COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT)

Service Continuum Table Discussions

Wednesday, October 30, 2013

These notes compile information captured from the notes of those facilitating the table discussions and initial DMH age group staff discussions. A few notes on how to read the document:

1. All information was transcribed directly from notes. If the facilitator's notes indicated that something 'resonated' with the group, it was transcribed in the 'resonated' category. If it was identified as a gap, it was transcribed into the gap category.
2. Redundant statements were removed.
3. Blank lines highlighted in yellow (_____) indicates that the words could not be read from the picture of the document.

ADULT SERVICE CONTINUUM	
What resonated?	1. Cultural Competency a. Increase culturally sensitive suicide prevention and anti stigma prevention in API community lacking. API continue to have lower rates for all measures and outcomes (_____) b. Increase in culturally sensitive suicide prevention and anti-stigma prevention efforts, particularly to Asian Pacific Islander and Hispanic American communities. c. Promotoras 2. Improve/expand services available in wellness centers. a. Complete a needs assessment to identify the need for expansion of wellness centers (beyond 1 per service area) b. Have client run centers in all SPAs 3. Housing options needed a. Address housing gap from FSP to FCCS b. Housing program funds depleted c. Housing is a huge issue d. Use CSS money broadly not enough for housing e. Increase housing 4. PEI –Trauma Focused Care 5. EBPs for Psychotic Adults 6. Incorporation of more peer services 7. Group agreed with everything but need to provide staff not just volunteers 8. Gaps: Psychotic symptomology (most important) 9. Intensive community services as seen by FSP truly work and we need more of them

What other gaps and/or issues do you see?	1. Outreach and Engagement a. African American outreach and engagement needs to increase b. Latino outreach and engagement for suicide prevention needs to increase c. For African-American Community, life expectancy is 20-25 years less. What specific interventions are being planned to increase life expectancy? d. Greater focus on African immigrants in outreach and engagement. e. Expand outreach and engagement to Latino populations via promotoras f. Improve outreach to monolingual, non-English speaking groups. g. FSP Enrollment Outreach and Engagement 2. Healthcare Integration a. Campaign to get people into ACA for primary health or mental health. b. More outreach to primary care c. Integration of support for healthcare needs at all levels of care – including communication and navigation networks with local health care homes and assuring connections with primary care. 3. Community Integration Support a. "Lifeline" to "check in" as needed for graduates of FSP and wellness 4. Is there a way to create a continuum of services rather than having the services being siloed. (for example a pilot project for seamless transition from FSP to FCCS)? a. This framework and process of identifying gaps seems artificial. Services should be more holistic. b. Rethink navigation systems to be more robust and expansive to provide client with everything they need. 5. Employment a. EBP that actually works to increase employment significantly b. More peer services c. Mentoring services d. Need more innovative employment services/ programs to assist clients with their vocational and educational goals and improve outcomes in this area. e. Paying WOW workers f. WRAP g. Need more staff not just volunteers h. Look into employment so they can afford housing i. Wellness outreach workers –peers who help clients navigate the system and cope and to share experiences.

	j. More innovations and employment opportunities 6. Cultural Competency a. Serving under-represented groups b. Stigma abatement c. Reducing stigma among DMH and provider staff d. Programs that use positive engagement within the service community and the community at large to address stigma and discrimination. 7. PEI a. Identification of evidence based practices addressing psychotic symptomology and other prodromal mental health issues. b. Identification of evidence based practices in group format. c. Identification of evidence based practices addressing untreated long term trauma. d. Ensuring model fidelity and sustainability of properly trained staff providing effective EBP 8. Housing a. Transitional services out of jail especially for UREP b. EBP housing models. c. Housing support network d. Housing options in Wellness Centers for FCCS e. The alignment of existing services with DMH clients living in site-based housing is a model that is not meeting the needs of developers, property managers, and tenants in many cases. f. Need on site mental health services specifically connected to permanent supportive housing sites. g. MHSA Housing Program funds are almost fully depleted. Need more one-time funds committed to develop more housing units. h. There is an opportunity to invest a local flexible Housing Subsidy Pool that can be used provide ongoing subsidies for Permanent Supportive Housing for DMH Clients 9. Community-based recovery center a. Client run center in all service areas that empower and employ clients, help with skills development, and promotes shared understanding b. Increase use of self-management. c. Wellness recovery action plan should be an EBP not just in wellness d. Consistent requirements for membership at all Wellness Centers and Client-Run Centers e. Dually diagnosed with developmental disabilities 10. Wellness Centers

	a. Wellness services need expansion to accommodate participants at various stages of recovery, from new FCCS or FSP graduates to those ready to transition to community or health based mental health services. Some providers will need expanded Wellness funding to fill gaps in their continuum of care. b. Wellness Programs cannot accommodate housing where needed. c. Some services areas lack adequate FSP services to ensure available capacity when needed. Not all outpatient sites have FSP capability. 11. FSP a. Some service areas lack adequate FSP services to ensure available capacity when needed. Not all outpatient sites have FSP capability b. Need to identify strategies to increase flow from FSP to lower levels of care c. Need to identify agreed upon graduation markers for FSP 12. FCCS a. FCCS cannot accommodate housing needed for clients with use of CSS funds b. FCCS availability is inconsistent across programs and service areas. Establish staff to client ration and expectations for treatment. 13. Navigation a. Need to ensure availability of positions for Per Health Care Navigators to support MHSA Outpatient programs. 14. Veterans a. Look at reprogramming unused FSP slots to VA populations b. Expand number of Veteran peer-run programs 15. Law Enforcement a. Increase LE by brining new Les into contracts. Include consumer driven and paraprofessional agencies b. Law enforcement training (utilizing consumers and parent partners) 16. Lack of services for the uninsured and the uninsurable. a. Particular concern for undocumented immigrants. b. PEI needs more funding to serve undocumented poplations. 17. Community based –no good way to measure outcomes. Need to define and measure them 18. Lack of transportation in Service areas 19. Evidence-based models in CSS and expansion in PEI's (e.g. Intentional Peer Support, WRAP, Self help Support Groups 20. Caregiver of foster children need more people caring for them. a. Respite for caregivers

	21. Academic enrichment to improve life function and quality of life. 22. Incorporate "from consumer to contributor" programs 23. Sensitivity training is needed regarding identifying and working with individuals with mental illness
OLDER ADULT SERVICE CONTINUUM	
What resonated?	1. Wellness Centers 2. OA needs a wellness center in each SPA a. Wellness center programs for older adults 3. Navigators 4. "Increase capacity and depth." 5. Allocate navigators to each SPA (peer navigators, promotoras, veterans, etc.) 6. Cultural Competency a. Older adult anti stigma and discrimination in senior centers b. API older adults one of the most underserved groups 7. OA needs a lot more FSP slots 8. Push for EBP for "OA" suicide prevention 9. Neglect resonates 10. Not enough funding 11. Did not have older adult category before the MHSA
What other gaps and/or issues do you see?	1. Identifying Best Practices a. Looking at OA needs across Counties to see if LA County can learn from what other Counties are doing b. EBP-group specific –for OA (grief & loss, depression, other MHS) c. EBP developed by MH consumers (Client operated services project) Need to increase the number of EBPS including (_____)DBT and individual CBT d. EBPSs are not culturally oriented. Actual translation needs to occur. If left to clinician it affects outcomes. 2. Outreach and Engagement a. Increase outreach and engagement for OA, given their tendency to isolate b. OA Vet specific services c. Older adult was not allocated funding for outreach and engagement staff in each of the service areas. 3. Peer Support and Peer Mentoring

	a. OA peer support b. Support use of peer volunteers c. Need more training on older adult issues. Need more navigators. 4. Wellness Centers a. Older adults specialists at the Adult Wellness Centers. b. Wellness centers seem to compete with existing CA Centers like ADHC's, and service centers. Would be better to use these existing service centers and integrate wellness services there to be more efficient and put more field based work (_____). c. Clarifying what a 'wellness center' is d. APIs under-utilize geographically based wellness centers e. Wellness centers integrated with FQHCs f. Wellness/CRC OA Programs g. Senior Centers with mental health components h. Wellness without walls. CBAS program. For homebound seniors, end in skilled facility. 5. Prevention a. The Suicide prevention Team is fairly small (2 FTE's) which is a barrier to maintaining adequately trained staff to meet the growing needs of LA County. More depth in the team would help promote Suicide prevention more effectively throughout the county. 6. Cultural Competency a. API need more services b. Need for culturally competent services for older adult population c. Anti-stigma services for the underrepresented population to increase mental health access d. Culturally competent services for baby boomers who do relate to the World War II generation 7. Training and Education a. Adding education for PH/MH co-morbid issues specific to OA (in senior centers, etc.) b. Sensitivity training is needed regarding identifying and working with individuals with mental illness c. Dual diagnosis, co-morbidity, alcoholism and substance abuse. Not enough cross training in substance abuse d. More workforce development e. Ongoing geriatric training and support 8. Integrating mental health and health a. Co-location with health services, especially cal medical connect. b. Intensive services have collocation with mental health 9. Service extenders

	a. Pay Service extenders b. Expanding service extenders c. FSP slots expanded d. Funding is needed to expand the number of stipends available to consumers who are volunteers 10. Housing a. Senior housing options b. More older adult specific housing. 11. CSS a. There are limited dedicated older adult staffing resources to serve older adults in the existing Wellness Centers. b. Few of the directly operated and none of the contracted agencies received funding to develop specialized wellness services for older adults. c. Original funding for Older Adult programs does not reflect current demographics and population growth. 12. FSP a. During Fiscal Year 12/13 Older Adult FSP slot utilization was 90% b. For Fiscal Year 11/12 FSP slot utilization was 97% c. Additional FSP slots are needed to crate more service capacity within the FSP programs 13. System Support a. Older adult was not allocated navigators in each service area b. Older adult navigators are needed in each of the service areas to strengthen integration of health, mental health, and substance abuse services to coordinate care. c. Navigators are needed to refer and link Older Adult to services in the community such as IHSS, Senior Centers, and low income housing. 14. What is the justification for increasing staff for older adult suicide prevention team? We need to see the date to support? 15. Need to distinguish services for those on the younger end of the older adult spectrum. Better planning for target groups within the Older adult category, or target subgroups based on needs instead of age. (Sedentary v. active Older adult) 16. Audio/video recording of vet & OA stories 17. Consider identifying an older adult sub-class, and appropriate interventions (Older adult over the age of 80 years) whose needs may changes as they age 18. Consider linking DMH services to public policy – designated outcomes (SL) 19. WRAP

	20. Lack of (_____) medical psychiatric staff (Nurse Practitioner) that work on the FCCS Older Adult Teams 21. Health Navigator for each service area and help getting older adults to and from appointments
CHILDREN'S SERVICE CONTINUUM	
What resonated?	1. Evidence Based Practices (EBPs), Community Defined Practices (CDPs), Promising Practices (PPs) *a.* Endorse using EBPs and CDPs in full continuum of services including intensive services, not just in PEI *b.* Important to not only hold on to only EBPs because many have short comings c. Increase B-5 providers with training for this population d. Increase training for B-5 trauma (including relevant EBPs) e. Increase the number of FCCS and FSP providers trained in EBPs 2. Prevention and Early Intervention a. More focus in MHSA for prevention and early intervention must continue b. Prevention and early intervention are in jeopardy of being stigmatized by providers already perpetuating stigma 3. Family Support a. Increase services for young fathers, support services for grandparents and great grandparents who are raising children should be improved b. Re-integration and transition of services from foster care back to family c. Services for parents to assume appropriate role in coordinating with schools. 4. Reach out to Head Start programs & preschools to do outreach and engagement and promote mental health services. 5. Need for medication support after PEI, FSP or FCCS services end 6. Respite services are needed 7. Connection between DCFS and DMH
What other gaps and/or issues do you see?	1. Outreach and engagement a. Outreach and engagement to parents who need resources to meet child's educational, social, mental health, and medication needs 2. Partnerships a. In light of lost relationships between mental health and schools due to realignment of AB3632, DMH should build relationship with schools – create gateways to help mental health services work more efficiently

	b. Host community fairs, where the County can bring together multiple services (physical health, mental health, head start, substance abuse providers, etc.). These fairs will attract children & families, decrease stigma and promote education of resources c. Partner with Parks and Recreation to provide parenting education in a "safer" environment d. Strengthen and refine DMH-DHS collaborative e. Better collaboration with DCFS hotline 3. Trainings and Education a. Educate children and parents regarding developing symptoms indicative of mental health issues b. Sensitivity training is needed regarding identifying and working with individuals with mental illness c. Training staff-budgets for sustainability of EBPs d. Untrained case workers who do not understand Mental Health Peer mentoring e. WRAP f. Nutritional guidance g. Too few parent advocates h. The need for 0-5 and 0-3 trainings. 4. Issues impacting 'flow' in the Children System of care a. Children who graduate from DCFS or probation they 'fall off the radar' b. Children in the community or placement who do not qualify to TBS unless they are in DCFS 5. Cultural Competency a. Lack of mention of being culturally sensitive to UREP groups and other underrepresented groups and improving in this area. (For example: juvenile justice and API groups) b. Ensure relevancy and competency of services related to community based services, promising practices and emergency practices especially for culturally diverse populations 6. Services needed a. Services to non-PEI and non-FSP kids are missing. b. Lack of services for children/youth that do not meet medical necessity but would benefit from counseling. c. Children with developmental disabilities need more robust set of services for children in juvenile justice services. d. Need for new service providers to implement PEI in a non-stigmatizing way in order to build capacity for traditional service providers e. Services for fathers f. Need for holistic resources beyond just mental health treatment.

	7. Evidence Based Practices a. EBPs for non -PEI services b. Post EBP, clients need to continue to take their medication or there will be no place to go c. Services to non-PEI and non-FSP kids are missing. 8. Early Intervention Programs a. With the transformation of CGF into PEI services which encompass various EBPs with varying eligibility criteria, target symptoms and behaviors, lengths of stay and treatment modalities, there left a gap in services for clients that complete an EBP but continue to need services (i.e. meds only). b. Currently there isn't a program that could provide meds only for these clients. c. Most traditional outpatient services were transformed into various EBPs which left gaps for clients that do not meet criteria for a particular EBP but continue to need mental health services. d. Lack of sufficient numbers of trained professional for children Birth to Five (Children's Commission) 9. FSP a. Transformation and reduction of CGF, there is a gap for clients needing services that are less intensive than FSP. FCCS currently fill this gap, but access to readily available services is limited because not all agencies have FCCS. b. As FSP is the most intensive mental health service and highest level of care, there is a gap in services for clients that are transitioning to lower levels of care from FSP. c. Historically clients would transition to outpatient services but reductions of GF traditional out-patent services are not readily available. d. Agencies use FCCS as a step down from FSP, but FCCS is not an enrollment based program so there is not a mechanism in place for clients to transition from FSP to FCCS. e. Respite services for families of children enrolled in FSP or receiving FCCS. Currently being piloted by 8 agencies. 10. Child Welfare and Juvenile Justice Programs a. Gap in services for clients that are transitioning out of the Child Welfare System that continue to need mental health services. b. Gap in services for clients who only need medications. 11. Therapeutic Services a. Child beds are limited b. Need additional child-crisis services, current UCCs are not available county-wide. 12. System Support a. FSS services for significant support persons of an enrolled child FSP clients is limited and dependent on the child's status with FSP (have to be enrolled)

	13. Develop age appropriate stigma reduction program- Recheck up Check-up model. 14. Huge gap for 'kids in the middle' (community not foster care) 15. Develop mentorships and mentees utilizing constituents at lower level to be mentors. 16. Safety net for non medical necessary for kids who need PEI 17. Children that do not meet the medical necessity rules for access to the community defined, promising and emerging practices, and prevention services. 18. Have systems to ensure that there is psycho-social rehabilitation before psycho-social medications 19. Provide some overlap and continuity of providers for youth to prevent interruption of services
TRANSITION AGE YOUTH SERVICE CONTINUUM	
What resonated?	1. Promotoras for TAY population – stigma reduction, increase outreach and engagement, recheck-up/check-up, connect TAY to resources in community. 2. Need more drop-in hot sport centers (similar to the peer partners center - Carson Center) 3. Inner city NAMI So Central specific to reunifying families 4. Increase outreach and engagement 5. Subject Matter investigators and subject matter experts (SL) 6. Lack of supportive employment services 7. CRC for TAY
What other gaps and/or issues do you see?	1. TAY Specific Drop In and Wellness Centers a. Need for TAY drop in centers in every service area with a peer advocate component. b. Expanding on TAY wellness centers c. Focus more on integrated, co-located school based services d. UCC in all service areas e. TAY Wellness / CRC f. Peer run TAY wellness Center g. Wellness Center for TAY, not just drop in center to reduce adult intimidation h. Wellness centers are currently geared more towards adult populations. 2. Veteran Services a. Female Vet specific EBPs treatment b. Pair up vet with vet (Vet-to-Vet program) to de-stigmatize MHS and increase access to mental health services c. TAY specific services for Vets ages 18-25. Focus on homelessness, mental health issues, suicide

	prevention, vocational; continuum of services 3. Employment a. Increase internship or apprenticeship opportunities leveraging and networking with appropriate agencies that specialize in these areas b. Increase TAY navigators (resources for job training, job preparation) c. Peer-to-peer workers (e.g., LAOTC – Chris Lloyd, executive director) d. Gap in employment services for TAY 4. Housing a. Gap in independent living program for foster kids aging out but not for community kids (skid row) b. Shared housing for TAY c. Improve employment and education outcome support. d. Provide TAY with continued stable housing. e. Continued support when they are out of the TAY age group f. Better focus on permanent housing for TAY 5. Trainings and Education a. Sensitivity training is needed regarding identifying and working with individuals with mental illness 6. FSP a. Gap in services for clients that are transitioning from a high level of care (FSP) to a lower level of care (FCCS). Tehre are no other services or traditional outpatient services b. Limited number of FSP slots and FCCS service capacity 7. Child Welfare a. Gap in services for clients who are transitioning out of the Child welfare system that continue to need mental health services b. Gap in services for clients who only need medication support services c. DCFS is reducing the number of slots available for WRAP and the number of WRAP providers which could create an additional burden on FSP/FCCS services. d. Gap in services for older TAY (18-25) who are exiting from probation. 8. Prevention a. Lack of suicide prevention srvices for TAY populations. 9. Services a. Still need alternative to (_____) -based integrated services for kids in probation and TAY out of schools (over 18 TAY) b. Provide more services and support to teens transitioning into adulthood (e.g. 17 and older). For example: identity issue, independence and family issues.

	c. TAY who are under 18 must be treated in different facilities then adults. d. Lack of services and support for families and parents of TAY youth. e. Limited therapeutic Services especially for those who are 16-17 years old. f. Need additional TAY crisis services. g. EESP, Indepenent Living Programs, and Permanent Supportive Housing rsources are currently not available in all service areas. h. Lack of co-occurring mental health and substance abuse services for TAY i. Lack of specifically designed IMD Step-down resources for TAY j. Peer mentoring k. UCC's are not currently available in all service areas l. More services for foster care kids particularly when they age out m. More mental health services in schools n. Need to get service for kids who do not yet meet medically necessary requirement o. More services in community colleges p. Employment services q. Increase services we are providing to individuals who "graduate" out of foster care (ages 18 years and older) r. More self help support groups for kids and parents (EBPs Rainbows for trauma, family centers, wellness for children, ALA TEEN, "because I love you' for parents.") s. LGBTQ Peer Run Support t. Train facilitator for TAY groups already existing u. TAY navigators assisting with transitions , creating a job category. 10. Evidence Based Practices a. EBP for reducing stigma in schools b. Issue of EBP clients aging out and still needing meds 11. 20% of people in UCCs are TAY –no UCC for TAY –especially that addresses co-occurring and substance abuse services for TAY (or adults) 12. County funds went away –transformed to PEI (small amount of CSS outpatient services) 13. FSP gap (21-25 years) 14. Linkage to community college 15. Need for better branding 16. Under-represented (LGBTQ, Blind, and hearing impaired) services 17. Promotoras for other populations with special needs. 18. FCCS TAY services in all service areas.

CROSS-SYSTEM SERVICE CONTINUUM	
Observations and Comments	1. Need a fifth category for systemic issues such as finding housing, providing family supports, providing services for those with multiple disabilities. a. Gap: Specialty Navigators in all service areas b. Gap: need to bridge trainings of personnel at all age levels 2. Cultural Competency a. Lack of culturally competent trainings and services for all UREP groups b. Need more multicultural bilingual staff –particularly in wellness centers and as peer advocates. 3. Transformation of CGF into PEI services which encompasses various EBPs with varying eligibility criteria target symptoms and behaviors, length of stay and treatment modalities, there left a gap in services to clients complete an EBP but continue to need services (i.e. medication only" a. Currently, there isn't a program that provides 'meds only' or counseling to clients. 4. Employment a. Gap in direction to employment for those transitioning out of services. b. Lack of partnership with Calwork or other employment agencies. c. Focus on improving transition into jobs for those who were previously incarcerated. d. Need to improve employment outcomes for those in FSP programs. 5. Housing a. Using new EBP models b. Focus on transitioning individuals out of supportive housing and integrating them into the community. 6. Wellness/CRC, peer providers promotoras, mentoring, service extenders across all age groups. 7. Real employment with real jobs e.g. Employer first models and other EBPs 8. Make sure EBPs are culturally responsive 9. Housing with new model EBP models 10. Reducing stigma within DMH and Providers in community 11. Better Branding of service names.