one of my favorite terms in the English language and it means the opposite of pathogenesis. What do we do to push people on the path of pathogenic track in the other direction? One of my most favorite words is eudaimonia coined by Aristotle. Eudaimonia is the highest human endeavor. Not about wealthy, or being happy, it's about flourishing. • **Cynthia Jackson** - The website looks great! What a change, it is amazing. • **Romalis Taylor** - Now that Proposition H has passed, in terms of housing, how are you going to connect to that effort in order to advocate for our client population? o **Dr. Sherin** - That is a hard effort. Needs to be pursued. I think Measure H is an incredible statement of Los Angeles County. Measure H results aren't for the Dept. to clamor over. This is a County problem so it needs to be County solution. What really needs to happen is for the different departments to come together with the CEO's office, support of the Supervisors, to pursue the strategy that has been articulated for some time as a group. There are things that we do that DHS does not do and there are things that DHS does and we don't do. Some things make us more flexible and some do not. We have to leverage everything we have in the toolkit together to get there. Those things in DMH that are constraining and prevent us to have the flexibility we need to deal with the individual's challenges. I am going after them. Those constraining items will be sought out and eliminated.

Department of Mental Health Update (Cont.)	• **Romalis Taylor** - I hope that your avocation is very strong because not everyone is on board, and hopefully your voice will be heard and you can advocate that. • **Cynthia Jackson** - We look forward to seeing you tomorrow at SAAC 1. I started off in mental health as a DMH client, I was a peer advocate, then I was a case manager and now I run a peer run center. My question to you on your peer plan that you want to incorporate is my agency has allowed to me to go from peer advocate to many different roles, is the department looking into allowing peers to move out of the peer role into other roles? o **Dr. Sherin** - I think that makes the light brighter and the hope that much more promising. If it means giving a peer employee the time and opportunity, maybe special access to training/education and allow them to satisfy the qualifications for something up the ladder. This is how we fuel the recovery movement. • **Helena Ditko** - Reminder about May being Mental Health month. o **Dr.Sherin** - It is likely a very large campaign will be coming to LA. That optimizes mental health anti-stigma. This campaign has grown and become international.
Update- State Legislative and Budget Items	***Susan Rajlal,* Legislative Analyst, County of Los Angeles, Department of Mental Health** **AB 727** - Bill that modifies MHSA regulations so that anyone that is a consumer in our MHSA services would be able to receive the housing subsidies. As you may remember, currently only people in the outreach and engagement and FSP are able to keep housing subsidies. Our thought is that there is no wrong door to housing. Housing is a very basic need, elementary, you would need that before you need anything else. The thought that you had to be in FSP to retain your housing. Such as when you don't need FSP and you are ready to go to a wellness center, or a client run center, we would not want you to lose your housing if you wanted to move to that level of services. This bill is sponsored by LA county and the California Behavioral Health Directors Associations and is carried by Assemblyman Nazarian. This bill will be heard for the first time with the Assembly Health Committee on April 4th. We need letters to be sent in support of this bill. Email address is on the back page of AB727 handout (Emellia Zamani). • **Jim Preis** - The way that Mental Health Services works now, there is a limit on who gets into housing. Under this bill what is the limit, what is the cutoff for no place like home funds and how will it be determine? o **Susan Rajlal** - This is completely different than No Place Like Home. This is using our current MHSA funds that we have through Flex Funds. This is for someone who is homeless or in danger of homelessness. This is for people that currently have services. • **Ruth** - Is this only for FSP people moving down, or anyone receiving MHSA services? o **Susan Rajlal** - Yes, it is for anybody. We don't think that anyone that comes that has a mental illness needs to go to FSP, but they may need housing. • **Ruth** - So we need to allocate money to that pot to provide housing subsidies to people, do we create a new line for our 3 year plan? o **Debbie** - We would have rental subsidies in the CSS plan in RRR as well as Alt Crisis. There would be an invoice line and we have to identify the funds for that. • **Ruth** - How long does this go? Once somebody is in recovery and they have a job do they then no longer get the subsidy or do they get it for the rest of their life? With RRR we are looking at reintegration but wondering how does that resolve or do we end up with people not wanting to go to work because they will lose the housing.

Update- State Legislative and Budget Items (Cont.)	o **Debbie** - That is a key issue as we focus more on reintegration and increase opportunities for self-sufficiency via employment and other meaningful roles. How do we do that and how do we eventually help someone to sustain their own housing. • **Jim Preis** - The concern that I have is that housing is such a huge need, how do we stop this funding source from eating up all the other services in the MHSA? o **Susan Rajlal** - We see this as a way to get to No Place Like Home. We are in a crisis right now, we have many people that are homeless that we are not able to assist. There is a burgeoning need for services, the most extensive services such as FSP, and that is because of diversion efforts. In the long run, we are looking at this being more cost effective to have these people have housing and it is much cheaper than keeping people in FSP and having housing there. In the long run we may be able to balance all this out with No Place Like Home. I don't foresee people receiving housing subsidies for life because the goal is to help people stabilize, get better and move forward. • **Eddie Lamon** - I have a concern, we keep adding more things, can we estimated how effective this will be on our original reason why we are doing this. I want this to happen but somehow ask for some funds elsewhere, because MHSA cannot cover everything. o **Susan Rajlal** - MHSA can't cover everything. We have a multi-prong approach to trying to get housing resources. We have about 2,000 housing vouchers in LA County through Section 8 and other programs but if you look at the number of people that are homeless (47K people on any given night in LA County and a third of them have a mental health issue. That means we have 12k-13,000 people that are homeless with mental health issue and 2,000 vouchers is not going to do it. Short term is AB727 and long term is No Place Like Home. • **Tony Leggitt** - There is no new funding associated with this new bill. It is intended to reprogram existing funding, is this true? o **Susan Rajlal** - We keep a reserve every year of the leftover funds and we save it up for a number of years then use it for a project. It won't take away from our programs. o **Debbie** - It provides an opportunity. Think of the clients going in and out jail, or institutions, they will stay in FSP until we can help them along in terms of their housing. • **Tony Leggitt** - I don't think its appropriate to encourage people to get into housing program and stay on for life, that is not the way to go, but we do need funding associated with it. • **Richard Van Horn** - We need to note that the only language change in this bill says: These services may include housing assistance as defined for the target population… Basically it is permissive and does not take away anything and gives you a way around the lockout that has been around for a long time. We need a way around that lockout if we're going to have a range of services, so this really is a good piece of legislation. • **Anna Suarez** - Clients that don't have SSI or Medi-Cal, will they be eligible as well? o **Susan Rajlal** - Yes, all MHSA clients are served, we don't discriminate on the way they pay. **SB688** - This bill modifies regulations to allow the department of health care services to negotiate a contract with University of California system in order to do research and performance outcome reports. It would produce performance outcome reports that we need to show that MHSA has been a success. This is a CBHDA sponsored bill and It is needed. It will be before the Assembly of Health on April 9th - we need letters of support. When I send out the

Update- State Legislative and Budget Items (Cont.)	fact sheet the email will be on that. • **Ruth** - Is there money attached to that, or is coming out of MHSA? o **Susan** - No, the money is already allocated to the Department of Health Care Services, but as you know, they have not performed. When they talk about vouchers, privatizing Medicare, that is a big change. With Medicaid they are looking at block grants to the state or a per capita cap in the way they pay the state. That means that we will get money based on some year that is allocated on as a basis, but right off the bat, they are suggested that it will be a decrease. Instead of Medicaid giving you an entitlement to services we will have a per capita cap or a block grant that gives us money to support our treatment, which is a different way of looking at it. If you are 55 and sick, you are not entitled to receive all the services you would have got under Medicaid. Only a certain amount of money to support your treatment, which is very different. Be mindful of what is happening in Washington. • **Jim Preis** - One more comment on the possibility of block granting Medicaid and the potential impact. The EPSTD program is based on enforcing federal law against the state, there is a billion and a half dollars going out for children's mental health every year, pursuant to litigation. If it is block granted and no federal rules, the states get to spend the money any way they want, it is up for grabs whether the counties will be entitled to that money. All issues become debatable and lots of ramifications.
Endorsement from SLT Budget Work Group	***Robin Kay, Ph.D., Chief Deputy Director,* County of Los Angeles, Department of Mental Health** Periodically we have an update from the SLT budget group, usually because we have unspent money and we are coming up with a plan or we are planning for implementation of new programs. Every once in a while, we come terms with the fact that there are some needs that have emerged since the last plan that was developed that we need to be address. In the interest for transparency, we go to budget committee to vet those plans and get some endorsements for that the department needs to do, often in response to Board Priorities. We had first of 2 meetings to highlight those budget actions that needed to taken immediately and those that we think can be rolled out in the course of next year. We did come to a consensus about those actions that are urgent and that need immediate attention. We agreed to reconvene to discuss the other issues. **MET Teams -** The Board of Supervisors approved a motion that endorsed the expansion of the MET teams. We have doubled co-response teams through MHSA funding and SB82 funding in the last year. Currently has 24 smart teams, co-response team in every city that wanted to pair a police officer with a mental health clinician. At the time that we were doing the expansion the Sheriff's department wasn't ready to expand their operations, but they are ready now. The Board did approve a motion to direct the two departments to expand the MET teams, our portion of that is roughly 2.4 million dollars. This is a Board initiative and a board directive we have always listened strongly to those initiatives in the past and so we do have endorsement to move forward with the use of that 2.4 million dollars. It will be a little less than that, because there will be some revenue factored in, not a tremendous amount so between 2.1 and 2.4 million dollars.

Endorsement from SLT Budget Work Group (Cont.)	**Employment Pilot Project** - This group endorsed an employment pilot project. It was part of the 30-30-30 CSS expansion 2 years ago. What we found was that over the course of 2 years, we were about $400,000 short and it was not feasible due to needing multiple locations. It is a pilot we intend to look at the outcomes of that competitive employment project and we were missing some of the money needed to make is feasible. We did endorse moving forward to adding that $400,000 which is over 2 years to make sure it was a viable. These two programs won't be implemented until next year but we needed to take action now so we can get them into the budget process and move them forward. **Immediate Action in this fiscal year** - **Funding for emergency shelter beds.** SB82 homeless outreach program has been extremely successful that we have engaged a large number of homeless clients who in the past who have no been willing to go into shelters or housing. We have been exhausting the money we set aside or the emergency shelters and we need to add funding for that to ensure that we can continue that program to the end of the fiscal year and expand it next year. **Broken out two different components:** **General shelter program** - people picked up by the Homeless Outreach teams that need shelter. $400,000 for the Shelter beds accessed through the Homeless Outreach teams for the remainder of this fiscal year. **Shelter Beds** - for those homeless clients going into Urgent Care Centers we need to make sure that we have shelter beds. When somebody exiting an Urgent Care Center doesn't just turn around and go immediately in to a psychiatric emergency room or an Urgent Care Center because they do not have a place to stay. $100,000 for the shelter beds for those exiting Urgent Care Centers. The numbers are based on actual numbers, we know exactly the demand and we know exactly how much we need for rest of the year. Medical hubs, we are moving on with that as a Board priority. We are already in several of the Medical hubs, we have staff at the MLK hub treating children who are newly detained by DCFS. We have some staff in the Harbor Hub. We had made earlier commitment for having staff in all of the hubs. $2 million dollars that will start next year is to ensure that we have staff in all the medical hubs. **Whole Person Care** - the numbers you see for next year, those are gross numbers, and it's less than that. We need to fix this exhibit. Whole Person Care is coming, it is a Board initiative, a County initiative, and the County approved a motion, directing the Board to do all that is required to fully implement Whole Person Care. DMH is the lead on 2 portions of Whole Person Care. **Intensive Service Recipient Program (ISR)** - Go into DHS hospitals to identify people with 4 or more hospitalizations in a rolling 12-month period. Engaging those clients, working to prevent avoidable re-hospitalizations and working to support people in the community. We know that is the front end in most cases to FSP. That ISR project aligns with our FSP program here. MHSA funding that we need for that is $1.9 million.

Endorsement from SLT Budget Work Group (Cont.)	**Residential and Bridging Program** - This program moves people through IMDs and the locked residential treatment programs more efficiently. As clients are ready to leave and be supported in the community it is our intent that they get every opportunity and every support to do so. The RBC program aligns with Alt Crisis service because we will be moving people out of locked residential facilities into enriched residential programs in the community. MHSA dollars required for that total $1.6 million. We will continue this discussion in the budget work group but we do have endorsement of proceeding immediately with the MET expansion, the employment pilot project and the shelter beds for this year. • **Ruth Belonsky** - How do you reach out to the Urgent Care facilities to let them know of the availabilities of these beds? o **Robin Kay** - The idea is that we have a team that goes into a hospital and we have 90 days to work with clients to work with clients that have been in the hospitals a lot. Helping to support them as they move into beds that will be available through Whole Person Care, which is different than the shelter beds. There are beds available from both projects just from different stock. We will be meeting with Hospital Association of California to talk to them about the ISR project and what is available to them as we start to move people out of the hospitals that do not need to remain there. We also have designated teams that will be working on an ongoing basis with each of the hospitals to keep that momentum going. It will be a collaboration as clients who have been hospitalized frequently go into hospitals, our staffs will follow them into the hospitals, working with the hospital staff, it will be an ongoing collaboration, we have done this before. For the urgent care centers, we tried to build in shelter beds for the urgent care centers, they are aware of that resource. The issue is not that they aren't aware of those resource its about the lack of funding for the rest of the year. • **Jim Preis** - Are there County run shelter beds? Do you have contracts with shelter providers for a certain number of beds within their shelter? Can those beds be filled with only the work that we are doing? o **Robin Kay** - They are not directly run by the County, they are contracted. We have an open solicitation and we are always searching for more shelter bed operators to contract with us. We have to approve someone going into one of those beds. The shelters have never set aside beds specifically for the department, It is an open process, as we refer people, if they have an available bed, they bill us for the beds that we use. We are changing that model for a number of reasons. There are other entities that have purchasing designated blocks of beds and what that means is that this year the number of beds available to us is starting to decrease. We are looking at a model where we might, in the future, purchase dedicated shelter beds, we still pay for them if they go unused, but at this point that is not much of an issue, we are using everything that we can.

MHSA 3 Year Program and Expenditure Plan	***Debbie Innes-Gomberg, Ph.D.,* Deputy Director , County of Los Angeles, Department of Mental Health** Mental Health Commission Deliberations on March 23, 2017 regarding the 3 Year Plan. **FCCS Migration to FSP** - Field Capable Clinical Services for each of the age groups will not be FCCS anymore as a work plan. It will be Field based services in RRR. Engaged with the District Chiefs, administration to work with providers with a review of their data. It resulted in $43.1 migrating from FCCS to FSP across the age groups. Includes service dollars and built in dollars for client supportive services. Estimated 2,031 clients will become FSP clients come July 1st. Breakdowns: 755 child FSP clients, 765 FCCS child clients, 230 TAY, 265 Adults, 16 Older Adults.) **Mariko Khan** - Am I reading this right, only 16 older adult slots? **Martin** - In terms of older adults as you know our capacity is quite a bit smaller than most programs – There was no additional funding so programs were challenged to do their analysis, and transition over enough to create a team without negatively impacting the existing services in FCCS including the flex funds support. Our programs at this time did not have enough to transition more slots to FSP. On the flipside we have programs such as Heritage, and Telecare that are already 100 percent FSP as a result of the integrated pilot. A couple of our larger programs have already done this exercise and transitioned over. **Mariko Khan** - My concern with API Older Adult is county wide, and we made specific request for increases for the older adult population. I am uncomfortable with just accepting just 16 slots, maybe we can talk later so I can report back to group. **Cynthia Jackson** - To add to what Mariko said, the API older adult is the most underserved. In new budget section of negotiating it does not breakdown in age group. So what worries me is for other age groups that serve a variety of age groups, how do we continue to track that an adequate number of older adults were being served in general? **Debbie** - We will track by age of client now. Often we report by the program that the client is in, the age group. I suspect there are a number of older adults being served in adult program and we will see start to see those differences start to emerge. The second thing relates to how the department will change the way in which we monitor programs in the past. We will monitor programs more effectively than in the past. **Next Steps:** Provider meeting - Second week in May for all age groups. Overview of CSS WPC - We have a 1-page document that describes the work plan consolidation. We will go over what is CSS work plan consolidation and what are the next steps for providers. Direction of closing clients out of FCCS Direction on completion of FSP Notification forms Overview of FSP - We will have FSP orientation and materials. Orientation to WPC, answers addressed OMA training - Orientation for Outcome Measure Application for those that haven't used it, including all the details surrounding that. DMH to change Financial Summary

MHSA 3 Year Program and Expenditure Plan (Cont.)

Funding plan modifications being worked on so the funding plan aligns.
FSP Guidelines Revision to reflect the priority populations or the eligibility changes as well as some language to remain consistent.
Re-draft FSP and RRR Service Exhibits - in process of that and it will be longer exhibits since there are two instead of 10-15 exhibits.
Finalize FSP slots by provider, Service Area and Age Groups

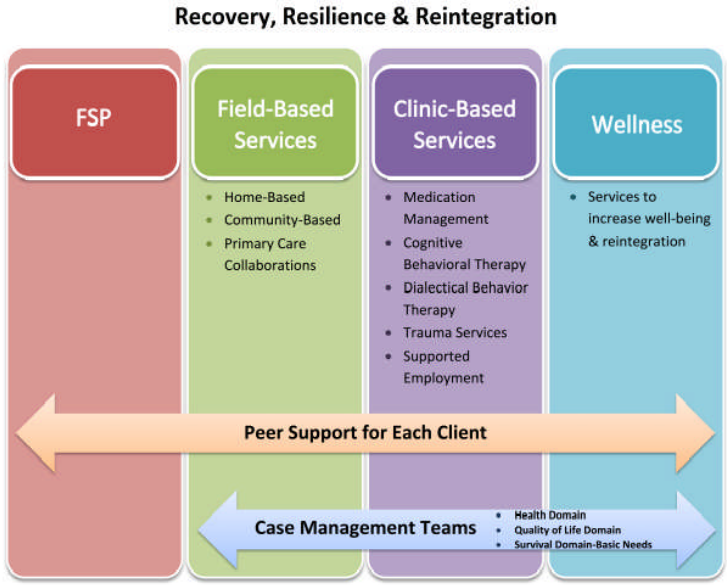
121.6 Million MHSA Allocation

FSP Expansion:

Solicitation for Whole Person Care, homeless initiatives - Do we issued a second solicitation or group the homeless initiative particularly Measure HHH housing supports into that SCI.
Directly Operated Expansion - To date we identified 130 new client slots for the directly operated system over 4 programs. 3 of them are expansion programs. At this point, Coastal Asian-small FSP program for the Asian population, Long Beach Asian- add 15 slots, add 50 slots to Long Beach Adults, add FSP programs to San Pedro Mental Health. The criteria we used so far was what are the programs that are over capacity that can benefit from this service and the need is present. There are a number of larger programs in other service areas that have a little ways to go. As programs reach capacity, we will be able to have a sense of how we can add directly operated expansion.

- **Lawrence Lue** - What is the order in what we look at allocation of new resources? Look at our whole county, look at geographic distribution, ethnic, special populations, age groups, and asking what are the needs and then matching up and looking at the picture on how spreading out the resources. As you described it, I am a little concerned, there are always "Where is the immediate capacity available", "where we can fill", or "expand quickly". The challenge is always are we going to put resources where they are needed but where we may have to do more heavy lifting in terms of creating the capacity. At some point, at some level- the commission is looking to start at that first level, how are we by geography, by service area, age groups, special populations, just overall needs and then identify where are the low hanging fruit to build on and what are we going to do in those areas that is an emerging need but we need to build that capacity
    - **Debbie** - In depth discussion yesterday in Executive Management around high utilizers and identifying those individuals and being as proactive as possible in terms of identification. The information that was presented to us may help us in identifying the emerging needs you were talking about, where these clients live, where they are getting care. The second thing we would be interested in talking with the Commission and SLT is that as providers respond to SCI, where is the need. Bidirectional process, historically the need for homeless people has been in Service Area 4 and 6 but the need is growing across the county. The degree to which the providers are there and able to respond and expand the department needs to support those efforts so that we can increase capacity in the areas that might need them. There is work to be done to do that.
- **Lawrence Lue** - There may be areas that providers aren't available. Do we take existing providers and encourage them to expand to an area. Given the nature of new populations we need to build that local capacity that is very responsive and close to those populations.

MHSA 3 Year Program and Expenditure Plan (Cont.)	o **Dennis Murata** - We need to be mindful of the Board priorities as that also dictate where the funding gets allocated. In terms of resource allocations, we know where some of the area of needs is and it may depend on focal populations. Such as Service Area 1, where it is hard to find and recruit and retain staff to work up in that area. Also, when we put things out to bid, few agencies are willing to relocate their services to those areas. In Service Areas 6 and 7, we need to increase Spanish speaking clinicians and agencies; it is difficult to get people. The priority is what we know about those areas and the demand that we can meet. That is how we proceed. • **Eddie Lamon** - Isn't there a way you can go out there to let people know in those areas, to explain to them what is needed out there. They need to get the people out in those areas since they are already there instead of trying to get people from other areas to come to that area. • **Cynthia Perez** - I work for Mental Health America; we do as much as we can with the resources we have. There are many in the community that works towards getting our community the resources and recognition. I am interested in the fact that you say some slots are not filled. We have had to turn people away at some times so maybe that is why we have the available slots. We do have the need. • **Karen Macedonio** - Debbie, you made the statement "Where do the clients live and where do they get care?" Do we track that now? Do we have that as a report? o **Dennis** - Yes, we report that, but we also need to make sure when they enroll consumers into our system they need good addresses. Where they live not where they were served. Where are the resources assigned and where are they needed. The problem we had was what do we do with 25% that have no address/homeless. Where do we distribute them, it was guide to where folks lived. • **Mara Pelsman** - In regards to the solicitation to Whole Person Care directly operated expansion, was the client slots supposed to be under the solicitations, isn't that something new on adding it to directly operated clinic expansion? Whole Person Care and Homeless Initiatives. o **Debbie** - No we had not established a balance between directly operated and contracted. These are slots either for Measure HHH, whole person care, etc. • **Bernice Mascher** - Getting more peers supportive volunteers out there. Finding ways to get their community involved. Finding ways to work with grass roots, train people to go out and be more involved. • **Ruth Hollman** - We need to find out why people aren't applying. Why they aren't using the programs. Maybe we advertise it differently. We don't have a way to giving feedback. Why aren't people expanding to Service area 7? If there is a way to why they are not responding or applying to these. • **Eddie Lamon** - Not many mental health services in Service Area 1. We need some kind of way to get to the people. Tell them what is needed out there. • **Karen Macedonio** - Comment- in the conversations that I have in rural areas. I talk about mental health and I won't get much of a response, but when I talk with people it comes back to the issue on how to get primary care or use primary care. We have primary care that does not understand mental health. We need to partner with Primary care. **Updates from Age Group Leads:** **Adults System of Care** - **Debbie Innes-Gomberg** Outcome Measures: We decided on two outcome measures, IMR clinician version and CIOM. 1 is the Illness

MHSA 3 Year Program and Expenditure Plan (Cont.)	Management Recovery Scale (IMR), the clinician version that has roughly 17 questions. We used in Innovation1. For the client measure we decide on the CIOM that is completed by the client. It includes 30 different items including a section on employment and housing. We chose these two because we had familiarity, they were good measures, we can translate them into the languages we need to, both are free, and they are easy to measure. Level of Care Metric: Determinants of Care coupled with the MORs. • **Ruth** - How often are you asking for these measures to be filled out? o **Debbie** - I don't recall and I don't believe we made a decision on that. We had some discussion, we don't want to ask them too often, but maybe when clients improve we can decrease the frequency. • **Ruth** - What about the people that come without an appointment, or the self run support groups. I would recommend that they not be done more than every 6 months in those environments. In terms of staff doing them, I don't know how we are going to deal with that on COS. Will need to iron out details. Recovery Resilience and Reintegration Service continuum  3 main key components: Field-Based services, Clinic-Based Service and Wellness. RRR will have opportunity to do things that will make a difference. Field-based services - It is an opportunity to provide services in the field, in the home, in a community setting, in a primary care setting, where-ever the client needs services. Clinic-based services - This is the real addition to the Adult System of Care. Cognitive behavior therapy, dialectical

MHSA 3 Year Program and Expenditure Plan (Cont.)	behavior therapy, trauma services and supported employment. The more we can get people employed the more they become more self-sufficient. Wellness - we have a large number of wellness centers. Wellness in the reintegration. We want to be able to use peers as effectively as we can. **Case Management Teams** - Health Domain- peers being used to navigate people through health settings. Quality of Life Domain - moving into employment and education. Survival Domain - Basic needs and Maslow's Hierarchy. • **Jim Preis** - I am trying to understand line between clinic-based services and wellness. How do you determine supportive employment as a clinic based service as opposed to wellness? o **Debbie** - It can be provided anywhere in the spectrum, it needs to be across as a continuum. • **Helena Ditko** - They intend to overlap and so it's hard to put them in a box. Recovery is not linear, and almost insulting to say to the consumer that "you fit in this box or that box", it's easier to say what the person needs. o **Debbie** - If we do this right, our intentions behind all this is not to have boxes. All of these people will be on one team across FSP, Field-based, client-based and Wellness. • **Jury Candelaria** - How and where does housing fit in o **Debbie** - Housing should go throughout. If legislation passes, then we need to dedicate dollars for rental subsidies in RRR. I need to think about how that reelects on diagram • **Ana Suarez** - In the implementation of RRR, how will it work if someone in Clinic-Based service, receiving CBT and they have crisis at home, and need them someone to come to their home, but they also have a peer support group they drop into. How are we going to allow flexibility between these programs/services? How and can providers navigate through all these programs? o **Debbie** - That is the intent and beauty of this, they will be able to. It is one funding program, RRR. The client will get the services they need and from 1 funding plan. • **Karen Macedonio** - I am having a problem with what I think is an assumption with the reintegration part. My question is what happens if the life skills were not there in the first place? How can we have reintegration if the skill was never learned? How are we assessing that to build the skills as we move along, rather than get to a point where we set someone up for failure? o **Debbie** - Reintegration might happen in small areas in the types of people that you are describing, but we wouldn't want to reintegrate fully into the community and lessen the mental health involvement until somebody got that treatment and develop those life skills. • **Karen Macedonio** - It has to be an intentional component. o **Debbie** - Can you think of how we would add that? • **Karen Macedonio** - Something in the wellness center to figure out who has what. o **Debbie** - The service you are describing would be provided. • **Karen Macedonio** - Which takes us back to community, to the non traditional partnerships, to some kind of community center. • **Tony Leggitt** - I have an idea on how to conceptualize the RRR diagram. Having the client as the center of the diagram. Some type of Venn diagram with the surrounding programs around the client. • **Cynthia Perez** - As far as the life skills go, the peer support for each client throughout would be a good place to put those life skills supports.

MHSA 3 Year Program and Expenditure Plan (Cont.)	**Older Adult System of Care - Martin Jones** One of the concerns that stands out was there is a higher Flex Fund cost in having individuals in FSP as opposed to FCCS due to the housing cost. In our meeting, this was discussed in some length to not totally exhaust the FCCS programs in order to expand the FSP programs. In particular, since API was mentioned earlier, this was an issue that one of our large API providers did mention in terms at looking at the availability of flex funds to be able to support Older Adults FSP expansion. **Level of Care** - Older Adults will be using the Older Adults specific MORS along with the determinants. Working with MHA to schedule and move forward on training to use that as our level of care tools. **Outcome tools** - In terms of RRR we have looked at the same types of tools that Adults were looking at. We did not get to stage in terms of selecting the tools because we had much discussion on language, availability of tools, whether they were in the public domain or not. We have a follow up meeting to select outcome tool. One of the challenges is that most of these tools are not normed for older adults, so it is a matter of looking at what is out there and seeing which one will actually be the most useful for Older Adult. We looked at OQ, IMR, and CIOM, there were pros and cons on each, and we will further drill down and decide on one. Looking as a system how will RRR work with older adults. Most are in FSP area, how can we best develop our continuum in a way that will be most helpful but certainly, RRR gives some flexibility for clients to move freely between field-based to wellness. • **Eddie Lamon** - Statement: I think we need a glossary of the acronyms. **Children System of Care - Kanchana Tate** We reconvened our Child workgroup on February 27th; it was a small group, with some returning and some new members. It was a good conversation, they were really advocating for children to define RRR. They felt that it was to vague on how we were presenting it. It helped us take a look at RRR. We are looking at a range of services we offer now, field base, outpatient programs and wellness. Putting families in boxes, we don't want to do that. How do we ensure the clinician involved can follow them from field-based, to outpatient, to wellness? The level of service the family needs, sometimes they need two times a week versus once a week. Meeting the needs of the families. Asked providers to look at their service area needs as well as their system of care within their agency to find the gaps in and to think outside of the box when they are developing their new programs. **Outcome Measure** - We talked about education; we want to see children improve in school performance, getting involved in the community, and developing healthy relationships. Prevention or reduction of systems involvement, such as justice system, DCFS, etc. Also to reduce substance abuse. **Levels of care** - CASSI- We understand AXA (?) is doing a pilot. We are interested in finding out results. We are also reaching out to other Child providers to see if they have a system in place that identify levels of care that is working for them. CASSI is a tool that looks at different domains, looks are where they are, the severity of their symptoms and

MHSA 3 Year Program and Expenditure Plan (Cont.)	behaviors, and can assign a level of care. EPSTD is also looking at a tool so we want to be mindful in choosing a tool so our clinicians aren't using too many tools. We are waiting to identify which tool will be most helpful. • **Sandra Villano** - I hate to state the obvious again, but I keep hearing about the fear of children not wanting to go to school and the worry about deportation. How afraid they are to leave their parents and go to school. We need to get ahead of this. o **Kanchana** - We currently have a PEI program, for the children who have come to the country without a parent or caregiver. We just had training where we shared what we are learning in the process. We will be providing training so we can support our clinicians to help our families plan and prepare their children. • **Jury Candelaria** - I don't think you address the question. Children being taken or parents are being taken and the children witnessing their parents being taken away. o **Kalene Gilbert** - We have many big discussions about this issue in the Department and have heard many horrifying stories. The Department and the County have taken a stance that number one, we are supportive. We will continue to be supportive of our full community, documented or not. We serve folks that come in the door and we treat. We do not keep records of who is documented or not. We know there is a lot of trauma and fear out there. Develop material and tips not just for our community but also on our clinicians on how to talk with families about this kind of trauma. There is an effort to coordinate all of the services so we can give a consistent message to the community. o **Ana Suarez** - We are looking at different ways to address this. How to educate both our directly operated and contract providers on the issues, bringing in legal experts to talk about the legal issues. Trauma experts to talk about the trauma that this is causing for people. Talking about training clergy, utilizing Promotoras, lots of ideas that are in the hopper. Just want to make sure we are working in conjunction with the office of immigration collaboratively. • **Carmen Diaz** - You mentioned community activities for our children, a lot of time some cannot afford these activities. Is there a stipulation looking at the funding for that? o **Kanchana** - We will have flex funds to help support that. How can we support that family to continue the activities programs? The Flex Funds that are identified in RRR are already attached to our FCCS program, so those will roll over to RRR and will be available to our full populations. **TAY- Mary Romero** **Level of Care** - We agreed to adopt the MORS level of care and the determinants as the Adults System of Care is doing. For our youth that are 16 years to 18 years we are also looking at the CASSI assessment, and working with Children Systems of Care to make sure that we can asses those youth. **Outcome Measures** - We agreed on adopting the OMA for our FSP and outpatient services. For our wellness services for TAY, there is no specific TAY wellness services. Our TAY that are 18 years and older can go to Adult system to get services. We didn't really have anything specific for TAY. We talked about providing peer-led, peer leadership support for families of TAY as part of our wellness service to support resiliency and self-sufficiency. We looked at adopting the OQ- Outcomes Questionnaire, and the YOQ-Youth Outcomes Questionnaire, which looks at behavioral symptoms, interpersonal relationships and social roles. TAY system of care is very fluid, we have our FSP, Field-based service,

MHSA 3 Year Program and Expenditure Plan (Cont.)	Outpatient services, but we also have a lot of additional services such as housing programs, teen navigation program, peer-let support groups, and we also have our drop-in centers. We looked a modifying an existing survey for our permanent supportive housing and some of our housing programs to account for confirmed linkages. Many of TAY navigation and drop in centers are a point of contact, where the kids are coming in and entering the mental health system. We want to look at how are the linkages are confirmed. We want to tighten the net and look at confirmed linkages. Survey will be administered to all the kids in the program. There will be incentives and an explanation to the kids that based on their survey results it will allow us to help other kids. For TAY drop in centers we also look at unique client served. • **Ruth Hollman** - Self-help support group that don't have a paid peer facilitator in them have a much better outcomes than the support groups that have a paid person in them. Please add that to your list that you are offering because you will get much better outcomes from that. • **Eddie Lamon** - I have concern for 18 year olds that are foster children. At 18 they are no longer in the system. They are we need to educate so there is a place for the foster children to go. o **Renee** - Absolutely, we also develop a relationship with the non-minor dependency court (Those kids that are 18 years and above that are still part of the DCFS system.) Our TAY navigators attend the non-minor dependency court once a week and the help link all the youth that need mental health services and/or housing. That is how we are reaching out to that population, but I agree with you, our 18 year olds are definitely at risk. • **Eugenie Lewis** - For all the reports, you all mentioned different outcome measures, determinants, and then you have outcome measures, are they distinctly different, are they both outcome measures in a way? o **Renee** - You can use the MORS for outcome measures, but the MORS is more for determining in what level a client needs. The outcome measures are to check for benchmarks that we are looking at accomplishing.

Veterans service needs through Prevention and Early Intervention (Cont.)	***Carl McKnight*, MH Clinical Program Head, County of Los Angeles, Department of Mental Health** We have a unique opportunity now, to expand our services for our Veterans. To look at how we can use our Prevention and Early Intervention funds more appropriately and to do some things outside the box with veterans. Look at establishing a comprehensive program for reintegration to help our veterans come back into society. Military trains service members and provides all your basic needs, but some go in at a young age and they don't have the skills to retain housing, etc. The military does a good job training you, but fails at reintegration back to civilian life. How do we get them back to civilian life and society, to be fully functioning and develop a goal of self- sustainability and the reduction of any of the problematic symptoms they may have? The first area is to work with our community colleges to expand our existing programs at our community colleges to provide case management assistance, therapeutic care, and whatever is needed for our veterans at each of our community colleges throughout the county. Assist all the veterans that are coming back and being seen in our community colleges. Second area is a placeholder for $5M, establishing a comprehensive reintegration program for veterans. Something that addresses the needs of our veterans, those that are having a difficult time reintegrate back into society. **5 areas to focus on are:** 1) Supportive employment- learn job skills, and how to work in our environment 2) Families-emphasis on family issues. 3) Reintegration workshops- Working on adjusting on job, family, etc. 4) Focus on women's issues- focus on military sexual trauma, and 5) Peers- try to encourage to be part of supportive employment, workshops etc. • **Eddie Lamon** - Should be a mandate, that they train you before and train after, to demilitarize. So they can go back to society and reintegrate. o **Carl McKnight** - The closest we got to was working with the Guard, we did that pilot program with that one unit, so we will try to get the Guard to work with us. • **Sandra Villano** - NAMI has a family program called Home Front and I am sure we can gather volunteers to assist you in creating training for family members. I didn't hear anything about homeless outreach to veterans. o **Carl McKnight** - The reason why I didn't talk about that is that we do have a Veteran specific FSP program. We also have a separate outreach program through SAMSA the PATH team. I didn't talk about that because I was talking about PEI, we do have the CSS and FSP programs for homelessness. • **Paco Retana** - I have firsthand experience being at Rio Hondo College, and seeing the great work that is being down out there. It is visible, just so you know.

Veterans service needs through Prevention and Early Intervention (Cont.)	***Lillian Bando, JD. MSW,* Program Manager III, County of Los Angeles, Department of Mental Health** Prevention orientated and we wanted to have a broad-based strategy. We want to be able to get in as soon as possible in working with families. They have them there for a week in Cypress to decompress and reorient. When we are planning about these family retreats we would like to have an opportunity to do that. The other thing we are talking about is that many of the veterans go in very young and many miss the transition age to develop life skills of how to get a house, etc. We are also excited about working with peers having them be an integral part of the program. With the discussion and various input from veterans groups and other people that have been working with them what we are looking at is really prevention. If we can de-stigmatize the need for services and get them into services if they need them or to normalize some of that. • **Ruth Hollman** - We have many self-help groups that help vets in Los Angeles. It is a good place to get jobs. Wanted to let you know there are support groups out there.
Public Comment and Announcements	**Mark** - We just finished the Western Recovery Conference, it went great. **Maribel** - I am with For the Child in Long Beach. I am glad to hear that other people are concerned about immigration because we are feeling it. We have a lot of our families that don't want to come into our offices or even to ride the bus. We are trying to get training for staff on how to handle it and address it in a way that is sensitive to them. For them to feel safe and it is happening. There is a lot of fear and trauma and I thank you for addressing it. **Pam Inaba** - More details of techniques and therapies that are being used to do RRR. To understand a little more of how things are being achieved and how clients are getting the skills to reintegrate. Adjourned: 12:22pm