



# MENTAL HEALTH SERVICES ACT System Leadership Team

*Focus Group  
Findings & Recommendations*

**September 2013**



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## Executive Summary

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***In November 2004, California voters passed the Mental Health Services Act (MHSA) to offer mental health services and programs designed by County residents. The MHSA guides the design of voluntary programs that are rooted in wellness and recovery.***

The overall purpose of this report is to understand how the County of Los Angeles Department of Mental Health (DMH) and the Systems Leadership Team (SLT) engage stakeholders in the process of developing, approving, monitoring and adapting the Mental Health Services Act (MHSA) Plans in order to transform the public mental health system to achieve recovery, wellness and hope.

This report has three objectives:

1. To describe the structure and process by which DMH and the SLT engages stakeholders in the development, approval, monitoring and adapting of the MHSA Plans.
2. To gauge the strengths and challenges in three areas: stakeholder participation to obtain meaningful input; the role of the SLT in monitoring the implementation of the MHSA Plans; and identifying the changing program priorities.
3. To provide background information that clarifies the following areas: (a) MHSA funding (including the process of accessing the Prudent Reserve); and (b) the differences between the Annual Update, Mid-Year Adjustments and the Three-Year Integration Plan.

The Chief Executive Office (CEO) worked with DMH and the SLT to gather information to achieve the above objectives. Three data sources were used:

1. Review of State DMH and County of Los Angeles DMH current and historical files describing: (a) the purpose, structure, and functions of the SLT; and (b) MHSA regulations pertaining to the Prudent Reserve, Annual Update and Mid-Year Adjustment.
2. A focus group discussion with the SLT covering three topics: stakeholder participation; SLT roles and functions; and changing program priorities.
3. Key informant interviews with DMH staff, consultants and others to provide additional contextual information.

Based on the examination of content from the above sources, this report presents the following findings and recommendations with regards to stakeholder participation, program priorities, and SLT capacity.

- First, through prior planning processes, DMH has engaged a wide range of stakeholders to develop the five MHSA Plans. With the MHSA 3-Year Integrated Plan in the horizon, we recommend that the DMH and the SLT begin to develop planning principles that build upon

what has worked well from prior years to ensure broad-based and meaningful participation in the development of the MHSA Three-Year Integrated Plan.

- Second, the SLT has been building capacity to monitor the implementation of the MHSA Plans, including a clear function, membership, and decision-making methods. We recommend that the SLT continues to work on the following: strengthen communication among SLT members; expand stakeholder groups; clarify the SLT's advisory role; and document the decision-making process for major policies and practices.
- Third, DMH has previously tried to clarify the regulations pertaining to the Prudent Reserve, Annual Updates, Mid-Year Adjustments, and the Three-Year Integrated Plan. We recommend that DMH further clarify these regulations so that all SLT members understand these important regulations and protocols.

This remainder of this report is organized into three sections, providing information that supports the above findings and recommendations and that seeks to clarify important regulations.

- The first section provides high-level description of the MHSA planning process, MHSA funding (including the process of accessing the Prudent Reserve).
- The second section describes key milestones in the evolution of the SLT.
- The third section summarizes the results of the SLT focus group discussion conducted on March 20, 2013.

On March 20, 2013, the SLT conducted a high-level analysis of the overall role and responsibilities of the SLT in prior planning years, highlighting successes well as well as potential areas for improvement. SLT members were dispersed into three committees which analyzed a specific assessment area. Each committee developed a list of recommendations and the SLT members voted for their top three priorities. The assessment areas along with the SLT's recommendations for each area are provided below.

### **Stakeholder Participation**

Committee members considered how they previously organized stakeholder input, when developing the PEI and CSS plans and how they can apply those lessons moving forward. They also discussed strategies for gathering more meaningful input from stakeholders.

#### *Committee Recommendations:*

1. Obtain community input before finalizing plan so that the community's needs drive the development of programs.
2. Restore the MHSA Planning Division that previously existed within the DMH. This division served as a repository for stakeholders' input as well as a feedback loop from the DMH to stakeholders on MHSA matters. Upon further discussion at the June SLT meeting, DMH

recommends for the Program Support Bureau of DMH to support the 3-Year Integrated Planning process.

3. Provide additional support to the Service Area Advisory Committees (SAACs) so that they can do more community outreach to ensure the public's needs are being considered.
4. Obtain input from community stakeholders such as schools, police, fire, etc. (In addition to the input from the SAACs).
5. Gather feedback from DMH Executive team to ensure departmental goals are met.
6. Communicate the County's approval process which requires that the DMH present information to the Board of Supervisor's for final decision.
7. Ensure equal representation amongst committee members to ensure one group is not unfairly represented over another. For example, providers may outnumber family members on a committee.

### **Program Participation**

Committee members discussed the ongoing changes and priorities to programs once plans are implemented and the system evolves. They discussed how those insights can be carried forward into planning for the next 3-year plan.

#### *Committee Recommendations:*

1. Create a mental health system with built in flexibility to ensure that clients receive needed services.
2. Ensure that data considered by the membership is current to facilitate the identification of trends and disparities. For example, obtain information on underrepresented groups such as API (Asian and Pacific Islander) and older adults.
3. Consider Health Care Reform when mapping out the policy and planning process to ensure the knowledge is integrated and/or built into the process.
4. Expand the list of groups identified as priority groups and/or underrepresented groups to focus on addressing disparities, such as the deaf and hard of hearing, immigrants, and the physically disabled. Work with other County Departments and SAACs to see how they are prioritizing and addressing the underrepresented groups.
5. Develop a set of core values to assist with identifying priorities. Key values identified were: service integration amongst County Departments; outreach and engagement throughout the planning process; respecting cultural values; recovery on the front end of services; balancing the commitment to provide "whatever it takes" services against resource constraints; and avoid having a dual system of care.
6. Obtain and use information from peer run programs to help with engagement and the transition of clients through the system.
7. Ensure outreach and engagement throughout the planning process.

## System Leadership Team

The formation of open committees helps achieve more meaningful SLT involvement in shaping future program direction. Committee members considered the role of the SLT in developing the PEI and CSS plans. They discussed how those insights can be carried forward into planning for the next 3-year plan.

### *Committee Recommendations:*

1. Engage the SLT in shaping the future program direction prior to final decision being made by the DMH.
2. Clarify role and responsibilities of SLT members. Is the SLT an Advisory or Decision-Making Body?
3. Document the DMH's decision-making process on major policies and practices, such as funding decisions for programs including prudent reserve.
4. Provide information in a timely manner to allow members the opportunity to get feedback from their constituency.
5. Continue utilization of facilitator at SLT meetings and providing written answers to questions at next meeting.
6. Develop new member orientation so that new members are familiar with the acronyms used and their role and responsibilities.
7. When speakers are presenting information at SLT meetings, clearly delineate when presenters are simply providing information or if they are asking for a vote.
8. Provide information on how well peer-run programs work and information on aging and mental health populations. Provide avenue for members to understand and be responsible for tracking outcomes.
9. Consider how the SLT can play an advocacy role in communicating and influencing the broader arenas.

**Section 1:  
MHSA Regulations and Protocols**



## Section 1: MHSA Regulations and Protocols

### MHSA Regulations

The MHSA authorized the California Department of Mental Health to establish guidelines and criteria by which county plans were evaluated and ultimately approved. While integrated, the five components that make up MHSA are distinctly different, and thus State requirements differ for each component. A description, along with the State requirements of each component, is provided in the table below. The Community and Services Support (CSS) and Prevention and Early Intervention (PEI) components address the needs of four age groups (children, youth, adults, and older adults), and funding for the Innovations component focuses mainly on the adult population. In Los Angeles County, stakeholders approved that the funding for the Innovations component focus on adults with severe mental illnesses.

### State Requirements by Plan

MHSA COMPONENTS	PLAN DESCRIPTION	REQUIREMENT		
<b>Community Services Support (CSS)</b>	<ul style="list-style-type: none"> <li>By Statute, at least 51% of funds must be used for Full Service Partnership (FSPs) across all age groups</li> <li>Services and supports for individuals with serious mental illness and children/youth with serious emotional disturbances</li> </ul>	<b>80% Ongoing</b>		
<b>Prevention &amp; Early Intervention (PEI)</b>	<ul style="list-style-type: none"> <li>State defined priority populations. A total of 13 PEI Projects are in Los Angeles County</li> <li>Required planning be done within specific geographic areas (8 SPAs)</li> <li>Each SPA required to develop priorities to meet population needs</li> <li>Some services centralized to meet specific population such as Native Americans</li> </ul>	<b>20% Ongoing</b>		
<b>Innovations</b>	<ul style="list-style-type: none"> <li>Innovative Pilot Program – LA County selected to dedicate efforts in preparing for Health Care Reform</li> </ul>	<b>5% PEI &amp; 5% CSS</b>		
<b>Capital Facility and Information Technology</b>	<table border="0"> <tr> <td style="vertical-align: top;"> <p><b>Capital Facilities</b></p> <ul style="list-style-type: none"> <li>Distribution to County Departments Only</li> <li>Used to remodel or build new facilities where MHSA services are delivered</li> </ul> </td> <td style="vertical-align: top;"> <p><b>Technology</b></p> <ul style="list-style-type: none"> <li>Development of Electronic Health Record System for DMH and Contractors</li> <li>Technical Assistance for Contractors</li> <li>Family and Client Computer Lab</li> </ul> </td> </tr> </table>	<p><b>Capital Facilities</b></p> <ul style="list-style-type: none"> <li>Distribution to County Departments Only</li> <li>Used to remodel or build new facilities where MHSA services are delivered</li> </ul>	<p><b>Technology</b></p> <ul style="list-style-type: none"> <li>Development of Electronic Health Record System for DMH and Contractors</li> <li>Technical Assistance for Contractors</li> <li>Family and Client Computer Lab</li> </ul>	<b>One time</b>
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<b>Workforce Education and Training</b>	<p><b>Training and education to develop, enhance, and broaden the public mental health workforce, including (but not limited to):</b></p> <ul style="list-style-type: none"> <li>Support for Graduate Students</li> <li>Education for individuals whose family member has Mental Health related issues</li> </ul>	<b>One time</b>		

Consistent with State guidelines, MHSA regulations and the MHSA, CSS, PEI, and WET plans were drafted as 3-year plans and updated annually. CFTN and INN plans are one-time funds that may be spent over a 10-year period. Innovation is a time-limited project, defined by the County, with funds reverting three years after accrual. Once approved, regular updates to the plans are required. These updates are referred to as Annual Updates. AB 1467 added the need for meaningful

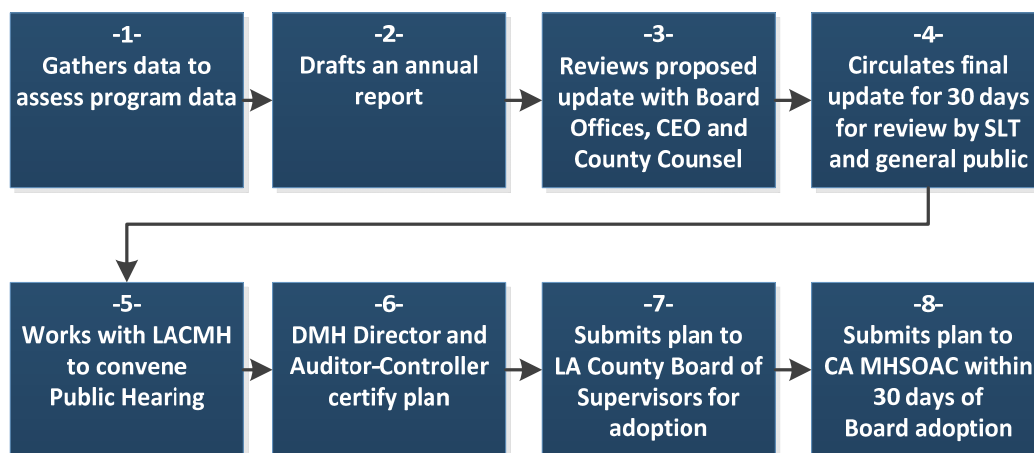
involvement of stakeholders in the development of both 3-year plans and annual updates is required. The development and approval process used in FY 2010 is depicted next.

Counties are required to prepare and submit annual updates to the State on a yearly basis. The development and approval process for the annual updates is provided below.

## Development and Approval Process of the Annual Update

The following steps outline the development of the Annual Update that DMH coordinates:

1. Gathers and assesses relevant information regarding the implementation of the approved MHSAs programs (i.e. what population was served and services provided).
2. Drafts report to include information based on the CA Mental Health Services Oversight and Accountability Commission (MHSOAC) guidelines issued on November 21, 2012. The following lists a few requirements, but this list is not inclusive of all guidelines:
  - Number of children, adults, and seniors served and the cost per person
  - Utilization of unspent funds allocated in the previous year
  - Proposed expenditure for the same purpose
3. Reviews Proposed Update with Board Offices and CEO; coordinates County Counsel review.
4. Circulates the Proposed Update at Service Area meetings, provider meetings, the monthly SLT meeting, and posts to DMH website for 30 days for review by SLT and general public.
5. Organizes logistics for Public Hearing meeting that the the Los Angeles Commission on Mental Health (LACMH) convenes after the public comment period.
6. Coordinates the review by the DMH Director and Auditor-Controller to certify that the Update complies with the MHSAs requirement and that expenditures are consistent with MHSAs and approved plans.
7. Submits the plan to the Board of Supervisors for final adoption.
8. Submits plan to the MHSOAC within 30 days of Board adoption.



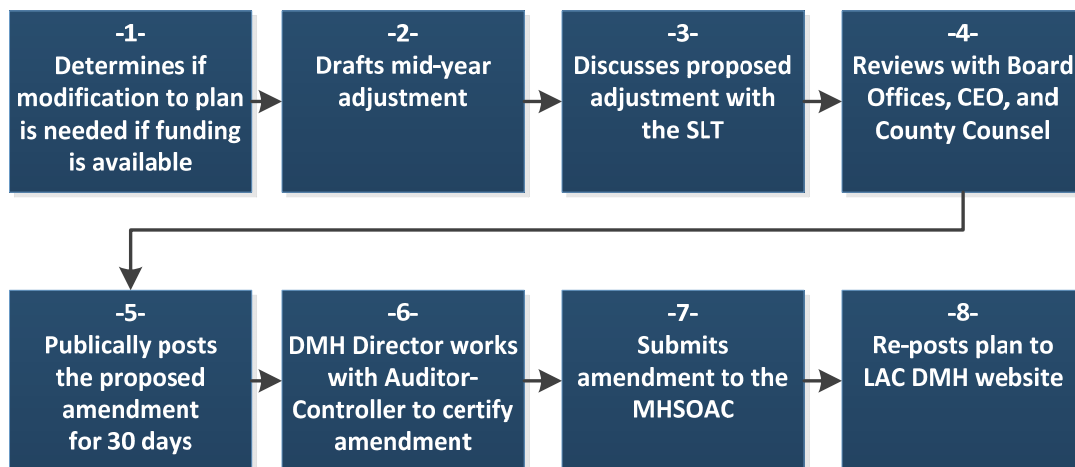
## Development and Approval Process for Mid-Year Adjustments

The DMH may initiate amendments to an approved plan at any time. Since the passage of AB 100 in 2011, DMH no longer is required to request funds. Therefore, DMH processes a mid-year adjustment to:

- Propose a new program/service that was not included in the County’s MHSa Plan.
- Change or modify an approved MHSa program within a specific component of MHSa.
- Eliminate an approved MHSa program within a specific component of MHSa

DMH’s process for submitting a mid-year adjustment is as follows:

1. Determines if modification to plan is needed and if funding is available.
2. Drafts mid-year adjustment.
3. Discusses proposed adjustment with the SLT.
4. DMH reviews amendment with Board Offices, CEO, and County Counsel.
5. Publically posts the proposed amendment for 30 days.
6. DMH Director works with Auditor-Controller to certify amendment.
7. Submits amendment to the MHSOAC.
8. Re-posts plan to LAC DMH website.



## Development and Approval Process for the 3-Year Plan

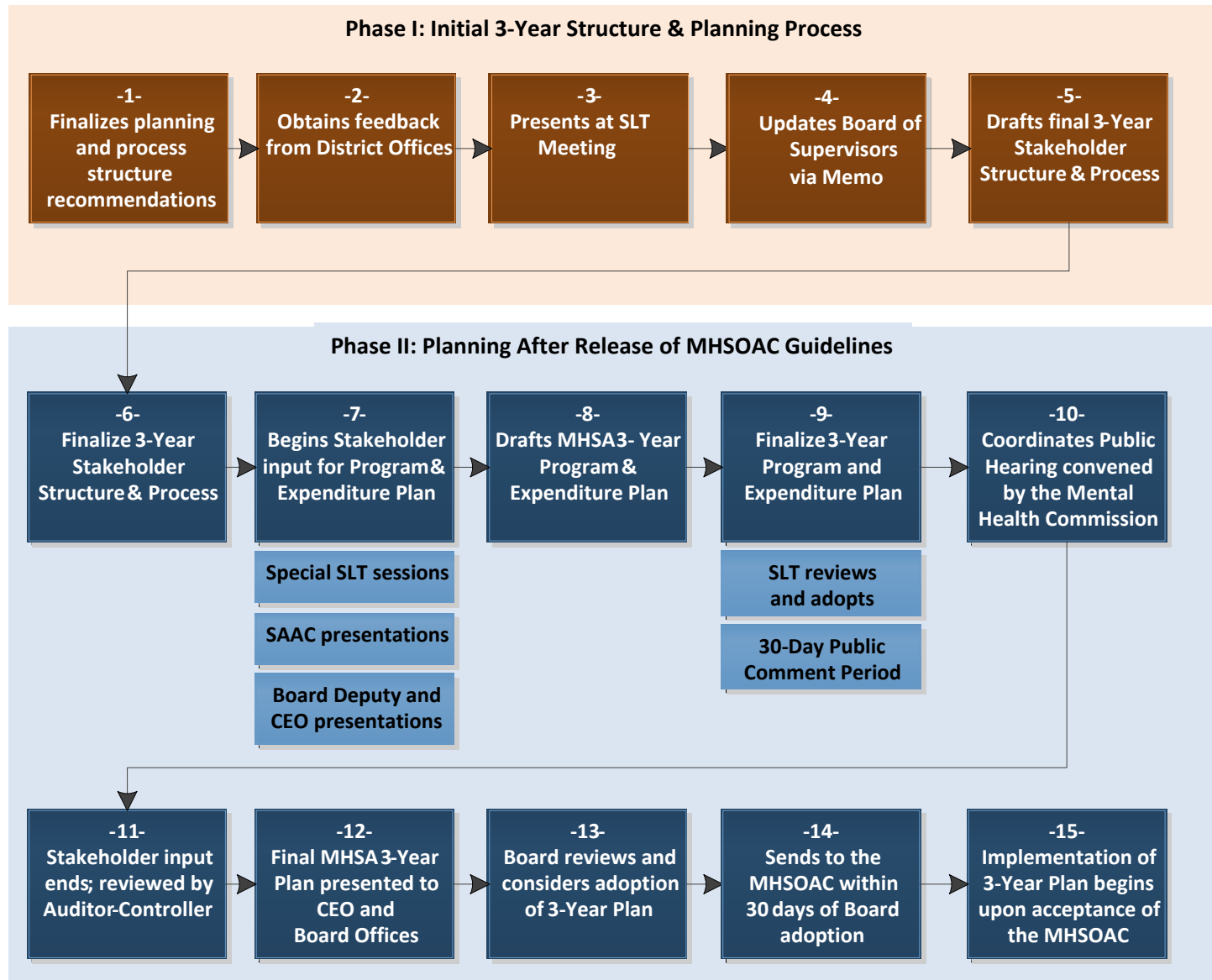
The 3-Year planning process is an opportunity to ensure stakeholder participation; achieve active SLT membership; realign services; develop guiding principles; and re-establish priorities. The 3-Year Planning Process consists of two phases.

- Phase I: The County drafts the 3-Year Stakeholder Structure and Planning Process. The expected completion is August 2013.
- Phase II: After release of the CA Mental Health Services Oversight and Accountability Commission’s (MHSOAC) guidelines in September 2013, the 3-Year Stakeholder Structure and Process plan is finalized. Then, the County focuses on the MHSA 3-Year Program and Expenditure Plan. Once adopted by the Board in June 2014 and accepted by the MHSOAC, the County begins to implement the Plan.

### 3-Year Planning Process Timeline

I. Initial 3-Year Stakeholder Structure & Planning Process	
July 2, 2013	1. DMH Executive Management Team (EMT) drafts 3-Year Stakeholder Structure and Planning Process
July 3, 2013	2. Obtained feedback from DMH District Chiefs on the planning document
July 17, 2013	3. Presented Plan to SLT
July 2013	4. Provided update to Board on the Plan via Board Memo
August 2013	5. DMH drafts final 3-Year Stakeholder Structure & Planning Process
II. Planning After Release of MHSOAC Guidelines	
September 2013	6. Finalization of the 3-Year Stakeholder Structure & Planning Process (2 weeks after release of guidelines in September 2013)
September 2013 through February 2014	7. Stakeholder input regarding programs and expenditures begins <ul style="list-style-type: none"> <li>○ Special SLT sessions (i.e., Mental Health Commission, Board of Supervisors’ deputies, other departments and stakeholders)</li> <li>○ Service Area Advisory Committee (SAAC) presentations</li> <li>○ Board Deputy and CEO presentations</li> </ul>
February/ March 2014	8. MHSA 3-Year Program and Expenditure Plan Drafted
March/ April 2014	9. Finalization of the MHSA 3-Year program and expenditure plan <ul style="list-style-type: none"> <li>○ SLT reviews and adopts MHSA 3-Year Program and Expenditure Plan</li> <li>○ 30-Day Public Comment Period</li> </ul>
April/ May 2014	10. Public Hearing Convened by the Mental Health Commission
May 2014	11. Stakeholder Input Ends; MHSA 3-Year Program and Expenditure Plan reviewed by Auditor-Controller 12. Final MHSA 3-Year Program and Expenditure Plan presented to the CEO and Board Offices
June 2014	13. Board reviews and considers adoption of the 3-Year Plan 14. Sends to the MHSOAC within 30 days of Board of Supervisors adoption
July 1, 2014 (estimated)	15. Implementation of the 3-Year Plan begins upon acceptance from the MHSOAC

## MHSA 3-Year Planning Process



## MHSA Funding

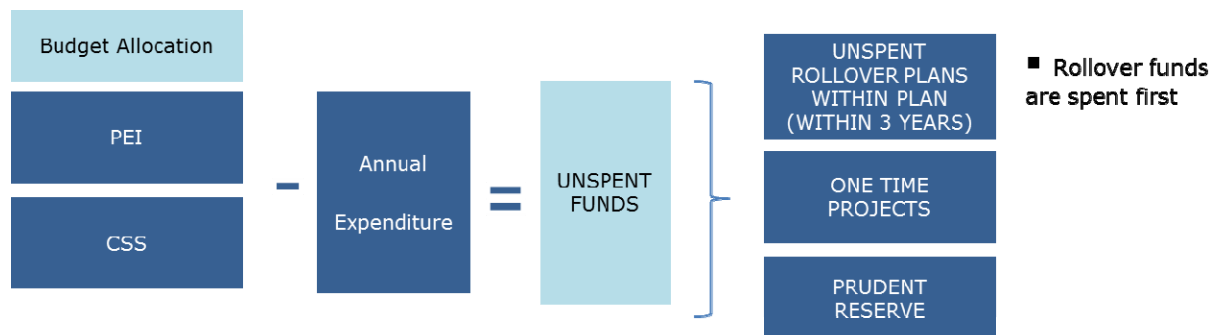
The MHSA imposes a 1% income tax on personal income in excess of \$1 million. MHSA funding varies significantly from year to year depending on the number of individuals in this tax bracket. Per MHSA regulations, counties must establish a prudent reserve to ensure that MHSA services are not significantly reduced in years that revenues are below the average of previous years. The intent of establishing a County MHSA Prudent Reserve is to ensure that County MHSA programs will continue to serve existing clients in years when MHSA revenues decline.

Initially the State mandated that counties maintain a reserve of at least 50% of the highest year of CSS. When the State authorized counties to access their Prudent Reserve, the State also suspended the 50% Prudent Reserve requirement during these years.

Allocation of MHSA funding is determined by a formula developed by the State based on population and statistical enumeration of potential new eligible people for services. At the end of three years, counties may transfer unspent MHSA dollars to the Prudent Reserve, as part of an Annual Update or mid-year adjustment process.

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### Unspent Dollars and Prudent Reserve Process



A county can access these funds to support any services allowable under the CSS and PEI components (excluding statewide PEI projects). Access to the Prudent Reserve is determined on a statewide level and requires approval by the State DMH/MHSOAC.

**Section 2:  
Evolution of the SLT**

## Section 2: Evolution of the SLT

Since its inception in 2006, the SLT composition, role and responsibilities have evolved significantly. While much of the evolution has been in response to changes by the State in its implementation of the MHSA, some changes have stemmed from the SLT's internal review. The following section provides a brief chronology of the SLT, followed by a review of current roles and responsibilities, present membership, and a comparison with the role of the Delegates.

### Chronology of Events for SLT

FY	ACTIVITIES
2004	<ul style="list-style-type: none"> <li>▪ California voters passed Proposition 63, the Mental Health Services Act. One key requirement under MHSA is meaningful involvement of stakeholders in the development of component plans and annual updates.</li> </ul>
2005	<ul style="list-style-type: none"> <li>▪ DMH formed the Los Angeles County MHSA Stakeholder Delegates group (Delegates) to obtain community input to the MHSA CSS plan. Delegates were responsible for overseeing the development of all MHSA components.</li> </ul>
2006	<ul style="list-style-type: none"> <li>▪ After the submission of the CSS Plan, the Delegates approved creation of the System Leadership Team and capped membership at 29 representatives.</li> <li>▪ The SLT's purpose was to serve as a rapid-response team for the delegates to help with the planning of the MHSA Plans and to be an advisory group to the DMH Director on the implementation of MHSA Plans and other issues impacting the broader public mental health system. The Delegate's purpose was to develop and recommend the MHSA Plans; the SLT was responsible for overseeing the implementation of the plans [Chart 1].</li> <li>▪ Guidelines for membership required the group reflect:               <ul style="list-style-type: none"> <li>○ Substantial Service Area representation</li> <li>○ The diversity of ethnic communities in Los Angeles County</li> <li>○ Representatives with co-occurring disorder expertise, including expertise with substance abuse and mental health issues</li> </ul> </li> <li>▪ Representatives with expertise with physical and developmental disabilities and mental health issues</li> <li>▪ Individuals were required to have served as a delegate or an alternate with regular attendance at the Delegate, Standing Committee or Ad hoc workgroup</li> <li>▪ Once the membership was established, members served a three-year term.</li> <li>▪ Delegates completed their work with the submission of the MHSA Capital Facilities Plan, the last of the MHSA Plans.</li> <li>▪ Delegates sunset.</li> <li>▪ The SLT began to address service gaps after the sunset of the Delegates.</li> </ul>
2010	<ul style="list-style-type: none"> <li>▪ SLT Membership increased from 29 to 40 members to expand representation of:               <ul style="list-style-type: none"> <li>○ Individuals with serious mental health illness and/or their families</li> <li>○ Underserved cultural populations,</li> <li>○ Providers of mental health services, social services, education, health, and law enforcement</li> <li>○ Community family resource centers, employment, and media</li> </ul> </li> </ul>
2010	<ul style="list-style-type: none"> <li>▪ The SLT established specific diversity <i>targets</i> based in three areas:</li> </ul>



FY	ACTIVITIES
cont'd	<ul style="list-style-type: none"> <li>○ Lived Experience: At least 25% of the members possess lived experience as a consumer, family member, or caregiver.</li> <li>○ Service Area/Geography: At least two people from Service Areas, and at least one formally linked/actively participating in a Service Area Advisory Committee (SAAC).</li> <li>○ Race/Ethnicity: Ensure that the racial and ethnic composition of the SLT mirrors the ethnic/racial diversity of the County population. This goal also applied to other demographics, such as LGBT, Deaf and Hard of Hearing, etc.).</li> </ul>
2012	<ul style="list-style-type: none"> <li>● During FY 2011-12, the SLT conducted an evaluation to identify what was working well and potential areas for improvement. The committee expressed the need to strengthen the SLT's role with respect to implementation and monitoring of the MHSA Plans. The SLT formed an <i>Ad Hoc Committee</i> with 10 members who presented the following recommendations:             <ol style="list-style-type: none"> <li>1. <i>Improve Communications</i> – Ensure timely dissemination of SLT-related business materials prior to monthly meetings.</li> <li>2. <i>Enforce Attendance Policy for SLT Members</i> – Allow members to miss only three meetings per calendar year.</li> <li>3. <i>Contribute to SLT Meeting Agenda</i> – Provide input on monthly SLT meeting agendas.</li> <li>4. <i>Implement Protocol for Participation by Public</i> – Establish two rounds of public comment per meeting with a specified amount of time. Allow for written input from public via comment card.</li> <li>5. <i>Define Legislative Advocacy Role</i>– SLT's focus is to provide input on important and timely mental health issues to DMH. SLT is not to serve as a separate advocacy group on legislative matters.</li> <li>6. <i>Define Monitoring Function and Streamline Access to Data</i> – Develop prioritized set of measures/indicators (dashboard) for SLT to monitor on a regular basis.</li> <li>7. <i>Enhance SAAC Participation</i> – Establish protocol and designate liaisons for reporting information to and from SAACs and SLT.</li> <li>8. <i>Replicate SLT/DMH Model Within Service Regions</i> – Build infrastructure wherein SAAC's can serve as advisors to their respective Regions.</li> </ol> </li> </ul>

**Chart 1 – Delegates Role vs. SLT Role**

DELGATES ROLE	SLT ROLE
<ul style="list-style-type: none"> <li>▪ Obtain feedback from workgroups and make final recommendations about what gets included in MHSA plans.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Develop process and structural frameworks to support overall system transformation, including developing and tracking performance measures for progress.</li> </ul>

DELGATES ROLE	SLT ROLE
<ul style="list-style-type: none"> <li>Obtain feedback from workgroups and make recommendations about how to support long-term systems transformation, including substantial budget reductions and other transformation initiatives.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor CSS Plan implementation, including:               <ul style="list-style-type: none"> <li>Developing and tracking performance measures for progress on CSS plan implementation; and</li> <li>Identifying design issues, developing the workgroups to resolve them, and tracking progress on these issues, including receiving reports from the workgroups and the Department on resolution.</li> </ul> </li> <li>Offer feedback to DMH on proposed CSS Plan extensions and minor revisions.</li> <li>Have the opportunity, where possible, to comment on workgroup recommendations before DMH makes final decisions.</li> </ul>

### FY-13 SLT Membership Composition, Role & Responsibilities

In addition to the Director of DMH, the SLT is currently comprised of 49 members. The composition of the SLT is as follows.

CATEGORY	#	REPRESENTATIVES
Mental Health System	13	<ul style="list-style-type: none"> <li>Unions: (2) AFSCME, SEIU</li> <li>Service Area Advisory Committee: (2) SAAC 6</li> <li>Contracted Providers: (9) ACHSA, LA Gay &amp; Lesbian Center, Heritage Clinic, Masada Homes, MH Advocacy, PACSLA, Pacific Clinics, SHARE, UREP</li> </ul>
Education	3	<ul style="list-style-type: none"> <li>K-12 Schools: (2) Green Dot Public Schools, LAUSD</li> <li>University: University of Southern California (USC)</li> </ul>
Commissions/ Advisory Councils	4	<ul style="list-style-type: none"> <li>California Co-Occurring Joint Action Council</li> <li>Commission on Children &amp; Families</li> <li>Los Angeles County Mental Health Commission</li> <li>Mental Health Association in Los Angeles County</li> </ul>
Government Agencies	3	<ul style="list-style-type: none"> <li>City of Long Beach</li> <li>City of Los Angeles</li> <li>Los Angeles Police Department</li> </ul>
Los Angeles County Department	15	<ul style="list-style-type: none"> <li>Chief Executive Office (2); Children &amp; Family Services; Community &amp; Senior Services; Health Services; Mental Health (6); Probation; Public Defender; Public Health; Public Social Services</li> </ul>
Community Advocacy & Advisory Groups	6	<ul style="list-style-type: none"> <li>Consumers: (4) California Network of MH Clients, LACCC, Project Return</li> <li>Family Members: (2) In Our Own Voice, NAMI</li> </ul>
Community-Based Organizations	4	<ul style="list-style-type: none"> <li>Housing Providers: Community of Friends</li> <li>Community Agencies: (3) Consultant, GLAD, Junior Blind</li> </ul>
Health Care	1	<ul style="list-style-type: none"> <li>Hospital Association</li> </ul>

Each SLT member offers a unique perspective necessary for the enhancement of mental health services for county residents and the broader mental health system. The current role and responsibilities of the SLT are as follows.

**Role:**

- Advisory committee to the Director of DMH.
- Monitor progress on MHSA Plan implementation, including developing and tracking performance measures for progress.
- Resolve ongoing MHSA related issues that emerge during the implementation of MHSA Plans.
- Refine and recommend changes to existing MHSA programs and projects including endorsement of any potential changes.
- Provide advice on ongoing issues affecting the public mental health system.
- Develop process and structural frameworks to support overall system transformation including developing and tracking performance measures for progress.

**Responsibilities:**

- Voice the needs of specific stakeholder group(s) and consumers of the Los Angeles County public mental health system to address prevention through innovation and provider development.
- Provide advice and negotiate solutions that balance the needs of specific stakeholder groups and needs of the broader public mental health system.
- Assist the Los Angeles county public mental health system in fulfilling its move towards the goals of hope, wellness and recovery.
- Adhere to meeting principles and norms conducive to safe and effective deliberation.
- Give recommendation free of conflict of interest for their specific organizations.
- Participate in the Issues Resolution Committee when their expertise has a bearing on the issue at hand.
- Actively participate in at least one committee (in addition to the Issues Resolution Committee): Budget Mitigation, Community Services and Support (CSS), Innovations (INN), Issue Resolution, Prevention and Early Intervention (PEI), Workforce Education and Training (WET), or other ad hoc work groups.

The current SLT membership term ends in December 2013.

Through the use of an ad hoc team, the SLT is examining its stakeholder representation and membership terms (amount of years and the staggering of terms). The SLT ad hoc team will be developing specific recommendations to enhance the composition, role, and responsibilities of the SLT.

To begin such efforts, the CEO worked with the DMH and the SLT to draw on lessons learned in prior planning years. On March 20, 2013, the SLT conducted a high-level analysis of the overall role and responsibilities of the SLT highlighting what has worked well and potential areas of improvement. The assessment process used and the findings generated are as follows.

**Section 3:  
Annual SLT Assessment & Findings**

## Section 3: FY 2013 Annual SLT Assessment and Findings

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At the SLT meeting on March 20, 2013, the SLT conducted a high-level analysis of the overall role and responsibilities of the SLT, identified successes, and noted areas for improvement. SLT members were divided into three groups to analyze the following three assessment areas:

- **Stakeholder Participation** – Committee members considered how they previously organized stakeholder input when developing the PEI and CSS plans and how they can apply those lessons moving forward. They also discussed strategies for gathering more meaningful input from stakeholders.
- **Program Participation** – Committee members discussed the ongoing changes and priorities to programs once plans are implemented and the system evolves. They discussed how those insights can be carried forward into planning for the next 3-year plan.
- **System Leadership Team** – Members considered the role of the SLT in developing the PEI and CSS plans. They discussed how those insights can be carried forward into planning for the next 3-year plan.

Each committee developed a list of recommendations. SLT members were given the opportunity to provide additional input on committees they did not participate, and they were asked to vote for their top three priorities. The next section highlights recommendations made by each committee.

### Stakeholder Participation

#### *Committee Considerations:*

- What did we learn about how we organized the last PEI & CSS and how can we apply those lessons for the future?
- How can we best gather input from stakeholders?

#### *Committee Recommendations:*

- \*1. Obtain community input before finalizing plan so that the community's needs drive the development of programs.
- \*2. Restore the MHSA Planning Division that previously existed within the DMH. This division served as a repository for stakeholders' input as well as a feedback loop from the DMH to stakeholders on MHSA matters. Upon further discussion at the June SLT meeting, DMH recommends for the Program Support Bureau of DMH to support the 3-Year Integrated Planning process.
- \*3. Provide additional support to the SAACs so that they can do more community outreach to ensure the public's needs are being considered.
4. Obtain input from community stakeholders such as schools, police, fire, etc. (In addition to the input from the SAACs).
5. Gather feedback from DMH Executive team to ensure departmental goals are met.

6. Communicate the County's approval process which requires that the DMH present information to the Board of Supervisor's for final decision.
7. Ensure equal representation amongst committee members to ensure one group is not unfairly represented over another. For example, providers may outnumber family members on a committee.

### **Program Participation Committee**

#### *Committee Considerations:*

- As the plans have been implemented and as the system has evolved, what insights do we have about the ongoing changes and priorities?
- How can we best carry those insights forward into planning the 3-year plan?

#### *Committee Recommendations:*

- \*1. Create a mental health system with built in flexibility to ensure that clients receive needed services.
- \*2. Ensure that data considered by the membership is current to facilitate the identification of trends and disparities. For example, obtain information on underrepresented groups such as API (Asian and Pacific Islander) and older adults.
- \*3. Consider Health Care Reform when mapping out the policy and planning process to ensure the knowledge is integrated and/or built into the process.
4. Expand the list of groups identified as priority groups and/or underrepresented groups to focus on addressing disparities, such as the deaf and hard of hearing, immigrants, and the physically disabled. Work with other County Departments and SAACs to see how they are prioritizing and addressing the underrepresented groups.
5. Develop a set of core values to assist with identifying priorities. Key values identified were: service integration amongst County Departments; outreach and engagement throughout the planning process; respecting cultural values; recovery on the front end of services; balancing the commitment to provide "whatever it takes" services against resource constraints; and avoid having a dual system of care.
6. Obtain and use information from peer run programs to help with engagement and the transition of clients through the system.
7. Ensure outreach and engagement throughout the planning process.

### **System Leadership Team Committee**

#### *Committee Considerations:*

- What did we learn about how we organized the last PEI & CSS and how can we apply those lessons for the future?

#### *Committee Recommendations:*

- \*1. Engage the SLT in shaping the future program direction prior to final decision being made by the DMH.

- \*2. Clarify role and responsibilities of SLT members. Is the SLT an Advisory or Decision-Making Body?
- \*3. Document the DMH's decision-making process on major policies and practices, such as funding decisions for programs including prudent reserve.
4. Provide information in a timely manner to allow members the opportunity to get feedback from their constituency.
5. Continue utilization of facilitator at SLT meetings and providing written answers to questions at next meeting.
6. Develop new member orientation so that new members are familiar with the acronyms used and their role and responsibilities.
7. When speakers are presenting information at SLT meetings, clearly delineate when presenters are simply providing information or if they are asking for a vote.
8. Provide information on how well peer-run programs work and information on aging and mental health populations. Provide avenue for members to understand and be responsible for tracking outcomes.
9. Consider how the SLT can play an advocacy role in communicating and influencing the broader arenas.