COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM

Meeting Notes March 16, 2011
St. Anne's Auditorium
155 N. Occidental Blvd., Los Angeles, 90026
9:30a.m. – 12:00 p.m.

REASONS FOR MEETING

1. To provide an update from the Los Angeles County Department of Mental Health.
2. To give a presentation on The California Endowment's current projects and initiatives, and to discuss how these may align with priorities in the mental health field.
3. To identify key topics for the System Leadership Team in 2011.
4. To update the System Leadership Team on membership items.

I. Review Meeting Agenda and Materials

A. No questions or corrections to the meeting notes for the February 16, 2011 SLT meeting.

B. The facilitator indicated that an SLT member raised two concerns regarding the February meeting notes. The SLT member asked if there was information on the amount of PEI funds that have been spent and what PEI programs have been funded already. The SLT member also expressed a concern with the PEI target populations: if the PEI target populations are not the same as the population traditionally served by the Department of Mental Health, will this mean that the population traditionally served by the Department—which can benefit from early intervention—will experience a dilution the amount or quality of services?

II. Update: Department of Mental Health

A. Robin Kay, Ph.D., Chief Deputy Director, County of Los Angeles, Department of Mental Health

1. There are challenges ahead but also opportunities that relate to the implementation of the low-income health plan portion of the 1115 Waiver in Los Angeles County. We are working with stakeholders, including internal DMH staff, to identify the specific tasks to implement the low-income health plan. Our partners in Department of Health Services (DHS) have been participating in the 1115 Waiver for many years, but California new plan approved on November 2, 2011, includes mental health as a mandated service for the first time in many years. We are in a fast track looking at how we will expand, enhance, and supplement mental health services under the low income health plan. This means we will continue to focus on our priority population—the one we have always served.. The 1115 Waiver applies to a specific population of adults without children living at up to 133% of the federal poverty level and those with immigration status.

2. For DMH, we are conceptualizing the type of services that will be delivered. Services will be organized into three tiers. Tier 1 services are for the population that we have been serving in our adult system of care who have a serious or

persistent mental health illness, are homeless, have some difficulty in functioning. This population continues to be our priority for services.

3. We have been working with DHS to look at those clients that we share in common. Under the 1115 Waiver, we are expecting that there are a number of individuals who are seen in primary care settings who need mental health services but have difficulty accessing them right now. So we are exploring the opportunity to expand our services to be more effective in reaching those clients. We are working with our partners in the healthcare world on various types of collaborations.

4. There will be an expansion of directly operated programs. We are co-locating staff in DHS directly operated facilities, DHS comprehensive health centers, and IMCs. We are looking at opportunities for our contract agencies to partner with community clinics, and we are also creating partnerships in a broader sense to ensure linkage between the healthcare and mental health world. There is a 'Behavioral Healthcare Home' work group being established now in response to a Board motion to review those models to see what can work for Los Angeles County. We need to be focused on the implementation because it starts in July 2011, and much work needs to be done before then. We are actively focused on the human resource part of that implementation, and we are working to develop a curriculum for people who will act as care coordinators working in both the physical healthcare and the mental healthcare systems to help clients with problems accessing services between both systems.

5. The State budget is still a fluid situation because we do not know exactly what will happen with the Legislature and what it will endorse. We will have a better understanding in a week of what might happen. If the Governor's plan moves forward there will be an addition to realignment similar to the 1990s—a second type of realignment to EPSDT, Managed Care, and AB 3632. For next year, the Governor's proposal is to use $861 million statewide of MHSA funding to fund realigned programs and in June have California residents vote to extend tax increases to sales tax and Vehicle License Fees. This vote would be needed to continue funding for realigned programs beyond 2011. Much will depend on what happens in the special election in June.

6. We will continue to watch realignment, which provides the core funding for mental health services beyond the available MHSA funding. The bad news is that for this fiscal year the CEO this week released realignment numbers showing an additional $8 million shortfall for fiscal year 2010-11. We will be talking with the CEO about budget strategies we can implement because this additional shortfall at this point in the fiscal year gives us little opportunity to mitigate the effects.

7. For next year, the State budget looks a little confusing and continues to be fluid. We face the loss of the additional federal match portion for Medi-Cal, which represents a $20 million decrease to our structural budget. The good thing is that working together we addressed the budget shortfall for this year and next year,

with the exception of the loss of the additional federal match portion. If it was not for the additional loss of the FMAP we would not have a deficit. We continue to have a projected deficit of $20 million because of the loss in federal match. However, we should not worry too much about this issue right now because the CEO is projecting an additional $5 million of realignment which will help offset that deficit. We will also generate some additional revenue through the implementation of the 1115 Waiver that can cut into the deficit. We will be reconvening the Budget Mitigation work group in order to do a budget analysis and have something to present to the SLT.

8. Regarding AB 3632, Governor Schwarzenegger in October 2010 signed this year's budget with both the mandate and funding for AB 3632 services. This is the first time we deal with an elimination of a mandate. We received Board approval to enter into a Memorandum of Understanding (MOU) with local school districts. All but three school districts intend to sign the MOU. We are working with these school districts to ensure that services continue uninterrupted to the children served. This required tremendous amount of work from County Counsel, DMH staff, and the school districts.

B. Feedback:
   1. Question: Is the government taking MHSA money as a loan to be paid back or is it permanent taking?
      Response: It is not a loan and it is not a permanent taking. The change is with the way MHSA revenues are booked at State level. By changing the accounting practices from cash to accrual, the State can take that one year of excess funding and use it. There has been some pushback with regards to going from a cash to an accrual accounting system, but most counties accept it because it will not represent a decrease in the allocations going forward.

   2. Comment: Moving to an accrual basis means that each month there will be an estimate of how much money has come in and that money will be made immediately available for distribution within the State to individual counties.

   3. Question: Which are the three school districts that have not agreed to the MOU?
      a. Response: They are Glendale, Arcadia and Monrovia; but this could change because the Department has sent a letter to see if they would reconsider.

   4. Question: Would the use of MHSA funding establish a precedent and make it more likely to be repeated?
      a. Response: No, because the move from a system of booking the cash at the end of the fiscal year to an accrual system where cash is disbursed as it accrues (or comes in) can only be done once. The proposal is to do it one time only. This seems for most a more palatable way for voters to approve the State's use of MHSA funds to get over the hurdle. If the extension to tax increase is not approved by voters in June, then it is an entirely different discussion. There have been many discussions on the type of Constitutional

amendments and guarantees that counties might need going forward because the State proposal is only for three years.

5. Question: Are consumers going to be divided in three different tiers?
   a. Response: We are not dividing the clients into three tiers. The tiers are a way to conceptualize the type of services the Department delivers. Tier 1 services provide comprehensive rehabilitation options delivered largely through our specialty mental health clinics. Tier 2 are also specialty mental health services but delivered to individuals mainly in primary care locations and who do not typically receive services in our free standing clinics. Tier 3 is not an actual tier but it is for individuals in primary care locations that do not want more than what they are receiving in the form of medication; it also includes physicians who might want to consult the Department or a psychiatrist who is trained to manage complicated psychotropic medication.

6. Question: Where is the funding for the AB 3632 MOU coming from?
   a. Response: Our understanding is that school districts are required to pay or provide those services. The MOUs that were developed specify that the school districts will reimburse the County in full for the cost of delivering those services. We are unsure how the non-signing school districts intend to satisfy the federal mandate. We will continue to deliver services and not abandon the children until adequate notification is made to the Department of the districts' plan.

7. Question: Will the expansion of services to more people decrease the depth of services provided to our traditional population?
   a. Response: After July 2011, the 1115 Waiver will enable us to draw down federal revenue for services to unfunded clients for whom we pay 100% of the cost. It will enable us to begin enhancing those services and to provide people with what they need, not necessarily what we are able to afford right now. We have done the math and believe this will represent an expansion, not increased limitations, particularly for the Tier 2 services that are included in our PEI Plan.

8. Question: Will we go back to the way it was five years ago? Or is it a new world?
   a. Response: Increasingly, as we have implemented different components of the MHSA Plan, we have started to regain a continuum of services that we have not had in long time. The 1115 Waiver will enrich the services that we have been delivering and allow us to augment services, including for people for whom we can intervene earlier.

9. Question: How do the non-signing school districts intend to meet the federal mandate if they decline to participate with the county?
   a. Response: We do not know, but hopefully they will respond to the latest letter sent to them.

10. Question: Will direct service providers in AB 3632 keep their jobs?

a. Response: The large school districts and indeed most of the smaller school districts have signed that we will continue to have the program in place. We are looking carefully at the budget and the impact of those three school districts, but will continue the program.

III. The California Endowment: Presentation and Discussion

A. Beatriz Solis, Ph.D., Healthy Communities (South Region) Director

1. Presented an overview of the California Endowment Building Health Communities. For additional information, please refer to the handout entitled "Building Healthy Communities."

B. Feedback:

1. Question: Is there a specific vision of the public sector transformation needed to support this effort? How will it look?
   a. Response: The easiest way to begin transformation would be to start talking to each other about strategic direction and synergy around limited resources. There is energy and desire for this in the public sector, but we are unsure to what level. We are looking for opportunity structures that will help break down silos. We always hear that someone cannot do something because it is not in their specific scope of work. There needs to be synergy. In DC, the President has an Integration Team generating new federal opportunities to support and promote working together. At the federal level, there are funding mechanisms to incentivize the public sector to work across silos.

2. Comment: The place-based approach is a model that nationally we are hoping will work because it is the pathway from the standpoint of basic issues facing our communities. It offers enormous hope for the seriously mentally ill and their families to live in much healthier communities. The Institute of Medicine's Round Table on Health Equities is concerned that carrying out the evaluation of this work will be very difficult because there are many moving parts and different situations across the fourteen sites. In some sites it will work better and not so well in others, but knowing why it worked well or not is very important. Especially to ensure it is sustainable and transferable to other bodies to continue this work. So you have to think very seriously about what kind of things we can call evidence-based standards to employ elsewhere. The evidence-based standards must be durable and can actually be accessed in a way that is compelling. Without that, in my opinion, it will be a failed effort.
   a. Response: We are always thinking about evaluation. An example is the Annie E Cassie Foundation's place-based approach, where they spent $10 million on the evaluation. But it did not help them. The type of evaluation we need has to be iterative, fast, learning on the ground, and reactive. But the current evaluation tools are kind of limited in that way. We do have core quality data and are also documenting everything that is happening in each site. We think you need to see something qualitatively changed in the community, but sometimes data and indicators cannot show the qualitative change. So we want to change the narrative to show that qualitative shift, and our focus will be on the policy areas we will be working on. We are looking at early win

strategies because sometimes it is difficult to engage young people and families on this; it could be very boring. We released funds for youth to tell us what they wanted to do to build momentum around building healthy communities. They told us they wanted a barbeque and help on how to do social networking at the park. We got amazing stories about kids having trouble getting in the school lunch line because there are three thousand kids having lunch at the same time or the difficulty in getting to school through the park because it was controlled by people dealing drugs.

3. Comment: Whether you have insurance or not, sometimes you still cannot access services. In the upwardly mobile communities there is one public health clinic or one physical health provider for every ten thousand people. In a less financially able community you have one clinic per every 100,000 people to access services. Also in these communities because of funding and shortcuts, school nurses are eliminated. They are not looking at the whole picture of preventive healthcare but are still looking at this narrow focus. There needs to be a community education project to redefine what the Endowment is doing so that it eliminates that narrow focus into having more of a global understanding of what you are trying to provide.

4. Question: Is the California Endowment involved with support of programs operated by mental health consumers?
   a. Response: The Endowment has supported efforts to look at how to provide mental health services in a more cultural competent way. We provided a grant through the Tide's Foundation that helps community clinics to think more broadly at how they provide care to patients. We also worked with Probation to begin looking at mental health needs in an institutional way for the youth.

5. Comment: It is not surprising that the high percentage of post-traumatic stress disorder (PTSD) is higher with our youth than in Iraq. We do not address the war out on our streets that has not been declared a war, but yet these kids are seeing their family and friends shot to death.
   a. Response: We have more data and support that infants and toddlers where the mother lives in a community with a heavy presence of violence and structural racism, this has an impact on brain development. There is a direct correlation between what is happening with children's' brain development and exposure to violence.

6. Question: Would it be possible to send the power point slides to everyone?
   a. Response: Yes we will email them out to everyone with the meeting notes.

7. Question: How were the criteria for the ten outcomes developed?
   a. Response: We developed them by looking at our investment sites in terms of the different strategies. We funded about 35 different strategies, so we looked at what really made a difference and the model of where we wanted to go.

8. Comment: I want to thank you for the work you have done. Many years ago we did something similar in education in the Compton area. Someone said that people do not access our services because we sit in our Ivory Tower and plan for them. So we got community leaders to meet with families in their homes to tell us what they needed. The community did not trust the government because their funds only lasted three years, and programs were not funded after the three years. If the Endowment is going to do something for ten years, you have to be sure to get a strong advocate or fundraiser group to fund it beyond the ten years.
    a. Response: We are working heavily on building partnerships to leverage more funds because we know partnerships are very important. We are working with the U.S. Soccer Foundation, for example, to build a soccer field in South Los Angeles to keep kids active and bring Black and Brown communities together. We are not interested in providing specific services or programs. What we want to do is explicitly help build the capacity around local policy and system change locally and how to take it to a statewide and national level.

9. Comment: I want to congratulate you on your work, especially for explicitly addressing the push-out rate, institutional racism and the prison pipeline and reentry. This language and these words have not been heard here at the SLT meetings yet and yet they are really critical to our work. We always hear the need to feel the pulse of our youth and residents and it is appealing to talk about that. It is beautiful to see the youth on a video and it touches our hearts. But how do we involve them to where they are central to providing their stories and narratives and do go beyond the ten years?
    a. Response: The youth are important so we have a youth leadership program across our fourteen sites where we bring youth leaders together. The first cohort is those who want to be part of it, but we are hoping that over the ten years we are connecting 14 groups of kids from different sites together by using Skype, in person meetings and regional meetings. What we have heard so far is that once youth in Del Norte understood that a youth in South Los Angeles is having similar problems, they can connect together and build a relationship together. That will be a very powerful thing. We can also take them to Sacramento to talk about why we do not have hospitals in South Los Angeles or Del Norte. We feel we have to be very intentional about creating youth leadership around issues, but with a point of view.

IV. SLT Membership: Update

A. Rigoberto Rodriguez provided an update on the nomination process to fill the empty seat on the SLT.
    1. The ad hoc committee met last week and this morning to nominate a person to replace the prior SLT member.
    2. The committee identified three people to nominate. The criteria used for nominations were: someone who self-identified as a consumer; someone with a systems perspective; and someone who could contribute to the diversity of the SLT with regards to region, ethnicity, etc.
    3. The ad hoc committee will send the nominations directly to Dr. Southard and he will be making the final decision.

SLT Calendar: Identifying Key Topics

B. Rigoberto Rodriguez, Facilitator, asked SLT members to identify possible topics to address during SLT meetings:

1. What is happening with regards to County efforts across Departments to establish information technology system and database?

2. Jim Randall: Concern around the depth of services being provided to the population traditionally served by the Department.

3. Stella March: I want to ask for a consumer trained In Our Voice to give a presentation.

4. Eddie Lamon: I met with the chair of the Los Angeles County Mental Health Commission regarding the different chairs of the different Service Area Advisory Committees (SAACs). The SAAC chairs want to know who on the SLT is representing them, and to let the SAAC chairs if any of them are not showing up to the SLT.

5. Nina Sorkin: We need to focus on youth, especially TAY, in terms of services for them and how do we empower them to become successful as adults.

6. Nina Sorkin: In light of what Dr. Kay mentioned about AB 3632 and education, it would be good to know what are we going to do to meet that funding challenge.

7. Carmen Diaz: I would like to see maybe a presentation on children's mental health and the family movement, which is also the parent movement. It is different from the family movement for the adults. Not many people know about the children's mental health history and how it is different than that of the adults.

8. Romalis Taylor: I would like to see a presentation from DCFS, DMH and DHS on services provided to youth and children in our communities. It would also be instructive to learn about the outcome of the Katie A. work: I would like to know what they are really doing with that project and what the actual outcomes are for these children.

9. Emma Oshagan: I would like to have a discussion about the underserved communities, specifically the Middle Eastern/Eastern European population. What are we doing, what we can do for them, and how we can outreach to this community? They are the least served communities because they are classified under 'White,' so even the numbers are not good numbers.

10. Cynthia Jackson: I would like to talk about what is going on with the PEI funding, how is it being used and whether we need to revisit some of that in light of other various issues.

11. Pamela Inaba: I wanted to see a presentation on client-run centers, like the San Fernando Valley Community mental health center or someplace where they are doing client-run, peer-run activities and programs.

12. Jim Randall: I would like to have a presentation on how we can use outcome data to improve the quality of services that agencies deliver.

13. Mara Pelsman: I would like more information on forensic population exiting the State jails and prison system and that is coming to Los Angeles.

14. Dora Gallo: I would like to know more about how FSPs and FCCSs are being integrated into supportive housing and how those services are actually being delivered to the people who live in supportive housing.

15. Andrea Gordon: With all the recent discussion about realignment and budget issues—and now the elimination of community redevelopment agencies—and knowing that many of them are partners with DMH and all the different housing initiatives we have in Southern California, and how many mentally ill and Probationers are in need of that supportive housing, I would like to know more about how we can plan at a more integrated kind of level to work effectively with our housing partners depending on which way these things go.

16. Dorothy Banks: I would like to see a presentation on Lets Erase the Stigma (LETS) Education Foundation with the youth.

17. Paco Retana: I would like to have a presentation by an organization called *Community Coalition,* who is leading a mental health initiative campaign that is very consumer driven. I want to hear what they are identifying in South Los Angeles as mental health needs from a consumer driven perspective.

V. Public Comments and Announcements

A. Public comment section:

1. Comment: I want to know whether you could alert all the members that this is the time for them to find out from the register of voters who their own State Senator and Assembly person is so that when the time comes to let them know when the bills are in committee hearing and would be glad to share that with you. I am doing that for NAMI. Let them know when to write but they have to be ready to get that. Its different, people get them confused the state and federal are two different senators and assembly persons.

2. Comment: Dennis O'Brien appreciated the assistance that I received at the last meeting. It meant a lot to me that there were people that cared when I was in a vulnerable moment. The Client Coalition had a meeting with Dr. Southard and he is letting us formulate the job description for Eduardo's former position. There needs to be collaboration and no exclusionary tactics used. Also, I hope that budget deliberations go well today and that the Republicans are willing to see that it is the vote of the people not just the Republicans.

3. Comment: On May 17, 2011, there will be a TAY conference at the California Endowment Center for Healthy Communities. We have a call for papers in the E-News. Our keynote speaker will be Mia St. John. We also engaged some of our TAY consumers to advise us how to run the conference and who and what we should include. Registration materials should be available after April 1st and it will be a one day conference from 8:00 am to 4:30 pm.

4. Comment: The Department announced in the E-News that it is currently doing a radio program on Sundays between 7:00-8:00 AM to talk about the changes happening in the system. Consumers do not have access to the E-News and are unaware that there is a talk show going on. Initially the shows were going to be archived and could be downloaded but the radio station will not do that till after they get their Arbitron rating in June. Also, they are only focusing on bi-polar disorder and schizophrenia; they are focusing on those two because they are the most common and most difficult to treat. They are only going to focus on two from the three hundred classifications. The orientation of the host, who is a family member and not a consumer, is to promote that medication management supersedes peer support and talk therapy.

B. Members of the public identified the following as key topics:
   1. Claudia: Discussion on how individual agencies are collaborating or gaining information from their surrounding communities. Specifically interested in TAY and adult programs.

   2. Gwen: A presentation from the Department of Rehabilitation in regards to the transition program they have for TAY coming out of high school.

   3. Maria: Presentation from the Department of Los Angeles Homeless Services Authority (LAHSLA) regarding the housing they provide for TAY programs for DMH and families that are in low poverty population.

   4. Mark: Discussion on programs such as the supportive housing of New Jersey. Shared housing that Ruth Hollman talks about, also the impact My Front Door program that Mental Health Association and Project Return have.

VI. Adjourn

A. Meeting adjourned at 12:35 PM