LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, January 17, 2018 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

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REASONS FOR MEETING

1. Provide an annual update on MHSA: A Synopsis of Outcomes
2. Provide an update on PEI in schools
3. Provide an Innovation Projects Overview
4. Provide an update on housing projects

MEETING NOTES

MHSA Annual Update: A Synopsis of Outcomes	*Debbie Innes-Gomberg, Ph.D., Deputy Director County of Los Angeles, Department of Mental Health* Many of you have heard annual update presentations from me in the past. I wanted to take a slightly different approach this time and engage all of you in terms of the implication of the data that I am going to present. Many of you received a set of slides, and then an updated set of slides yesterday. The only difference is there was some employment data that we presented that we realized that there was an error in some of the data. We pulled that back and are going to refresh that and get the corrected information out to you. Before I begin, I wanted to introduce a discussion panel that is responsible for the in-depth analysis of the data that is presented on the slides. First off, Alex Silva, George Eckart, Ivy Levin, and Kara Taguchi. What I asked them to do is to jump in as I am discussing the slides, if they have a point they want to make around what the data represents. Certain slides I will be asking you about what that represents in terms of the implication of treatment, in terms of gap analysis. Before we jump into that, I want to give you a small update on the unspent dollars plan that Dr. Sherin talked about conceptually at our last meeting. Dr. Sherin will hopefully be here by noon, Mimi is away on travel. What they have told me was in February they will have an in-depth discussion about the role of the System Leadership Team. Developing plans and particularly around budgetary issues. I cannot address much on that particular piece of it today but I wanted to give you a high-level overview of what we are likely going to be posting in the next 5 days or so. What you are going to see over a period of two or three fiscal years, maybe more, is a plan to spend about $453 unspent million dollars in CSS money. That CSS money is really focused on expanding a lot of what Dr. Sherin talked about last month. The visibility in the community so that there is real time access to services. Real time access to the Department of Mental Health when it's needed. Whether it is in a school, fire department, or psychiatric mobile response team where a person does not need to be hospitalized but needs care. We are looking at those sorts of things. The second thing is Prevention and Early Intervention. I wanted to walk you through a couple different pieces. There were unspent dollars in PEI that would have reverted June 30th, had AB114 not been signed by the Governor. We are in

	the process of validating information from DHCS. DHCS sent out information to each county last week about what was scheduled to revert, they did not include 1516 so that is an issue. They acknowledged a calculation errot of what was sent out. We are waiting for them to send a final for us to we will validate that, correct that, tell them why we don't think it is correct and develop a plan; part of which is what we are going to post. The second piece of it is that there are dollars that would revert June 30th of 2018, those aren't part of AB114 so we will be developing plans for that. The third piece of this is AB114 contained a clause. That clause is when and Oversight and Accountability Commission in Sacramento approves an innovation plan after July 1st of 2017, that resets the clock for those dollars. When we got our Innovation 3 Technology Suite plan approved for 33 million dollars, that reset the clock for the 33 Million dollars, so we don't revert any of those innovation dollars June 30th of 2018. The plan is very comprehensive. With Prevention and Early Intervention, it focuses a lot more on Prevention. It focuses much more upstream about being able to access services and identify children and families that are at risk of developing a mental illness, either because they've experience trauma, because of something else that has happened, or something that is going on in the schools. You will see more of a focus on Prevention as well as being available and being present at key access points. Those key access points could be the jail, the schools, the library, DHS medical hubs, it's those sorts of place where people coming into our system are likely to go and likely to receive a contact with mental health who will hopefully avert a mental illness. Third, PEI expansion plan represents a bringing together of departments in a way that we haven't partnered with key departments to date. It helps services, public health, DCFS, Libraries, and other entities in our communities, it really represents a coalition of bringing them together for the purpose of reducing the likelihood of mental illness in the people in our community. With CSS as you know from the 3-year plan, we are adding FSP slots to that. It looks like it will be a little over 5100 FSP slots, some of them will be directly operated, most of them will probably contracted. We issued an SCI, we've finalized the slots for the providers. They match the needs of service areas and of supervisorial districts and so we are going to go forward with that in two different ways. A board letter for at least 3 providers that have gone over their delegated authority. In other words, we added as much money to their contract to this fiscal year as we can, so we have to do a board letter to increase that. The other thing that the board letter will have is a request for positions for our directly operated programs. Then for providers who haven't gone over their delegated authority we are going to amend their contracts to put those dollars into that. Those are for people 18 and above, to serve key focal populations and we are very excited about that. That should bring our total of FSP slots to somewhere around 18,000 slots county wide across the age groups. The other thing that is going to be in our CSS unspent plan is dollars for the recovery, resiliency, reintegration providers that will allow the use of flex funding, the significance of this is AB 727 Nazarian bill provided for the use of flex funds.in CSS programs outside of FSP and outside of Engagement. We will add dollars into providers contract so that they can then initiate housing for people or continue housing of people graduating from FSP into RRR. Innovation 2 is in its final scoring process right now. We think that will finish in two weeks. Innovation 3 we have our first

status update to the Oversight and Accountability Commission on February. 22nd. We have identified a statewide project manager and who will be hired through Cal Mesa because that is where our funding goes through since this is a multi-county project and this is the technology suite. Karen Caulk will be our statewide project manager, for those of you who haven't met her, I can't think of anybody better at managing projects, so we are really excited about that. Once the dollars go into Cal Mesa and the board approves it, which we think would be early February, then we will do a launch once they are customized for LA County. We want everybody to know about them, and how to access them. We will come to you in a month's time to maybe talk about that.

Innovation 4 which is Mobile Transcranial Magnetic Stimulation. We will seek approval from the Oversight and Accountability Commission on February 22nd. Again, the focus of that is on treating people in a new and innovative way that hasn't been tested out in the public Mental health system and the focus would be on clients that have not responded well to depression treatment and medication in board and cares. Some of you know there is an Innovation pipeline workgroup that Wendy Tovey is going to talk about a little later on.

Annual Update:

Every 3 years we do a 3-year plan. Last year we did a 3-year plan, and then we update that plan annually. That's what we are doing. When we report on information what we do is report on the last full fiscal year. The information presented is for fiscal year 16-17 and the budget will be a projection for fiscal year 18-19 and beyond. The director has to sign an attestation around the truthfulness of this, the auditor controller signs it, the mental health commission approves the plan and the board of supervisors adopt it.

Purpose and Facts

- The Mental Health Services Act stipulates that counties shall prepare and submit a MHSA Three-Year Program and Expenditure Plan with Annual Updates
- The Plan requires a 30-day public comment period and a Public Hearing
- Mental Health Director and County Auditor Controller certification as to compliance with laws and regulations
- The plan must be approved by the Mental Health Commission and adopted by the Board of Supervisors
- Information and data presented is from the prior Fiscal Year- 2016-17

Timeline and Key Dates:

January 17, 2018: Presentation of the Annual Update to the System Leadership Team
January 25, 2018: Presentation of the Annual Update to the Mental Health Commission
February 19-March 20, 2018": Public Posting of Plan for 30 days
March 22, 2018: Public Hearing convened by the Mental Health Commission
April 26, 2018: Mental Health Commission deliberation on approval of the MHSA Annual Update
May-July 2018: Board letter submission and adoption, posting of final Annual Update on website and submission to the Mental Health Services Oversight and Accountability Commission

Fiscal Year 2016-17 Community Services and Supports:
We consolidated CSS plans:
- Full service Partnerships
- Recovery, Resiliency & Reintegration
- Alternative Crisis Services
- Planning, Outreach & Engagement
- Linkage
- Housing

CSS Client Counts: Unique clients receiving a direct mental health service: 131,106
Out of those 43% were Latino or Hispanic, 24% were African American and a little over 5% were Asian and Pacific Islander. The 19% white category still represents not only white people, but people from the Middle Eastern/Eastern European backgrounds as well. The primary language remains about 76% English what this does not say is how well those people spoke English.
One of the things we look at is the percentage of those 131,106 clients that were new to our Mental Health System and 4,639 were new to our system. That is a significant amount and we are excited about that. 75% of those spoke English and you see the breakdown in the chart.

Unique Clients Served by Fiscal Year
Significant increase from FY 15-16 to FY 16-17, it went from 119,277 clients to 131,106. We are reaching more clients and are serving more clients. There are a number of reasons why this increase happened and one of them is because we did get more MHSA funds that particular fiscal year and that could be one of the reasons, but we do like to see that go up.

Clients Served by Service Area
Those of you that represent SAACs, this would be of interest to you. You have the unique clients served and new clients served. I did a little analysis of any changes from the last time we reported on this and what you see with the jump from 15-16 to 16-17 is that in service area 3, 5, and 7 there was an increase in clients, whereas the others stayed the pretty much the same.

Full Service Partnership (FSP) FY 2016-17

Age Group	Unique Clients Served in FY 2016-17	Average Cost Per Client[1]	Slots Allocated[2]
Child[3]	2,235	$14,417	2,295
TAY[4]	1,873	$12,000	1,541
Adult[5]	6,019	$11,469	5,705
Older Adult	1,322	$8,725	869

For Adult, the 6,019 is going to jump significantly in this fiscal year and next fiscal year obviously because of the additional 5100 slots. That will increase dramatically. The cost per client remains about the same, it is not too much different. That cost is not include the Outreach and Engagement before a person enrolls and does not include the flex funds. The only reason why it doesn't include that is because those two expenditures aren't tied to particular clients. It is a limitation of our data collection system.

FSP Slot allocation for FY 2017-18

Age Group	Slot Allocation FY 2017-18	Number of Slots Increased from FY 2016-17
Child	3,371	1,076
TAY	1,621	80
Adult	11,441	5,736
Older Adult	885	16
Total Slots	17,238	6,828

The number of slots increased from FY 16-17, here is where you see a jump in Adults for 11,441 which represents 5,736 additional slots. If I were you in the audience I would ask How are we going to hire that many people, where are you going to find space for these programs, etc. We are aware that this is going to take time to ramp up in terms of all those programs. Of course, training the staff, getting them LPS designated, all those things that are required are going to take some time. We are aware of that.

FSP What did we learn?

This is a slide put together by Dr. Eckart and one of the things I asked him to do was to take a look at all the reports that we produce and really think through what the data is telling us. Originally, I had this slide at the end but a recommendation to bring it to the front because I think it will help frame some of the slides you see after this.

•Most experience the greatest benefit the first year in partnership.

By partnership we mean enrollment into FSP. Those of you that are providers have a sense of this because that first year you are doing an awful lot to stabilize that client, to get them into housing, to appointments, the right medication, get them their benefits, all kinds of different things that you are doing and that first year really makes a difference.

•Older adults experience most improvement in acute hospitalizations over 3 years.

•Adult, TAY and older adults experience the most improvement in employment over two years.

(We are looking at this to validate this, there was a calculation error)

•Child and TAY all improve their grade distribution over two years in partnership but experience the most change during the first year in partnership.

Alex Silva — What we see for Child and TAY becomes like an educational see saw. At the beginning, it is tilted to being grades being poor or below average prior to partnership. Post partnership, the fourth quarter, one year later we are assessing again and they are actually tilting back to the opposite, we are seeing children in average, above average, very good categories and that is exactly what we want to see. I think there is a trend

for Children and TAY. The first year you see the most improvement in educational category and it's maintained in the second year. **George Eckart** — All the evidence we have seen so far, in this preliminary analysis, we call it exploratory at this point, all the grades are moving in the direction we would hope them to go. By the end of the first year the lower grades are decreasing, and the higher grades are going up and it's all in the right direction and we are very excited to see that. That was one of the things when we ran the data we were really excited because it looked like we are really having a tremendous impact. **Kara Taguchi** — We actually saw some interesting stuff where it wasn't just the below average and the poor that were shifting, a lot of them do that but there were some that swung completely the other way from below average to above average so that was nice to see. **Debbie Innes-Gomberg** — One of the things Kara and her team are working on is there are social support questions in the child and transition age youth FSP baseline and shortly we have a report on the social report changes as a result of FSP for Child and TAY.

•Possibly explore outcomes within service areas against the background of tenure length and population characteristics.

What we mean by that is the tenure length is the length of time you are in treatment. Ultimately in FSP, we would like to identify the optimal length of time in treatment for specific sorts of individuals. I realize that that is going to vary but it would be really helpful to know that. When we adopt our level of care systems that might help inform that. In population characteristics, it may vary between chronically homeless people, people that are homeless for less periods of time and people in hospitals and in jails.

•In all programs that have enough data to make observations, client meeting goals for treatment becomes the dominate reason for disenrollment during the first (full) year in partnership. Client having met goals seems to mirror actual success in outcomes.

If someone leaves FSP you hope they met their goals or they moved away, that it is a positive thing and you hope that they met their goals the outcomes would support that, and they do. **George Eckart** — That was a surprising thing when looking at the outcome data and the disenrollment figures. Less than 1 year of the predominant reason for leaving FSP was not because of met goals, it was one of the other reasons that we dis-enroll or clients dis-enroll themselves. Beginning in the first year everything shifts, and I want to call your attention to that because you are going to see it in the data. It is very exciting it means something profound is happening around that first year and it continues into the second and third year as we follow them through that process. Very exciting to watch that and you will see it in all the slides.

•Moderate relationships exist between client having lost contact and homelessness. Data suggests a moderate relationship between field-based work and a client not losing contact.

It is not a causal relationship, it is a correlation between those two. I talked about this in an assisted outpatient treatment meeting yesterday where that in of itself really supports the importance of being able to respond and go out into the field regularly, you are going to have better outcomes if you do that.

Child FSP Slot Capacity-

The next several slides are about each age group FSP capacity. We looked at Service area 1 through 8 and we looked at percent of authorized slots. We identified service areas where we have a lot of capacity (unfilled slots) and those that have no capacity. I don't want to go through all of these but if at a certain point you have questions about it, or you can take it back to your own SAACs. The other thing that I wanted to do was tie in these analysis to gaps. I mentioned

	earlier the 5100 slots that we are increasing for 18 years and above were pretty equivalent to where we are putting them in service areas and matched some of the gap analysis that we had done. I wanted to bring that back to you at a later month to engage you in that and make sure we ae on the right track in terms of our gaps. **Ruth Hollman** — I want to make a point of clarification here, the number of authorized slots is the tan color, but isn't the number of authorized slots the entire line? **Debbie Innes- Gomberg**- the tan color is authorized and the rust color is the available or unauthorized slot. **Ruth Hollman** — When you say they are unauthorized you mean that people are people performing above and beyond? **Debbie Innes-Gomberg** — No, I am sorry we need to change the language, it is the availability. This is DMH lingo that isn't translating well. Those in DMH know this. When someone is in enrolled in a FSP we say they are authorized for the most part. We need to for public presentations we need to change the language. The tan color is filled slots and the red/rust color is unfilled slots. **Richard Van Horn**— Why is service area 8 doing so poorly? **Debbie Innes-Gomberg**— Let's reframe the question to not say poorly… **Richard Van Horn**— It's my service area, I can say poorly if I want to. **Debbie Innes-Gomberg**—Again, I don't want to make a value judgement. That is the question to ask, what is happening in service area 8? **Jackie Wilcoxen** — When you have service areas that need more slots and some that aren't utilizing slots, is there any kind of interim opportunity to move slots around so people can get into services and not have the perception that we have a lot of unused capacity in the department? **Debbie Innes-Gomberg**— When you say unused, meaning a program would give up slots to another program? **Jackie Wilcoxen**— It could be temporarily for a period of time, I know that issues around allocations. In service area 5's perspective we often had waitlists while other service areas had lots of unused capacity and there was no way to address that. **Debbie Innes-Gomberg** —I think that we do need to explore that, as you know there are multiple issues and we need to understand what's behind it. This data can help articulate that. **Child FSP Focal Population-** •38% of the 1,662-authorized child FSP clients reported experiencing truancy or sporadic attendance, suspension or expulsion and/or failing classes at school as one of the reasons for referral. That is a significant amount, that is over a third are experiencing school problems. •SA 8 reported the largest percentage, 45% One of the reasons we put this down is because it has implications for treatment and interventions that you might want to employ. •Child FSP clients experiencing truancy or sporadic attendance, suspension or expulsion and/or failing classes at school as one of the reasons for referral makes up the largest reason for referral for all Service Areas, with the exception of SA3 and SA6 **TAY FSP Slot Capacity-**

	SA2 has the largest percent of authorized at 94% SA5 has the lowest percent authorized at 70% SA6 has the largest number of slots, 268 and is at 72% capacity. It was noted that SA6's chart and numbers is incorrect and it will be corrected. **TAY FSP Focal Population-** •46% of the 1,105 authorized TAY FSP clients reported homeless as one of the reasons for referral •33% of the authorized clients reported substance abuse as one of the reasons for referral •30% of the authorized clients reported aging out of the child mental health system, child welfare system or juvenile justice system as one of the reasons for referral •SA1 has the largest percentage, 60%, of authorized clients reporting homeless as one of the reasons for referral **Adult FSP Slot Capacity-** •SA1 has the largest percent authorized at 101% but has the smallest number of total slots. •SA4 has lowest percent authorized at 64%, there are staffing challenges there. •SA 8 has the largest number of slots, 1069 and is at 89% capacity. **Adult FST Focal Population-** • 51% of the 2,224-authorized adult FSP clients reported homeless as one of the reasons for referral •SA1 has the largest percentage, 62%, of authorized clients reporting homeless as one of the reasons for referral •Homeless makes up the largest reason for referral for all Service Areas, with the exception of SA2 •SA8 has the largest number of authorized clients reporting homeless, 496, as one of the reasons for referral **Older Adult FSP Slot Capacity-** •Older Adult FSP is at capacity •Service Area 4 has the largest percent authorized at 130% •Service Area 6 has the lowest percent authorized at 98% •Service Area 3 has the largest number of slots, 203 and is at 103% capacity The numbers need correcting, and Debbie will take it back to the Department to address the issue that Older Adult has very little capacity. **Older Adult FSP Focal Population-** •29% of the 963 authorized older adult FSP clients reported homeless as one of the reasons for referral •28% of the authorized older adult FSP clients reported being hospitalized one or more days in the last 12 months as one of the reasons for referral •Older Adult risk factors (45%) makes up for the largest reason for referral for all Service Areas, with the exception of SA1 •SA2 has the largest percentage, 44%, of authorized clients reporting homeless as one of the reasons for referral **Cynthia Jackson**— I think the reason why SA2 looks like that is because of an older adult housing program that is

located in Service are 2.

FSP Residential Outcomes— we do an annualization process. We look at the year prior to enrolling into a FSP program and then we look at how the clients lives changed based on the state required data elements and even some County ones that are specific to us. When a client is in FSP in two years, but we are comparing 1 year of baseline data we apply what we call an annualization factor. The longer someone is in FSP the less that annualization factor tells us what we are looking for. We are also now looking at cohorts. People that have been in 1 year, people that have been in 2 years, and people who have been in 3 years. What you are going to see there is generally, the first year makes a huge difference but you'll see a continual progress in year 2 and 3.

•Comparison of residential data for 12 months immediately prior to receiving FSP services (pre-partnership) and for 12 months of residential status while receiving FSP services (post-partnership) for client's outcomes entered through June 30, 2017

•Data is adjusted (annualized) by a percentage based on average length of stay in the FSP program

•Data must meet data quality standards to be included in the analysis

FSP Child's Hospitalization Outcomes-

45% reduction in days hospitalized.

36% reduction in number of clients hospitalized.

FSP TAY Living Arrangement Outcomes

You will see a number of data but basically what you are seeing is reductions in clients and in days, hospitalized, days incarcerated, and in juvenile hall. FSP is making a difference, and again this is an annualization process. Then you see increased in independent living after enrolling in a FSP program for TAY.

Marcelo Cavalheiro— Regarding the baseline data, the 12 months prior to admission. The question is for folks that come from locked facilities or folks coming from jails. You look at 12 months prior, when they were in a locked facility, so they have 0 homelessness, and 0 hospitalization, and then the first year they may become homeless for a month or go to hospitals. If you compare the 12 months prior and the 12 months after it looks like we made their lives worst. Is there any way to collect baseline data not for the 12 months prior to admission to the program, but the 12 months prior in the community? This may pose a problem for someone spending 27 years in prison, they may not remember 28 years ago. It may be contaminating our data with those who have been in jail the last year with no hospitalizations.

> **Kara Taguchi**— What you are describing can be very complicate to collect, for not a huge population in FSP. Although significant, it doesn't affect every provider equally and it would add burden to what they are collecting. However, I think we can analyze the IMD, clients that have 12 months of an IMD, or clients that have recent IMD admissions and look at that data differently to see how much they are contributing to the increases to those things. Those folks are solely responsible for our almost 100% decrease in IMD while they are in FSP. We will commit to looking at that. See how much overall population in FSP are clients coming from a year's worth of IMD and then look at their data differently. Whether they are racking up hospitalizations, racking up homelessness when they come out, I think it will help inform about transitioning those folks back to the community and what is working and what is not.

Debbie Innes-Gomberg— Another thing is that we have an opportunity to engage RAND corporation in some evaluation, it is a short-term window of evaluation of the Mental Health Services Act in LA. They are doing a quantitative as well as a qualitative analysis of our data. What we could do for providers that are willing to do this is we could look at a qualitative analysis of individuals that meet the criteria that you are talking about. As a picture of somebody prior to the IMD stay, and maybe you and I can talk about that further. I am very impressed with the preliminary analysis that Rand has done so far.

Helena Ditko— There is also a few workgroups for LPS Board of Supervisors motions and I think I can connect you to several workgroups that have similar thinking.

FSP Adult Living Arrangement Outcomes-
- 69% reduction in days homeless
- 67% reduction in days hospitalized
- 63% reduction in days in jail
- 46% increase in days living independently
- 30% reduction in clients homeless
- 25% reduction in clients hospitalized
- 17% reduction in clients in jail
- 47% increase in clients living independently

One of the implications is "What is the team doing that is resulting in the increase in living arrangements for independent and the decreases in the negative outcomes?" Is it because the team gets into the hospital and works quickly with the treatment team in the hospital, works well with the mental health jail staff, etc.

Jaime Garcia— When I see this data, I am having a little trouble translating that from what I hear from the hospitals, in terms of the case management component. What I heard from hospitals, they admit FSP clients, but when it comes to the discharge component, or in terms of the follow up, that isn't necessarily taking place so those individuals are recycling right back into the facilities in a matter of days. When I see this data, I am having trouble connecting these numbers to what I am hearing at the hospitals reports in terms of FSP populations.

Debbie Innes-Gomberg- I can understand the discrepancy that you are experiencing. Your constituents are telling you one thing and the data is saying another thing. I will say, anytime you are hearing that or experiencing that, please let me know. We will work with that FSP provider and investigate and ensure that doesn't happen.

Kara Taguchi- I also want to say that this is a huge amount of data that we are talking about. It is in excess of probably over 20,000 partnerships that we have served since 2005. In so far as there is may have been recent changes in policies or upticks in hospitalizations, reductions in beds, you aren't going to be able to see that in the way we are looking at the data here. More of a trend analysis, change over time, or the cohort analysis that Debbie was talking about, where we are looking at recent partnerships over the last 5 years. Looking at the actual number of days that have been racked up for hospitalizations as opposed to adjusted or annualized days, we will be able to see more of that but we are still trying to perfect that analysis.

Patricia Russell— When you say treatment team in hospitals, it makes my blood boil. My son has been in practically

every hospital in Los Angeles County. I have never observed a really honest treatment team other than Olive View and Harbor, those two have treatment teams, all the other hospitals that my son has been in, the social worker is there to strictly get them out the door as soon as possible. They don't speak to the doctors, parents aren't allowed to speak to the doctor. I as a conservator haven't been able to speak to most of the doctors, they don't call back. One of the reasons why we have so many people going in and out of the hospitals and jail is because the insanity of what is going on in these hospitals. They are bus tokens to nowhere. I have a picture of my son outside of UCLA neuropsychiatric hospital, the new doctor threw him out with no clothes. He was outside in his hospital gown. We have serious issues and we wonder why we have people in and out of jail. We have to working on why there aren't any treatment teams, why they aren't talking with families, etc.

Richard Van Horn—When we first started what we call now FSP, that was in 1990, the first 3 years was the experimental period. We had total control of any hospital admissions, our docs were staffed at Long Beach Community hospitals, we can bring people in, you can keep them overnight, bring them out in the morning, send them to work during the day, whatever you needed to do. That privilege disappeared when we had to start taking Medi-Cal. Once we had Medi-Cal we lost control over hospital days. I think this is something to look at, get control back in the community agency that is trying to enroll and help that person get their life back together get that disconnected. Currently it is disconnected from the hospital experience, and yes, we don't have a treatment team in the hospital, yes, you don't have the person from their daily program visiting them in the hospitals because you can't get reimbursed for that, there is a myriad of problems that I understand what Patricia is saying because we had that experience and once we had to give up control and branch out and let our people be admitted to whatever hospital picked them up, we lost a lot of headway and I think this is something that is a major policy issue at the state level and it needs to be settled and it hasn't been.
Debbie Innes-Gomberg— That is where I was going as well, I think what Richard is saying is the future of Mental Health. Part of it is payment reform and part of it is there are a lot of different things going on, the waivers that expire in 2020 are a big part of that, so absolutely.

FSP Older Adult Living Arrangement Outcomes
Again, you see reductions in homeless and days hospitalizations, both in days and clients, and some increases in independent living in terms of clients and then a little reduction in days. I don't know if that change is significant. In jails, you see a small reduction in terms of days and clients.

Cynthia Jackson— have said that before, but sometimes independent living is not the goal.
Debbie Innes-Gomberg— absolutely, I don't mean to imply that it is, and I realize for children and older adults some of this data is not as informative as other age groups.

One of the things that we are going to have to get better at is looking at the reason for disenrollment and improving by age groups the percentage of people that dis-enroll from FSP because they met their goals.
What this reflects is the rust color is percentage by age groups that dis-enroll because they've met their goals, and the other reasons on the bottom of chart. We would like to see this happen, one of the interest that I have and would like feedback on is what are the factors that contribute to somebody not dis-enrolling. I think strong Outreach and

Engagement on the front end as well as through services is really important. Gearing the type of treatment and the dosage of that treatment is important, really listening to the client, particularly if it is a family to understand what their needs and interests are, and being able to move with them, meaning going into the field, due to value in reducing losing contact. Any thoughts or feedback on how we can improve this?
Helena Ditko—I am not a fan of the warm handoff. I think obviously peers are a big part of keeping continuity with families, and pseudo families because FSP can be a pseudo family for some people. It's not warm and it's not a handoff, generally its lost. Why would you ask me to change my doctor, change my psychiatrist and get a whole new treatment team again, because I am getting better, and it doesn't make any sense. I think people naturally relapse or naturally don't want to give up that relationship. There has to be a way to have that relationship that will move with the program and I get the flow, Wendy Tovey. The flow from one thing to another, I cannot handle it because it's not fair, we aren't looking at the consumers, we are looking at what is best for the programs and that's not helpful.

Richard Van Horn- another comment on that issue, back in 1996 when we finished the experimental period, long before prop 63 was written. We had a problem that we said that we would increase from the 120, which was the experimental group which were randomly chosen, to 275 and we would do it with no change in dollars other than that we would take Medi-Cal, which I did not like, but we had no choice. The difference that happened is we can do this is that I convinced Kathleen Snook, then the Chief Deputy to say ok, let's do two different rates. We had one for full service partnerships, not called that back then. And we had a rate for people who gotten a lot of recovery in the first couple of years and did not need that level of service anymore. We didn't want them to change their treatment team, their support system, etc. We were allowed to bill a two-rate system. My commitment to Kathleen and Arita at that point was that we would reevaluate that every year and adjust the numbers on the high cost side and the moderate cost side. Guess what never happened? There was never a readjustment, it stayed like it was. I think that is unfortunate, this is another area where we followed our noses in terms of what seems to be working.

Karen Macedonio— Specifically, the topic of dis-enrollment. Human nature is such that we all have belief systems or assumptions within our own minds that the choices that we are making are the choices that will provide the greatest benefit. When we are locked in those choices we fail to see other options and none of us can change another person's mind except to be there one on one and listen and having conversations. Specifically, on disenrollment we have a lack of understanding that needs to be addressed.

Eddie Lamon— Why do we have this word dis-enrollment?

> **Debbie Innes-Gomberg**— In order to create capacity in this program, unless you are thinking of the whole system as FSP, like Richard has advocated for. You have to have flow and graduation, that is the tension right there.

Eddie Lamon- Why should it be called disenrollment? They aren't getting this service right now, but this is the service they are getting after, and if they need to go back, they can.

Dorothy Banks- sometimes the words bother me, when I hear better, who determines what better is? The person getting the services, or the person issuing the service to the client? Is this person being pushed out, I agree with Mrs. Lamon, when she says if a person completed a level and they are ready to move on and then continue services, instead

	of being pushed out. **Debbie Innes-Gomberg**— You have said something incredibly valuable and something that encapsulates what we need to do. You are speaking to the partnership, what I mean by that is that the partnership needs to be capitalized so that decision about when do I go to my next phase of treatment happens jointly. Sometimes between the family member, the client and the provider, there is not always agreement on that. There is an opportunity for discussion. **Dorothy Banks**— Right, because the person receiving the services should be the one that people listen to. I am going to use myself for example, when I came and received services, then I determine when I was ready and that I didn't need any more services, so I moved on. I cannot say that a person with similar issues will be ready at the same amount of time. I was ready because I felt that I received what I needed to move to my next level and say I don't need services anymore because I got enough tools to know what to work with. I am going to move us along, we have a lot more slides. **Child FSP Disenrollment Reasons by Number of Years Enrolled** The slide you are seeing here is not particularly helpful, the slide really reflects the fact that the first year is so incredibly important. Clients that dis-enrolled before 1 year, and you see 32% dis-enrolled because they met their goals, whereas in 1, 2, and 3 years that number increases. On average the longer someone is in FSP the more likely they are going to graduate because they met goals and presumably in a lower level of service or need. Child FSP Disenrollment Reasons by Number of Years Enrolled- These are some interesting slides, what you see here is that something happens to those children that remain in Child FSP for at least 1 year as opposed to leaving and what you see here is a tremendous increase in the number of clients that met their goals over time in program verses those that discontinued, moved or lost contact. This illustrates the importance of a FSP program particularly in its first year in terms of ongoing engagement and matching needs and desires. **Eddie Lamon**- did someone ask who determines the goals, the client or the program? **Debbie Innes-Gomberg**—it's the client and often times there is a motivational approach that is taken so that if somebody doesn't think they may not achieve a goal, they can talk more about why that is. With TAY, you see a similar trajectory in terms for dis-enrolling because they met their goals, so I am going to move on from there. Again, similar with Adults. Again, I think the takeaway here is how important that service package is to somebody meeting their goals and moving on. **Older Adult FSP Disenrollment Reasons by Number of Years Enrolled**- **George Eckart**— We have an overall pic of dis-enrollment figures work out over a three-year period and you can see that as in the other cases we have those that met goals are really reaching the ascendency, year 1 and year 2, they keep going up. As I was taking a look at this and you take a look at the information that is below that, there was something that bothered me about this. This is speculation, I don't know if this is really true, it's one of the things I was asked to do, was to ask questions. I am pretty good at that, I don't have any of the answers, you guys have the

answers, I have the questions. I saw this relationship and it looked kind of as if one is going up and one is going down, and they meet in the middle, they cross they exchange places. It raised a concern, it is something to look at and take a closer look at the data. The concern is that people are actually leaving the program the way we wouldn't want anyone to leave the program, dying before they get housing. Those are the two things in opposition. I don't know if that is actually true or not, or if it is just an oddity.

Debbie Innes-Gomberg— we want to channel Cynthia about housing issues, did you want to say more about that?

Cynthia Jackson—Honestly, I don't want to jump in and say anything because I do think it is interesting, I can think of some other reasons. I think what might be useful is to look at the last hundred disenrollment's with a deep dive like Marcelo was talking about earlier. I think that is where we need to go, kind of case by case, if you guys are interested, we would be more than happy to participate with that.

Kara Taguchi— I just want to clarify that if they dis-enroll from FSP due to needing residential care, it's that they have a need for such a level of residential or institutional care that would be equivalent that they would get in FSP, so it's not just that they didn't get housing or they didn't get an apartment, or couldn't connect with family. This is just that they probably have decompensated to the point where they can no longer be cared for in the community.

Cynthia Jackson—Or they need to be in a SNF a non IMD of physical health related SNF, and so we are discharging for that reason, that is why we need to do that deep dive because the other option is concerning.

Ana Suarez— It would be really interesting to do a deeper analysis of the whys instead of the numbers. Why are people dis-enrolling, why are we losing contact with people? Even if it is a representative sample, not everybody. Just to try to get a better understanding of the whys. Also, I think there is a little bit of a bias in our treatment services. That we feel that if somebody disappears, it's because they must feel like they don't need it anymore, or they feel like they met their goals. I don't think we do as exhaustive engagement and outreach effort for people that have disappeared, then we do with new outreach and engagement situations. Maybe we need to look at what is the level of effort that we put into finding people who have dropped out.

Richard Van Horn—I feel like I am the historian. Back in 1987 when we were writing the 3777 bill, there were a number of parents involved in writing that, notably of Don Richardson of late memory, Dan Weisberg who is still alive but I haven't talked to him for a few years, a woman who I can't think of her name right now and a couple other parents. The principal goal involved, you tagged me correctly in the last comment, I think the whole system needs to be "FSP." The goal in 3777 that nobody would be booted out, this was a lifetime arrangement, you could always have a community to come back to. You didn't have to stay in treatment, but you had to have a place where you could return, we don't have that, and I think that is a major tragedy in this system. I have a felling Patricia would agree with me, but she's off doing something

Ruth Hollman— What I am seeing here is that we have the dis-enrollments, I know lots of disenrollment where we dis-enroll from one and they say it's mutual when it wasn't. If your treatment team doesn't want to treat you anymore what are you going to do? They then move to another FSP, so that is one way of looking at it. If somebody is dis-enrolled and then immediately gets enrolled in another FSP within the year, that to me is not a disenrollment. I think we need to recognize that a lot of these dis-enrollments are A typical people. People who don't follow the thing that if you get the

medication, you get them housing, you get them benefits, you get them these things that they are going to get better. I think we need another level of care there to make that happen. The other thing is that there is nothing to say that you don't get the same peer through your whole time at DMH, that would be really easy. The peer visits you in the hospital, the peer is with you in the FSP. The other thing is we need to open up the wellness centers to be the place where you go all the time, not just when you graduate. Of course, everyone needs to be sent to a self-help support group as soon as possible because that also provides support that doesn't go away, it continues going on and has incredibly positive results with all the research done on them. They are free and why we don't use them I still cannot fathom, but we don't.

Ruth Belonsky—I want to focus on the word despair because I really think that this hasn't been covered. Yes, there are many aspects of why people don't return and why we can't get a hold of them, but I think very often despair is why they say they are out of there. They say I can't get what I need, nobody is really listening to me, or hearing me. I think what you mentioned early that would really help people is the peers and I also think the wellness centers. I think they need to be, as like the grief support groups, that there needs to be despair support group. People who really haven't received or achieved what they have been waiting for or they haven't felt better or felt heard.

> **Kara Taguchi**— you bring up a very interesting point. I think to me, not all of these reasons that people leave the program are equivalent based on how long a client has been in a program. For example, a client deciding to not continue with their Full-Service Partnership while in their first year, is one thing, versus a client not continuing with their partnership in their 6th year. They stuck with it for 5 or 6 years and all of a sudden, they don't want to continue on, which to me means there is a factor like despair, something that has gone array with the treatment team. We haven't really done that, the closest we have gotten is what you saw on the slides as far as looking at dis-enrollment reasons based on how many years the client has been in the program. You noticed that I stopped at 3+, however in doing that we've discovered that a lot for Adult FSP, if they are in for more than 3 years, they are in on average of 6 years, so I have to go a little farther out that way. I think that it is interesting to look at, maybe the meaning of what the dis-enrollments are based on how long the clients have been in the program.

Mark Kazmark- Are there Peer Run FSPs? We have a little bit of a model already with Collaborative Housing and Peer Run models, but FSP and clinical stuff.

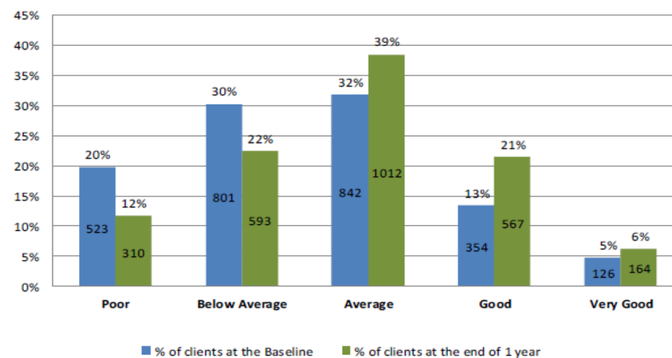
> **Debbie Innes-Gomberg**— Thank you Mark for going through Helena, we hope to have them. Right now, under Public Comment its 30-day posting is a Peer FSP Program and we will then get on the Oversight and Accountability Commission's calendar and hopefully make that a reality in the next year or so, we are very excited about that.

The feedback that we have been receiving has been very helpful, when you look around the room there are representatives from the department, from the different age groups, the different service areas, and from the different functions of the department, and I can tell as I look around, they are very engaged with the feedback that you are giving so this is very helpful for the department.

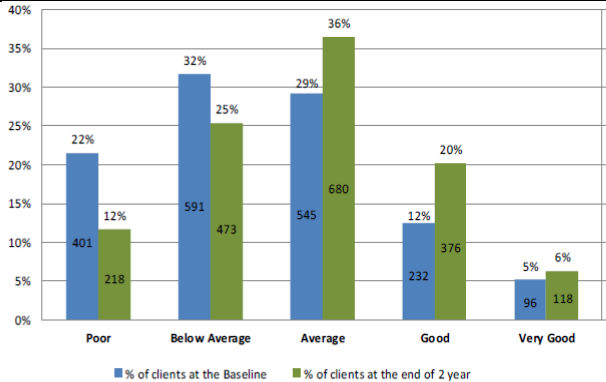
The next several slides really reflect that new way of thinking and that is that if we look at change over time, in this particular slide you have Child FSP, 20% of the children coming in with a psychiatric hospitalization the year prior and in that first year it goes down to 11%, and then 8% in two years and then 4% after that. Again, your numbers get a lot

smaller so by that 3rd year you are talking about 40 clients but nevertheless I think that it is a very interesting trajectory. Now you will see that justice and homeless, far fewer clients end up in that category so it is a bit harder to do those analysis.
Kara Taguchi—- let me say something about homeless for children, it doesn't mean that we don't have homeless children in LA County. This has to do with how the state has instructed us to collect homelessness for Full Service Partnerships. If children are homeless with their families and they are living with their parents on the street, the programs are instructed to put that they are living with their parents, not that they are homeless. It is just a factor, Kalene and I have talked about this a lot, it is not a way to indicate how much homelessness we have amongst our children and families. That's how we were instructed by State, DMH in the beginning to collect the data. It's a data dictionary. I am not sure what it would take to have a conversation amongst other counties to change that but that's how we were instructed to do it ten years ago.

Lawrence Lue—Can I make a comment on that. The school districts they have McKinney-Vento. They have a different category system which includes observing whether it is sufficient, living in a trailer that is disconnected from everything, or no bathing facility, that should be noted, schools can do a better job, but I am wondering if there is at least a way to reflect more of those kinds of conditions.
Debbie Innes-Gomberg— I think it's a really good idea, there might be a good opportunity in the next couple of years, legislatively or in some other way administratively to re-look at what we are collecting for FSP, to re-look at FSP itself and then the definitions which we've learned a lot in the last 11 years. Dr. Sherin has been querying the deputies of what we might change in terms of MHSA and FSP in particular.



I want to focus on this particular slide and then we will go on to some others but this is the Child FSP distribution of grades at baseline and at the end of the first year. I think it was articulated a bit earlier that this is the percentage of clients at baseline and at the end of the year, poor goes down, below average goes down, average goes up, good goes up and very good goes up a little bit as well.



At the end of the second year, again, poor drops more, below average and then you get 12-20% versus 13-21% so not too much difference in second year.

Living arrangements for TAY similar to what we described but you get reductions each year in hospitalizations, in terms of homelessness and in terms of justice involvement. You don't see much change from years 1,2, and 3. There is an analysis of psychiatric hospitalizations and what we are looking at is the percent in each of these years.

I have 11 minutes left, so I am going to go to move through quickly here.
TAY FSP Outcomes: this is a scatter plot that George put together. This is a moderate negative correlation between those living with family and homelessness. Negative correlation, to refresh your statistic and math memory, is when one thing goes up, one thing goes down. I think this is important in terms of living with family and reducing homelessness. Maybe living with family is a protective factor for becoming homeless. It certainly a support and very valuable support. Again, negative correlation between living with family and being in a justice facility.
These are grades, and it's a bit more challenging since TAY start at 16 and if you aren't in school after the age of 18, this won't be as relevant.

In Adults, you see very dramatic decreases and I am going to run through these due to time.
George Eckart—One little note, on these slides the data was re-run, so some of the narrative descriptions have to be updated a bit because the nuance has shifted a little bit. Generally, it's the same, in early in treatment we see a lot of benefit and with some cases like Older Adult they tend to take a little more time. We have to fix the narrative a little bit.

PEI Client Counts-
I want to spend the last 10 minutes on Prevention and Early Intervention. There are some issues that we need to address, and as I mentioned earlier we are developing an unspent dollar plan for Prevention and Early Intervention that really focuses a lot on Prevention of Mental Illness to begin with. Last year we saw 41,962 clients mostly in our Early Intervention programs. 26,000 of those has no PEI services prior. One of the things that we have learned, as you know our Early Intervention programs are highly focused on Evidence Based Practices. Using Evidence Based Practices, one of the things we are challenged with is completion rate. When we have measures that we do at the beginning of treatment and then at the end of treatment. What we are finding is that not everybody is completing treatment. The

question is are they not completing treatment because the treatment wasn't helpful, or was it because they got enough of the treatment and they don't need the last two sessions, or for other reasons. Some of the assumptions that we have made, we need to rethink. I think completion rate is we need to understand and articulate the reason why someone leaves treatment early, and by early we are really referring to if trauma focused CBT is supposed to be 7-20 sessions, and somebody completes 16 and feel they got what they need, we need to consider that in the analysis we do and the approach we take in implementing those services. That is something we are looking at and again, is it related to the practice? Is the practice not exactly what the client needs and sometimes we know that when you get to the trauma part, and you have to relive it or create a narrative around it, it is not easy and we know people drop out at that point. That is an example of "Is there a way to help the people in that exposure process?"

Marcelo Cavalheiro—one issue we have with immigrants, in our service area 7 our PEI programs serves Older Adults mostly from Mexico. They go to Mexico for a month, to visit family, and often we have to dis-enroll them because the EBP isn't' culturally appropriate.

> **Debbie Innes-Gomberg**—If we understand more of those scenarios, maybe there is a theme here, the qualitative analysis of what we are seeing. If you are taking a break for the holidays or the summer, we need to take that into consideration. Thank you.

Once of the things that we are seeing is the EBPs are delivered, whether a group or family modality tend to have better completion rates. I guess it's kind of intuitive. Parent Child Interaction Therapy, parents leaving treatment after child module is completed. CAPPS (Early Psychosis) program, the clients were not meeting the requirements for treatment until they were opened.

> **Alex Silva**—There is various reasons why someone would drop out of treatment. In these particulars, its actually maybe because of the actual Evidence Based Practice. For PCIT, I think we were known that these are the two modules, once the identified patient, in this case, the child successfully went through the module, all of a sudden, they said they are ok, they didn't see the full effect of the EBP. For CAPPs it's more ultimately protocol. What happened was that once you start assessing and doing an assessment on a potential client they already started the treatment, you are engaging the client. What's happening later on is that they are using a screening tool on the third session and realizing that they are not meeting the criteria of the EBP. At that point, they are dropping out of treatment with a higher dropout rate. There are reasons why we see dropout rate in various cases, those are just two examples of that.

Debbie Innes-Gomberg— Yes, thank you, those are helpful. As we start to identify those sorts of issues, the department is going to have to figure out how we operationalize course of treatment and make some changes.

Romalis Taylor—Is that the same for families dealing with welfare? When the court orders them to take these practices? In PCIT they drop out because they chose to, meaning the parent, when it's really the parent that needs the continuation?

> **Kara Taguchi**—Unfortunately, in the outcome data that we see, that we analyze, we don't capture that information. In so far as the client has a record with child welfare or something like that we may be able to cross those data points, it's not something that we capture along with the outcomes. I wouldn't be able to answer your question Romalis, unfortunately.

Amber Cardenas (Practice lead for PCIT)— On the foster care situation, and to clarify the CDI. The first part is Child Directed Intervention, so it is not that were just focusing on improving the child's behavior but in that part of the module we are working on the parent increasing their attachment and relationship with the child, so they are good in that part. Then they see great outcomes because now they have a much better relationship with their child, their child's behavior is decreased and they don't feel the need to go onto the second module which is where the parent learns how to enforce the rules and that doesn't fit well with some parents and what we see most of the time is that the children feel better about their relationship so they drop out there. Even if it is a foster parent, it is a different situation because if it is a court mandated they will generally finish the whole treatment protocol.

Romalis Taylor— so they do finish the whole treatment if the court mandated it? Right?

Amber Cardenas—yes, if is court mandated usually they finish the treatment, however if their case gets closed, then sometimes they don't.

Romalis Taylor— You hit the mark on the second part about how the parent disciplines and deals with the child in a safe manner, that is critical issue. When they come back to the court, if they relapse, the court is going to hammer away at them and they might lose their child. This need be very clear to them why they need to finish that practice because they system doesn't forgive, and it doesn't forget. I just want to hit that point on when you deal with the court system and the child welfare they can't not do it because they don't feel like it. They need to do it because the court will see it as the parent not wanting to take care of the child in a safe manner and that would be willful on their part, and the court considers willful in a negative sense.

The next several slides represent areas we need to look further at, and that is that we have a pre-measure and a post-measure, sometimes we don't capture that post measure because somebody leaves treatment early. As we talked about their various reasons for that. What we have here, and we call that a matched pair when you have a pre and a post measure. EBP, what we employ in PEI by practice there is at least a 70% matched pair rate. At least 70% of the clients going through one of these practices have a pre and post, they have completed the practice. This is part of the fidelity to a practice that we have been talking about, that we need to further explore. You can look at the slides on your own, they are pretty self-explanatory. There are some practices that fall below that 70% range, and we need to look at why that is, bring the practice leads into that discussion with the Prevention Bureau.

Los Angeles County MSHA Estimates:

This slide just only reflects our latest understanding of our allocations for this fiscal year 17-18 according to CSS, PEI, INN. When the proposed Governor's budget came out in January, there was an increase in MHSA funds statewide. I calculated the number that it would represent, and I want to say it would be 58M increase for LA County. That would mean that in 18-19 the total of 550M you would add 58M to that. In March, the annual adjustment is identified and then we have a clear understanding of what our allocation will be for the next fiscal year. It could be as high as 600 M in Los Angeles County, not quite sure about that yet, this gives you a sense. This is just the allocation, not including the unspent dollars. In the actual Annual Update, there are complex budget tables that breaks all of this out in terms of expenditures, estimated expenditures, unspent dollars and rollover dollars, the prudent reserve and all of those things. We will go over that at the public hearing. That is my last slide, and I am 3 minutes over, I am going to turn it over to Kalene, and I want to thank you for this discussion.

	Karen Macedonio— I have been asking this for two days, clearly because of time, I don't have time for everything I want to say so expect a long email. What I have watched today, I want to look at this chart on page 4 that shows just for the sake of a discussion an increase in clients reached of approximately 10% a year on the last slide that Debbie just showed we have funds increasing at approximately 1% a year. If we continue on that trajectory, we are going down a road that we have to have a discussion ahead of time, but what I heard today with our institutional memory in the form of Richard Van Horn is tremendous ideas. When he said we as a system have not created the place where people can come and be whether they are under services or not, I am begging for the opportunity to have a conversation where all of this wisdom weighs in around all that. **Debbie Innes-Gomberg**—Thank you, and I do get your email. I am going to stop now because we have to get Kalene in here, we have a housing presentation, and innovation pipeline update.
PEI Schools Update	***Kalene Gilbert, LCSW, Program Manager III, County of Los Angeles, Department of Mental Health.*** My name is Kalene Gilbert, I am the Chief of the newly developing Prevention Bureau, we are still in transition, but really excited about the work ahead. I think a number of you know me, I have been in the Adult Systems of Care, and recently the Children Systems of Cares for the past couple years, my hope is that experience has laid a great path for the work that we have with Prevention. What I wanted to do with the time today is to give you a little update about the Prevention Bureau, who we are, where we think we are headed, I am going to talk a little about the projects that are in place now and what's rolling forward, Debbie alluded to some of those earlier. I will talk a little bit about the launch of school based work and those discussions. **Prevention Bureau:** The Prevention Bureau will be responsible for managing DMH's countywide prevention-related services currently funded as MHSA Prevention and Early Intervention (PEI) Programs and any new countywide prevention related services as they are developed. In partnership with community agencies, philanthropy and human service-focused County Departments, the Prevention Bureau will address the needs of children, families, and community members who have experienced or are at risk of trauma. I know that is a mouthful and Dr. Sherin has been up here talking about his vision for reorganization around the department so pulling together all the different threads of prevention and early intervention work allows us to bring it under one roof and have a more comprehensive vision and allow us to really focus on prevention, which I am going to talk a little more about. It's a whole new direction for the County. **Who are we:** The Prevention Bureau is made up of Dr. Bryan Mershon, he has been the Children System of Care Deputy, he is now the Prevention Bureau Deputy. Our 3 KDA related divisions are under the Prevention Bureau, this is a place where we want to house trauma informed care, where we want to address trauma needs and the needs of children and families, so this seemed like a natural fit. We have our new Chief of Child Welfare Division, Anabel Rodriguez. Our Continuum of Care Reform Chief is Dr. Robert Bryd. Our Specialized Foster Care Chief is Manny Rosas, folks know him from Service Area 3, he is now one of our new District Chiefs. I'll be taking the lead on Prevention Administration. To bridge the gap to where we were last time we had a conversation here about PEI is when Lillian presented some

	feedback around the 3-year plan. I am going to try to start from there and then talk about where I think we are headed next. We had a really large stakeholder process, each of the age groups held multiple meetings and talked with folks about where do we want to go with PEI, identified a number of prevention practices that we wanted to implement, and we collapsed our PEI work plans. These are the 7 that were identified: •PEI – 01 Suicide Prevention •PEI – 02 Stigma and Discrimination •PEI – 03 Strengthening Family Functioning •PEI – 04 Trauma Recovery Services •PEI – 05 Individuals and Families Under Stress •PEI – 06 At-Risk Youth •PEI – 07 Vulnerable Communities These are largely target areas that we wanted to focus on, the stakeholders wanted to focus on as part of the plan. That's not changing, everything we do will continue to fall under one of these categories. These are the PEI programs with the OAC, this is how they are categorizing PEI. I don't think this is anything new, necessarily, but they categorize around Early Intervention*, Prevention, Outreach for Recognizing Early Signs of Mental Illness, Stigma and Discrimination Reduction, and Access and Linkage to Treatment. Suicide Prevention fits into Early Intervention and Prevention, that was something that was called out in the early days. Everything that we report back to the state is going to report back up to one of these categories. The way we are going to be thinking about programs, under one of these categories and want to make sure we are identifying the target populations, and that's been identified with this group. There are usually multiple target populations, most of our programs will fit multiple targets. As I start talking about programs and MHSA and PEI programs I want to be clear about how we are splitting these things up. We paired Early Intervention and Prevention, we talk about them, and we have been really clear about Early Intervention being EBP work. Prevention we've categorized around COS services, that's how we've implemented it. This is where we want to move somewhere different with Prevention, allowing a different kind of services. Some the things I've heard you all talking about today getting out to the community and going out further upstream and getting in there earlier. **<u>Early Intervention:</u>** Current Investment* per year: $271.5 M This is the number that was on our 3-year plan that was posted a few months ago. It includes the yearly amount plus amounts that were carried over. We aren't seeing those kinds of expenditures right now, so this is where we are talking about having some additional funds. We heard challenges from providers about spending the dollars, narrow policies and guidelines. Our priorities are first we want to make sure these programs are accessible. We want to provide some more flexibility. We want to improve access and facilitate use. Some of the strategies for that is to expand early intervention population. One of the things that I heard last month was that the window was way too narrow for Early Intervention. We leverage

our services, by the time you get in, you are probably too sick already and you need to go into another program. Leveraging was about giving us more in terms of funding, you leverage, you get more. We have plenty and we really want to make sure we get these services to the folks who need them. This is an opportunity for us to make a switch and catch people before they fail. The goal here is considering folks who perhaps don't meet medical necessity, unchecking that Medi-Cal box. When we started to explore that we realized that there are some policy changes that we need to make, but that is something that is in the works right now. We want to open up this service and the EBPs that are available to folks who don't meet medical necessity, but clearly have had some kind of trauma or some kind of issue. Something is happening that made them a target for treatment, so that is the one we are starting with.

Increased flexibility to serve all age groups- this is another thing that we are looking at. Last year we consolidated our CSS buckets. This year we can look at PEI. I think that it's understood, my hope is that it's understood, that folks can serve multiple age groups with their funding. If that is not clear, that is something that I want to make clear. By the way some of this is going to come into a provider meeting that we are planning in February. We haven't set the date yet, but that is what we are planning. We want to bring all this into a discussion with providers. Right now, if you are a child provider you should be able to open up a chart and serve a parent who you are recognizing is coming in with a need. Some providers are concerned about somebody transitioning from TAY to Adult age, can they serve them because they only have TAY dollars. I think we have always been relatively flexible with that but its' those big leaps. You are working with children and maybe you have a caretaker or grandparent or parent, we want to make sure you have access to provide those services as well. Finally, providing technical assistance and support.

Again, the priority here is to provide better access to the folks who need the service and facilitating the use of the funds that are out there. better access to training

Cynthia Jackson— I love the expanding the Early Intervention population, I think that is wonderful. On the flip side of that is where we have gotten headaches from the department over the years. When we have people, who come to us that really could who can use the EBP, what seems like an early intervention, who had a diagnose maybe 40 years ago, and are grieving now. The other side of diagnostic criteria is not making sense either. Given the lack of FSP slots we have tried to use PEI as much as humanly possible at that level when that kind of intervention works. I guess I am questioning whether you can think about it that way as well.

> **Kalene Gilbert**— By the way, I remember Mariko sharing this at the last meeting, and we heard it loud and clear as well. First, who can come in the door if you had a diagnosis 20 years ago, you should be able to serve them. Especially if there is something new that is going on. If there was a new tragedy, or trauma, we should be able to address that. In terms of EBPs is the other comment I want to make on this is there is no reason an EBPs cannot be used in other practices and I think it's about making those trainings available.

Prevention:
For prevention, when we looked at the 3-year plan and the numbers that was posted, we saw about 38M that was identified to deliver new prevention programming. We are looking at a number of providers who already had excess funding and allowing them to use now PEI for the 32 prevention programs that we delivered this year so far. Last check, we saw about 500,000 utilized for this. I think there were a variety of reasons for this that we can start to address. We

know some of it is confusion around delivering the services, some is around the contracting and that is something we want to get in there and address. We are not seeing the kind of expenditures that we had anticipated. Our priorities for this is to provide technical assistance to support the delivery of prevention. To consider expansion of prevention activities that are more community based. For example, Early Education Mental Health Consultation is something that we want to add, which looks a little different than those direct service kinds of practices that we have been delivering. Support for Board Initiatives and County Departments engaged in Prevention and Trauma Intervention Work. This is something Debbie mentioned early on. When it comes to Trauma and Prevention work, I think folks at the table know this, we are a little later to the party than some of our departmental counterparts, particularly DPH, DCFS. There is really great work going on in the community around Trauma and Prevention. One of the first things we want to do is to get out there and support that community work.

Ana Suarez—I just want to remind people about the Promotores model and Promotores for the Latinas population is of course very successful but it is not very widespread yet. I think that is something providers can think about doing. Use Prevention dollars if they have it available and the department will allow it, and obviously you can do the Promotores model in other languages, you just have to change the language that it is presented in and add a few culturally relevant modifications.

> **Kalene Gilbert**— yes, in fact right now our COS allows for Outreach and Engagement, Outreach and Education, so I think there wouldn't even be much in the way of modifications at this point. If you wanted to bring on Promotores, which has been highly successful model with the department, we would encourage that. If folks want to talk about training, we can talk about that as well.

Ana Suarez— I am talking about if the Department will allow it, we can consider having the providers start developing that program.

Prevention Bureau:
Where are we starting? What is our Vision? Dr. Sherin has said in here and certainly we have been excited thinking about Public Health Approach to Mental Health and Wellbeing. Again, we typically implement direct service models so how do we get into the community and function differently? How do we use funds to impact or increase resiliency in the community, or to increase protective factors? This will allow us to address Trauma in communities, families, and individuals in new ways. It will allow us to partner with county departments, schools, and community agencies and leverage existing initiatives to address community trauma and build healthy, resilient families and communities.

A Prevention Framework to Build on….
The framework, when we talked about where we are headed. We look across the county, we look across the state and we look across the nation and there are a number of prevention movements. I just came from a conference in New York where they had their City's Thrive campaign. They are doing a lot of this similar work, they are looking at a public health approach to mental health. It is all about a lot of Mental Health First Aid training, helping non-mental health folks be first responders and understand mental health, changing the conversation, acting early, we have the opportunity to do the same.
We started locally, looking at the Office of Child Protection. They finished their report last June on Paving the Road to

	Safety. It is a prevention plan for Los Angeles County. They are using the strengthening families approach. It is a well-known model, it's used in a number of places. It's all about how do you frame the work, where do you focus the work that you want to do and what are the protective factors that you want to impact. Under the Strengthening Families approach we are talking about programs that build social connectedness, programs that parental resilience, programs that offer concrete supports in times of need, knowledge of parenting, building socio-emotional skills in children. We think this is a pretty good approach for families and we think it's a pretty good approach for communities as well. It is a good way to think about where do we want to make an impact in our work. **Patricia Russell**— I am going back to training. I am wondering if there are any dollars going into training for co-occurring disorders so that the clinicians and the treatment people can treat the whole person. **Kalene Gilbert**— in terms of PEI dollars for substance abuse training? **Patricia Russell**— Co-Occurring, that is a whole lot different than substance abuse, it is understanding the spectrum of illnesses, not just one or the other. **Kalene Gilbert**—For Co-occurring disorders, that is something we can certainly add to the list to the things we need to be addressing. I think when we talk about Prevention a number of things go into impacting health and mental health, substance abuse is certainly one, and it is our radar. **Patricia Russell**—it is not just substance abuse impacting mental health, it's the combination that are together, and if they aren't treated together they don't seem to get better. **Kalene Gilbert**—Yes. My apologies coming from the Co-occurring surfaces, as part of FSP, this is something that we tried to implement in all of our services, I agree. **Ruth Belonsky**—I am interested in how you are thinking of reaching out to the faith-based communities? **Kalene Gilbert**— Let me get to that in a couple slides. Some other major initiatives that we are going to be talking about are high quality early education programs, community level child abuse prevention strategies, home visitation programs, these are some other places we can start to look for work. How do we reach communities and families? I am already meeting with Department of Public Health and some other folks already doing the work, we have to reach them where they are at. Schools, Library Parks, Faith Based settings is certainly one we need to outreach to, and homes. What is driving the planning process for the work ahead? To start with, stakeholder input. The 3-year plan gave us a lot of direction around the work that we want to do and the target populations that we wanted to focus on. SAAC meetings, Dr. Sherin did his SAAC tours and came back with a whole lot of input and thoughts on where we needed to start and where he wanted to focus. In particular, we heard communities and really, schools. That was one piece we heard, not just from SAACs but from all over. Health neighborhoods and community stakeholders. We have a Director's Vision and he's been in here talking about a Public Health approach to Mental Health. He's talked about his prioritization in schools and what he calls hub to home. Which is the hub plan that we talked about in here a couple months ago. That is a child welfare initiative.

Board Priorities- we need to respond to some board priorities around the Office of Child Protection. There are board initiatives around home visiting and expanding and coordinating home visiting in a better way. This is a great opportunity to get in there. This is as early as you get, working with pregnant women and helping them with attachment to their kid and making sure they have all the supports that they need. The Agency Prevention work, DPH has their trauma prevention initiative. They are focusing on the highest risk areas, particularly in 6, to bring together a variety of departments, education and folks to try to impact trauma and trauma due to violence in the community.

Some of the County Agencies and Partners that have come to the table to partner with us are:

- Los Angeles County Library,
- Schools, we are talking with LAUSD and LACOE,
- Department of Public Health,
- Department of Parks and Recreation,
- Department of Probation,
- Department of Health,
- And children family services.

County Department Collaborations FY 17-18 through FY19-20

These are some of the things that have come up. Some of them have been posted already, and a few others that have not been posted. These are the two we talked about a few months ago:
Department of Public Health – we are talking about increasing Nurse Family Partnership, access to home visiting.
Department of Children and Family Services investing in prevention and after care networks. These are really cool programs down the community level. If folks haven't heard about this particular program, its where there was a call into DCFS and there is not a substantiated issue but there is clearly a need. This is a program that will engage with the family, help them get whatever assistance they need. These are usually community-based organizations that deliver this service. They do a lot of community building at the ground level. It is all about social connectedness, they really are about these five factors. How do you get into a community and build a better connection? There is some really cool work that is getting done there.
County of Los Angeles Public Library some of our projects that were to be posted, we are revisiting a previous project around Parent and caregiver support which is PPP in libraries. We trained some librarians to deliver the PPP practice and they were able to reach both families and children. Now they have something really cool called the Reading Machine, which are mobile vans. They bring the mobile vans to family courts, health centers and other places where children and families find themselves waiting and they are able to deliver the service there and engage parents.
At-Risk Youth Programming and Education- we know that we have a lot of TAY individuals that show up at the libraries after school, it is a safe place in some communities. It is a great opportunity to engage with them and deliver some support and same with the youth and adult programming to increase protective factors. We know with large homeless communities often times around the libraries, so we see them as a real partner in being able to reach folks.
The Department of Health Services- The Youth diversion and Development Summit (to be posted)
County of Los Angeles Probation Department- Youth Diversion ODR Project (to be posted) and Probation Youth Trauma Informed Vocational Program (to be posted).

	I want to talk a little bit about schools and community work because this is where we need to do a lot of the planning. We met just last week with some of the stakeholders here about how we are going to do some of the ongoing planning work. I am going to ask my team to talk about the experience we had last week. Just to frame it, we were charged with, by our director, building better partnerships with schools and responsiveness. He wants rapid triage. I think you all heard the story that he talks about the young women who was suicidal before we were able to get her some help. Again, we have the ability and the resources to address needs before folks fail, before they end up at that point. How do we create resources and make those things available? Make our triage team, assessments, access to services available long before they get to that point. We looked at successful use of PEI across the state. Alameda has some really innovative models and they are partnering up with schools in a different way. In particular they are really investing into prevention programs on school campuses. With teachers it's all about training teachers, faculty, anyone from the teachers to the lunch lady around trauma informed care. How do we get in there and support those? Finding local solutions and making resources available to not just schools but communities around the school. That is one of the things we heard loud and clear. That we need to also look at how do we make some of the programming and resources available for community-based organizations, faith-based organizations to deliver services and supports. **Daphne**- Just to give a little of the feedback on stakeholders meeting on the 11th. We had about 35 members, the meeting was very well received. The purpose was to partner with our stakeholders in regard to looking at the gaps and needs for school based mental health services. Reviewing the landscape of La County schools. We are looking at over 81 school districts and servicing over 1.5M children. Also looking at prevention model around the tiered approach to prevention. Out of that meeting we had a lot of great energy and a lot of wonderful feedback from our members to what are some of the components we need to look at when we are talking about partnering with the schools to bring in additional mental health services and looking at the gaps. Some of the themes that came out was making sure that it is done in partnership with the schools. Making sure the whole family, community, parent, teachers is involved in that process. Looking at training piece. We were looking at three particular projects. A concierge level which is providing that call center resource for school communities. Also looking at universal prevention and talking about what that means and what that looks like to us. We were also looking at customized support. Looking at, depending on the school, what the needs are what the community needs are, making sure that the services are customized to that community and those families that are a part of that community. Having a training institute that is going to support the professional development of the staff, as well as training for parents, for youth, making sure that the training isn't just one way. Training the entire community, staff and everyone involved. One of the next steps that we were looking at was outside of that meeting that we had. It was a great recommendation from our stakeholders for us to go out and talk with other stakeholders. We can find out from the communities, the schools, what are their feeling about the gaps and the needs. Be able to bring that information back and bring it back to this group to share the findings and go with next steps. Currently DMH is in the process with our school partnership initiative team to look at having more focus groups. To gather more feedback and for our internal process to see what it will take to staff a team to look at the development and implementation of a school-based model partnership.

	From here we want to take this conversation regional. That is something we want to keep you all involved in. That is what we heard loud and clear. These conversations need to happen at a local level, the planning and the discussions need to happen at the local level. We are engaging local leadership, health neighborhoods, SAACs. Beyond that, schools, PTAs, there are a lot of other stakeholders when we start talking about schools. A lot of these groups already exist. We've engaged LACOE to help us access them along with LAUSD. We will start a process and starting in SA6 and SA3. We want to get out there and start some of these conversations. You should start to see some invitations and availability in the next month. We plan to come back here on a regular basis and bring what we are hearing and what we are learning to this group for feedback. I have asked Mimi for ongoing opportunities to speak with you about what's happening in prevention, where are we with a lot of our projects and keeping you all up to date. We may try to utilize this group for some focus group work at some point. **Cynthia Perez**- I just want to make sure Service Area 1 is part of this because sometimes I know we are way out there. Any help you need making connections with schools or anything out there, I would be truly interested in helping you if I can. **Ruth Belonsky**- Just that you didn't respond the question I asked about how to outreach to faith-based communities. **Kalene Gilbert**- sure, so more specifically when we talk about making opportunities available at the community level, that is an opportunity that would be available to faith-based communities as well. By opportunities I am talking about CBO grants. A grant process, allowing local entities to propose prevention programs. I think it's more of an opportunity for them to come to the table and provide some of that work. **Ruth Belonsky**— I just encourage you to take advantage of the faith-based advocacy council because that is what we do. Thank you.
Innovation Projects Overview	***Wendy Tovey, LCSW, Program Manager III, County of Los Angeles, Department of Mental Health.*** My name is Wendy Tovey, I am with the Program Development and Outcomes bureau. I just wanted to inform you all and bring you up to date on our innovations pipeline workgroup. That was brought to SLT, announced and then an email was sent out asking for volunteers. We also reached out to the community. We had our first meeting on January 9th, where we had 23 individuals joining us. We put together some cheat sheets on regulations and requirements to make the process more streamlined. Often, we hear innovations and we think really broadly. While we want to be innovative we also have to fall within the constraints of the state regulations. We have a great meeting. We also discussed the groups role and expectations and our goals of the group meeting. We will be meeting twice a month at least through the fiscal year. Our goal is to put together 10 meaningful ideas for proposals to generate those ideas. We hope to come up with at least 5 proposals for innovations this fiscal year, to begin writing them. Hopefully we will be far along our way. We generated ideas in our first meeting. Which were from training with bilingual simulated services for training staff to peer certification program, veterans support and several other housings supports ideas as well. We created a fillable form that we called innovations project plan worksheet. It is fillable, and you can click submit and it comes back to us, so even if you are not involved in the workgroup or not able to be involved in the workgroup, you can submit this back

	and it can be discussed and hopefully move forward in the work group. We may need to call individuals that submit something just for question and clarification. We may also invite people that have a great idea that the group is very excited about to possibly join us and champion that specific project. That is where we are at, at this point we will be sending out the fillable form to all SLT members, SAAC chairs, wellness centers, our client run centers, to get as much feedback as we can. We also encourage people and the group members to share this form with other partners, or colleagues in their surrounding areas that they work with or that they know have some great ideas and would be willing to bring those forward. If someone wants the form directly or you don't get it, please feel free to email me. We will send it out to you, my email is wtovey@dmh.lacounty.gov.
	
	We are continuing and once we have our groups and we solidify our form we will make it beautiful. Our deputy, Debbie Gomberg will look at these with us and take them up to DMT to look at. Once they think that its ready for all of you, we will bring them to share with you and get feedback and move forward, hopefully in our writing process. Many members of the team have also spoke to their interest in writing the proposals with us which is wonderful. We are excited to be partnering with all of these wonderful people. It was a great group of people in the room. Our next meeting is on the 23rd.
	
	I also want to take this tiny opportunity, and I will ask if there are any question. The SB82 released a crisis triage service for both TAY and Adult group. We will also have a fillable form for that. We will be sending that out today as well. These would also be posted on our website and include that link today in the email that goes out. There will be a meeting on Feb 24th for the SB82. This is a very quick turnaround. We will be having one meeting to get feedback as well as reviewing the public comment forms that we will be submitting. As it is due March 9th, I will know much more about this when I go to Sacramento tomorrow for the bidder's conference. By the 24th we should be well on our way, hopefully with many public comment forms and what we need to do with crisis triage as well in the county.
	
	Eddie Lamon- When you talk about stakeholders, how are they chosen and when?
	    Wendy Tovey- This has been sent out, both of these have bene announced at SLT, sent out to SLT. I was giving you the SB82, preemptive, we are sending these out today. Mimi has been out of town, we will get that out today. We had to finalize the form, but it has gone to SLT, SAAC members, suggestions have come from DMT, members in the community, anyone who finds interest in this, that's why we created this public comment form. Many people aren't able to come to meetings but we know they have wonderful feedback for us so that is why this form is very simple, fillable and you push submit and it comes to us. This came solely from SLT
	Eddie Lamon- I understand that part, but I am saying is you said you had a meeting with LACOE, LAUSD…
	    Wendy Tovey- No, that wasn't me, it came through SLT. We had SLT members and other members that were given to me, of the community through DMT. This came solely through our SLT membership and input in this other department in the mental health field.
	Eddie Lamon- The reason why I say that, I am very involved in my schools. Compton Unified School District need a lot of help. I wanted to make sure we get the information. Our children have a lot of trauma. And that is all, I have been known stakeholders since Prop 63 and I hear other people talk about stakeholders and things and I am not sure If they formed another group.
	    Wendy Tovey — oh, no, it's a stakeholder process that we talk about. We go through SLT and what we ask of

	SLT is to assist us in engaging other additional community members, clients, families and what not. Kalene will definitely be addressing your many concerns with the schools. It's one of their priorities and we could possible look at the TAY age for crisis for triage as well an innovative idea that someone has for children that we can certainly incorporate into our innovations workgroup. **Eddie Lamon**- I am very interested in getting someone involved in the what you are talking about. **Wendy Tovey**— I will send that information to you Ms. Lamon. **Dorothy Banks**—Since Ms. Lamon has some problems on the computer, can you or someone send her the information in the mail? **Wendy Tovey**—Certainly. **Helena Ditko**— I am just relaying from Mimi McKay. She asked me to let everybody know that she is sorry that she is not here. She is at the Patrick Kennedy Forum. Things will be posted on website. Ms. Lamon, maybe you don't have access to it. Kalene's PowerPoint we didn't get a copy of that in SLT, so it's going to be posted on the website. People just need to go to website. It is public information. **Eddie Lamon**— Some of you already know, I am almost totally blind now. I can't read this stuff that you are giving me, but I will find a way to get the information.
Public Comments	**Ruth Belonsky**— if there are clients that come together with people who serve them, doctors and others and they don't have a good emotional connection with them, is it possible for them to change and have a different person? How does that work? Not everyone connects with everybody. If a client comes in see a psychologist, psychiatrist or anybody else, and they don't connect emotionally with that person and there is not good communication, is there a possibility for that person or family, whoever it is to actually be connected with a different psychologist/psychiatrist? And how does that work? **Kalene Gilbert**—Yes, in fact it's their right. You should make a request. You should be able to make a request of the management for a new doctor, psychiatrist. Etc. **Anonymous Public Comment form**— Look at peer run full service partnership. Look at supportive housing of New Jersey **Ruth Belonksky**—Is the idea of "Spiritual Isolation" ever considered for adults during treatment?

Housing Projects Update	***Maria Funk, Ph.D. Program Manager III, County of Los Angeles, Department of Mental Health*** I am Maria Funk, Department of Mental Health, the District Chief of Countywide Housing Employment and Education Resource Development Division. We have been asked to give you an update on what is happening with the housing money that we have allocated through the Community Development Commission's NOFA. That is what I am here to do today along with Lynn Katano from CDC and Molly Riesman from Supervisors Kuehl's office. Just to remind you all, we have done some presentations here before, but in case some people were not here. On Oct 3rd, the board passed a motion asking the Department to identify 50M dollars to allocate for the development of permanent housing, affordable housing for people with mental illness that could be invested through the CDC. Which, in case you don't know, Lynn can talk about a little about who they are. They are the County Housing's Department. They released their notice of funding availability in September and the Board saw an opportunity for us to invest money through their NOFA that would be dedicated for housing people with mental illness who are homeless. We came here and talked to the stakeholders about this. We had various meetings, conference calls, in person meetings, SLT presentations, housing workgroup, and have been discussing that with you all. We are here to give a report of what happened. CDC did release their NOFA in September, there was 25M dollars of MHSA funds that was allocated through their NOFA. I will let Lynn talk about the specifics about their NOFA, eligibility requirements, and the outcome of their NOFA. In engaging conversations with all of you and other stakeholders, we definitely heard support from the stakeholders for investing in housing. We all know that we have a very large homeless problem in Los Angeles. 57,000 people who are homeless on any given day. At least 30% of them have a mental illness. Since MHSA has started we have talking about housing and talking about the need to invest services and funds for housing with MHSA funds in helping solve that problem. In our conversations, what was interesting and really exciting are the ideas that people have had about other models besides the model that was allowed through CDC's NOFA. It was a very specific target, the developers that could apply for the funding, how much funding was allocated. What we heard from you is that we wanted to explore other housing models, besides that. The Department is very invested in doing that. Based on your input we put out a document about the housing models that people have put forth talking about whether they were allowable through CDC's NOFA, whether they were allowable through other opportunities in LA County that that are investing in affordable housing. We are going to continue that conversation but today we are going to focus on CDC's NOFA and the outcome of their NOFA. **Lynn Katano**— I am the manager of housing development for the Community Development Commission. For those of you who aren't familiar with our agency, we are a county department that overseas economic development of affordable housing. The administration of the federal funding home and CBDG for the County.

	I have been with the CDC for 27 years, I started when I was 3. We have been administering housing NOFA for 20 years now. This is our 20th year anniversary, so I am really excited to be able to oversee this NOFA that has been around for so long and has been so successful. This NOFA was really interesting to us. We had the opportunity to work with DMH on the funds. We have affordable housing trust funds for the County, from the County General Funds. We issued a NOFA on Sept 12th not knowing really what the response would be. We had 39.6M dollars in affordable housing trust funds and thanks to you we were able to include up to 25M dollar in mental health funds. Our housing authority included 300 project base VASH, or project based vouchers for rental subsidies. The results in October, we were overwhelmingly received 20 affordable housing applications. We had sufficient funds in the affordable housing trust funds and the project-based vouchers to fund 10 projects. That included 4 mental health service act funds, so that is 4 of your projects. Due to the cost of housing right now our caps had to go up, so we can be competitive, so we can get the housing out on the street faster. Unfortunately, we only had 4 out of the 10 applications that we could fund out of the DMH funding. 3 of the projects that are being funded are submitting affordable housing and sustainable communities' applications. That is the Cap and Trade, some of you are familiar with Cap and Trade funding that the State is administering. We are hopeful that will bring us more money to the county for street improvements in addition to affordable housing. We have 5 other projects applying for 4% tax credits, 4 in the city of LA and 1 in the city of Lancaster. Three of the projects are in the city of LA's 9% pipeline. I don't want to talk to technical here because we are talking tax credits, 4% and 9%. We have 3 County of LA projects competing for 9% credits. All of the projects that can be funded including the Department of Mental Health funded projects will generate 667 special needs units including those set aside for mentally ill. I would say almost 100% of those will be homeless. The reality is the majority of the homeless people do have some sort of mental illness. Whether we claim that they are chronically homeless, frequent users of the healthcare system, transition age youth, the majority of the residents of these units will be coming through DMH. We are also leveraging the creation of 344 non-special needs units. A lot of these housing projects, to make them financially viable, have both special needs projects that are at probably 30% or below average median income. Some of that goes up to 50% AMI. Those are targeted at very low income affordable housing households. **Ruth Hollman**—How many of those were non-special needs? **Lynn Katano**— 344 non-special needs. That is a total of 1000 units that we were able to fund with this NOFA, with a total of 57M dollars. Not all of the affordable housing trust funded projects, the funds got allocated. There was a bigger demand for the Mental Health Services Act funding. Out of the 10 projects that applied for the funding for the MHSA funding, only 4 of 10 projects were able to be funded by the 25M. **TJ**—The 4 projects that were funded, how many of those are specific MHSA units?

	Lynn Katano—Specifically set aside for MHSA units is 93 units. The rest of it we are using for leveraging other homeless projects. Overall in the project you may be getting 93 that would be coordinated entry system allocated specifically to mentally ill and the remainder of the special needs units are for homeless. **Cynthia Perez**— Am I correct, one of those projects is Lancaster? **Lynn Katano**— Not of MHSA projects, that was just in the affordable housing trust fund. We just completed our independent review panel where we have an impartial panel of volunteers, experts in financing industry and they approved all 20 of these projects for funding. Again, like I said, 6 of the projects that applied for MHSA funding were not eligible due to the constraints on our funding availability. We will be going to the Board with the projects that have all their entitlements in place in February, so they can apply for tax credits. The remainder of the projects will be applying for the tax credits at a later time during the year. We are also getting ready to issue our next NOFA at the end of this month. Hopefully we will be able to issue our term sheet this week for those funds also. At this point I want to introduce Molly Riesman which I am sure all of you know to give you a little update on the use of MHSA funds. **Molly Riesman**— Hi everyone, I am Molly Riesman with Supervisor Sheila Kuehl office. For folks that I haven't met in the room I have been a member of MHSA housing advisory board since 2012, so about 5 years collaborating with the Department through that body and so pretty intricately aware of what we've done with MHSA thus far to address housing needs which have been helpful moving into my role with the Board of Supervisors. As Lynn said, originally the way this funding was structured was that 25M of the MHSA funds would be available in the NOFA and another 25M would be available for the second NOFA that the CDC is getting ready to issue at the end of February. When we heard that there are 6 projects that would not get funded because there were not enough MHSA dollars to cover the other 6 of the 10, the Board did a motion. We worked collaboratively with the Department to allocate some of the funding from that second 25M in order to help meet that gap. We also put in roughly 2M in affordable housing trust fund dollars towards the DMH units so that we would be able to fund all 10 projects. We also held back 6.25M of the MHSA dollars for innovative housing typology, which I know something the SLT has talked quite a bit about. I know Mimi is leading a working group on alternative models like shared housing, different housing building types such as pre-fab, shipping containers, etc. That money will be help aside and DMH, that was a recommendation of the Department. Part of it is that we have built some innovative housing already. You may be aware of the Star Apartments which was pre-fab construction. There was a project call Potter's lane, in Orange County which was shipping containers. Through the MHSA housing program, your traditional housing program that Maria

| | runs, that funds a variety of housing types. They funded a shared housing project through the Alternative Living for the Aging in Lancaster. We have tried some of these models. I think a lot of them, what we found with the shipping containers and the pre-fab, we haven't seen much cost savings from those models unfortunately. We want to hold some funds back and keep trying. I think we have to keep experimenting and innovating and hopefully we start seeing more models that come in with cost savings and can be built faster which is really what all of us want. Part of the reason why the Board approved the motion yesterday to get these additional units built is because they past threshold. We are feeling a real sense of crisis right now around homelessness in the County. Not only do we have so many people who are homeless on any given night, 2/3s of them are unsheltered. When people are unsheltered, it is very dangerous for their health and we are feeling a lot of urgency to get as many people inside as quickly as possible. Knowing that we had 6 developments ready to go we wanted to get those funded as quickly as possible instead of saying come back and apply again at the end February which would have delayed the process quite a bit. I think that covers most of the motion.

Maria Funk— I would add that the Department is very appreciative of the Board for allocating the additional 9M dollars to allow all of the projects to be funded, all 10 projects for people with mental illness who are homeless. Our Department is committed to funding these other models that we have been discussing together. The initial investment of 6.25M dollars allows us to prime the pump for that and see how it goes. We definitely in talking to CDC really recognize that their current NOFA was not the right place to do these other models. It was structured in a very specific way and they don't have experience doing some of the models we have been talking about, some required further research in terms of zoning and ordinances. For instance, one of the ideas that came from Cynthia was the tiny houses. We have to really research the models and work with CDC on developing a separate NOFA that would allow for these other models. We will continue that conversation and continue with those that want to part of the housing workgroup, it is open to whoever wants to be a part of that. I believe Mimi had said that at the end of January or maybe early February that we would calling another meeting for that. Now I am going to open up for questions.

Patricia Russell — Because there is such an emergency need and there are not enough shelters, the model in San Antonio Texas. The Restoration Center, Leon Evans, he has an 800-bed place. People can come and then if they want to move forward in getting services and getting housing, they can, and if they don't want to they don't have to. In my idea has been and I will continue to say it, why can't we have a restorative center in each of our service areas? That way it would be a pathway for them to get at least a safe place to live until they can move on and get permanent supportive housing. Another idea is a huge piece of land with lots of functional RV's. We need to get these people off the streets, they are dying on the streets. We can't just wait, we have to do something even more innovative than even tiny houses, we have to get them somewhere safe. It is vital.
Maria Funk— I totally agree with you. I will say there are so many conversations going on in the County |

about exploring all the options including looking at the model in Texas. Some people call it a safe sleeping model. People have been looking at the big tent model which I guess has been done in San Diego. Yesterday it was in the paper that the city of LA is looking to bringing in trailers to put on their land. We know this is a crisis and what we are here talking about today is one option. It is one model that is going to get us further in having more permanent housing. People are looking at all models including immediate models, temporary shelters and moving into permanent housing. I totally agree with you and I can just tell you I am part of conversations. I am sure there are a lot of other conversations that are going on looking at all models because we all agree we have to do something and do more.

Patricia Russell— each service area can help you, we can help you find land within our service areas. If you could enroll the service area co-chairs or if we could enroll our members, we could be of help to you in each of the service areas.

> **Maria Funk**— We need help because we see that there are different projects that are out there. In developments that people went to commit to and often the public doesn't want them, and they shut down unfortunately. We definitely would embrace any help in the service areas to help all these models go forward and working with the community.

Romalis Taylor — First of all, let me say thank you. The last meeting, we had when we agreed with the director to move forward and not wait until the proposition H can move forward. We want to give kudos to the Board in moving forward. Hopefully when Prop H finally gets down here and the money gets here and we can do a much better job. My question was that I thought we agreed to 50 some million dollars, like 57-59M. I am only seeing 50M being allocated, what is going on with the other 9M, are you holding back?

> **Maria Funk**— the Board motion was asking the department to allocate 50M dollars. I am not certain where you are getting the 59M dollars. We definitely had 50M that was dedicated.to go through CDC's NOFA. We are open to 9M more.

Romalis Taylor— He came in and was very passionate and we heard him and we understand the need. We have always been forward about the needs for housing for people with disabilities that really need our support and help. This SLT has always been there on that, as we have gone through the past 5 or 6 years. So, all I am saying is I though he said 57-59M and we need to get it done.

> **Maria Funk**— I just want to make people aware that we still have, that Molly talked about our MHSA housing program that started Statewide in 2007. It started in LA County in 2008 and we have 53 projects that have been committed to that for over 1000 units. We still have money there and we are planning to release our next expression of interest through that in Feb. This process is not through CDC it's through California housing finance agency. That does allow for the other models, as Molly said that we have funded shared housing. We did hear concerns of 250K per unit. Through that we have different funding principals that we use to make decisions. Definitely one of the funding principals is that we prioritized projects that as for less than the allowable funds. The allowable funds are around \$140k/unit, it is much lower than the \$250k/unit. Typically, people hear that when we say that and they

ask for less than $100k/unit. This is just a model we are talking about through CDC, is one option. DMH's MHSA housing program that we had for many years. Through the homeless initiative you mention measure H, there is funding coming through that. There is an innovative model that is going through the CEO's office. The CEO has contracted with an agency to put out a NOFA in doing innovative projects with that funding. There are other housing models, there are other housing opportunities out there that don't come through just MHSA or with MHSA money.

Rachel Feldstein— This is wonderful news, thank you guys. I got a little confused with the NOFA that is coming out in February, if the money is already being released for the 6 that weren't funded originally. Is there additional funding?

Maria Funk— Actually, the second NOFA that CDC is doing, DMH will not have money in there. It was described by Molly, all of the money we were allocating we are just going to fund the initial projects that applied through the first NOFA. We are going to work with CDC on a separate process, not through their traditional NOFA that will probably come out in the late summer or early fall. We are working with them because that NOFA will be structured in a very different way than the NOFA that they have been doing and they are doing right now.

Rachel Feldstein— when are we hearing who those 10 are, has that been released yet?

Lynn Katano— we just finished our independent review panel that I was just talking about earlier. We will be making our recommendations to our executive director who will pass them on to the board. Initial projects will go to the board in a couple weeks and we will have an official report then. I can definitely share the full list with the SLT.

Maria Funk—I assume you all do it similar to us. Once you post it, its public and once its posted it will be on the Board Agenda or after the board approves it. We will send out the full list to this group so you know what projects are coming and where they are located and how many units are in each project.

Helena Ditko—I am just very grateful for the level of complexity that you all have to navigate and on behalf of the consumers that maybe aren't here and the people on the streets just want to thank you. I just want to mention; supportive services are also extremely important to keep people in housing. We don't want people to fail or set them up to fail. I also want to reiterate something that came up from Mimi's workgroup several weeks ago is that there are a lot of different models but very appreciative of these huge steps in this direction. I just wanted to express gratefulness on behalf of the people who can't. ad thanks for huge steps

Maria Funk— I will say one thing about services because I didn't mention that today. All of the new permanent supportive housing, the board has committed through Measure H, to provide supportive services to all new unit to permanent supportive housing that are coming on line. That is coming through the health agency, public health, through their SAPC, mental health and health services that presented in here several times about this model that we have this new model of integrated services that will be provided A very intensive package of services if you will to help support people in moving

	into housing and retaining housing. This funding will leverage that service money that will be funded through measure H. **Ruth Hollman**— Just on that, does that include the projects for the alternative housing as well that will get supportive services? I want to really commend the Department and the Board for finally seeing that there is more than one model of housing and that we really need to look at them SHARE! Just did their Annual Report and we housed 472 mental health consumers in 2017 and we did that for $328,000. 23% of our homeless, mentally ill don't have to be sober, don't have to be stabilized, get jobs within a year. Better than the Full-Service Partnership that they pulled the stuff on. Our model works, so I am really glad. The Sober living model, which is much bigger than the SHARE Recovery Housing works. The $250/unit that we were talking about for the first NOFA, we got 93 units out of it and we were supposed to get 100 at $250/units. You're saying that most came in at under $100/unit. I don't understand where the money has gone. **Maria Funk**— I think we've confused two things. First of all, the $250/unit is what they funded. If you are doing the math and you are saying that doesn't quite add up. We had to subtract the administrative fee that CDC is charging, which is 8% of the funds. 8% of the funding goes to administering the NOFA and administering the program, the remaining went to the units. The less than $100k/unit, I had moved onto the MHSA housing program. Our other program that we had since 2008, and that's what I was talking about there. **Ruth Hollman**— in terms of the other ¾ of the $25M that $6.25M is going to alternatives and the rest is going to traditional permanent supportive housing, what is the cap per unit for that? Is that also $250K/unit or were we able to get it lower than that? **Maria Funk**— Not for the 6.25, but for the rest, about 18M yes, it was at $250K/unit because it went to fund the projects that applied through the first NOFA. All of the 10 projects all at the same level of the first 4 that they were able to fund. All that funding had that same terms that they had under the first NOFA. The $250K/ unit funded 230 MHSA units. That includes the $9M that Board put forward is helping fund all those units. **Ruth Hollman—** I am going to do the math here and let someone else go on, but I want to reserve the right to tell us how much unit was spent. **Eddie Lamon**— What is NOFA **Maria Funk**— Notice of Funding Availability, that is their solicitation process. **Ruth Hollman**— That works out to $217,391 per unit. Usually a 300-square foot single. **Leticia Ximenez** – I am not sure if you mentioned it. Is there any money that has been set aside for housing retention? We know that with homelessness, one thing is quite difficult to get people into housing but also at the same time allowing them to keep the housing and helping them keep the housing and so forth. Is there

	any funding that has gone into housing retention? **Maria Funk**— When I referenced the Measure H money, that we are leveraging to provide supportive services, that would include housing retention funding. The services would be available to the people living in the housing as long as they are living there. That helps people retain their housing is providing those supports. Helping to intervening when there's issues that might put people at risk of losing their housing. **Leticia Ximenez**— are we using peers, or is that part of the models to help as well with housing retention. **Maria Funk**—yes, absolutely. **Cynthia Perez**— Is there going to be guidelines about individuals to qualify for housing? One of the biggest issues that we have is landlords will not accept people with a background or maybe they had an eviction on their record and that is a big issue for many of the individuals we serve. **Maria Funk**—That is the beauty of permanent supportive housing. When people apply for this funding they understand that the population are people that have many barriers. Including having prior evictions, bad credit, all of those kinds of things. When they commit to build this housing, their mission driven to serve a homeless population to serve people with special needs and they understand that those are exactly the tenants that are going to be moving in and who are our DMH clients.
Announcements	**Parking Lot Items:** SAAC8- Child FSP Slot Utilization Whole Person Care • Hospital • Outpatient • Engagement **Adjourned**: 12:31pm