COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, July 22, 2015 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the County of Los Angeles Department of Mental Health.
2. Follow up on MHSA-related issues.
3. Provide an update on implementation status of the MHSA Three-Year Program and Expenditure (3YPE) Plan.
4. Issue a recommendation on PEI-related funds priorities.

MEETING NOTES

DEPARTMENT OF MENTAL HEALTH UPDATE

Marvin J. Southard, Director, County of Los Angeles, Department of Mental Health

Diversion – The semifinal draft of the District Attorney's diversion report will be finalized this week and is scheduled to be taken up by the Board of Supervisors next Tuesday, July 28, 2015. The report looks at what the Department of Mental Health will do across all five intercepts, which are the five places where we may be able to divert people. The five intercepts are:

1. Pre-booking diversion
2. After arrest but before incarceration through the superior court
3. After incarceration if there are alternatives that are possible
4. Discharge planning in connection to the community
5. Creation of community support for success in the long term

The proposal that will be going to the Board comes from all the partners involved in the planning process, which included the criminal justice system, the courts, the public defender as well as the mental health and addiction treatment services in order to get a robust picture of what it takes to divert as many people as appropriate and possible, with the overall understanding that this is not a jail replacement plan. This will not replace the need for doing a better job with Men's Central Jail but rather a way of having a more appropriate treatment experience for people who can appropriately be diverted.

The proposal builds on all the things we are doing already. For example, it has more CIT (Crisis Intervention Training) like training for law enforcement and more mobile law enforcement mental health outreach teams. It also describes the implementation of the additional Urgent Care Centers and so forth. It highlights the SB 82 funded items and the like. It then adds additional questions: if we are going to do the most robust diversion possible, what additional resources would we need to make that take place? That plan will be discussed next week and we are looking forward to that discussion.

Homelessness - There has also been a new development in the area of homelessness. The Board is creating a centralized function within the CEO's Office to focus all County efforts on homelessness. Phil Ansell, who has been the Chief Deputy Director for the Department of Public Social Services, is going to take the position for a period of at least six months to head up this new integrative effort. All of the relevant County Departments are going to contribute resources to try to find a way to bring those LA County efforts into greater focus but also to work more collaboratively, as we have been trying to do for a long time, with other governmental and private entities such as the foundations and the City of Los Angeles. That effort will be moving forward. Of course, we will participate in that process.

Transition Age Youth - For transition age youth, we have developed a template of how we are going to move forward with all of the steps we think are necessary to do a better job engaging and treating transition age youth.

Additional Areas of Work –

Suicide Prevention in Jails - The Department of Justice and the County of Los Angeles are on the verge of coming to a settlement agreement on use of force, suicide and mental health treatment within the jail setting. The Board is expected to provide a final review of the proposed settlement. Once the settlement is approved, the County of Los Angeles and the Department of Justice will publicly commend each other for the better job we are able to do for those people who are incarcerated in our jail system. An additional point on suicides in a jail setting is that they are partly determined by conditions in the jail, but there is also a random element involved. The numbers fluctuate year by year. LA County had a spike a couple years ago where it had as many as 13 suicides; this year we have had only one. Part of that is due to the attention that everyone is paying to suicide and mental health as well as important procedural changes, the biggest of which may be paying more attention to those who come into our jails who do not have a significant history of mental illness but do have the experience of going through detox while they are in jail. This population turned out to be one of the highest risk categories. Law enforcement and medical services are paying more attention to this population as high risk and we believe it has averted suicides that might otherwise have happened. This was an important learning from analyzing suicides that led to policy and procedural changes that are making a difference.

LA County Health Integration - On August 11, 2015, the Board of Supervisors are scheduled to discuss and make a decision on the health integration motion and under what conditions the new agency should operate, if approved.

Ecology - If we focus on a particular part of our program, for example outreach and engagement, and we do a much better job doing outreach, engagement, and finding people with mental illness, then we bring them into the system, but have not created a flow through the system to ensure those people can be seen in a timely, appropriate way and receive the types of services we have promised as we go out and do the engagement…then we have not really improved things very much. Similarly, if we divert people from the jail setting but we put them, for example, in an IMD (Institution for Mental Disease). If the IMD's already have a long waiting list, and the waiting list that already exists ends up getting longer for those people who are in psychiatric emergency rooms or psychiatric hospitals then we have not really improved the system. We are not helping our community by transferring them from one locked setting to another locked setting, and at the same time making the system worse for those who may need that level of care in the community. As we undertake changes, whether they are due to diversion, implementation of Laura's Law, or creation of new urgent care centers, we are working on viewing it all in a systems way and not program by program.

An important lesson from those necessary changes undertook during the recession was that choices had impacts on not just programs but on the whole ecology of the system we are trying to create. As we interact with other entities (i.e. schools, law enforcement, justice system, etc.) we need ensure that we do not upset the ecologies of those programs unless the system is so bad that it requires us to engage in systems change. For example, one thing we are working to do with diversion is to change a system, particularly on the addiction and mental health treatment, on the front end. If we can focus on lessening the effects it can lead to changes in the way the justice system works for the people that engage our system. We are working towards a robust substance abuse treatment benefit that can match up with our mental health benefit. This is really crucial.

1915b Waiver - Approved for five additional years. The 1915b waiver creates the carve-out for specialty mental health services to be handled on a fee for service basis outside of the health system. The 1915b waiver was last approved for two years but this time DHCS was able to negotiate a full five year extension of that waiver. This is important for two reasons: 1) It shows that California was able to respond to some of the access and cultural competence issues the Center for Medicare and Medicaid Services (CMS) had complaints about previously and 2) It gives us the opportunity to prepare our system, in a robust way, for the ultimate capitation world that we will almost inevitably have to work in. Five years gives us a wonderful opportunity to plan and build our systems in such a way that we can survive when that takes place.

The waiver comes with special terms and conditions, among them that we create a dashboard, statewide, for outcomes from our system and that they be regularly reportable. Debbie Innes-Gomberg is heavily supporting the state in developing a proposal. If the plan is viable, it will be based on our successful experience in tracking outcomes here in Los Angeles County. We should be in a good position for not only being able here locally to meet those outcome expectations but also to shape them in such a way that they are meaningful for the whole state.

Questions and Discussion

Q: One thing that came up in our Service Area 2 meeting on 7/16 was how patients are being discharged without being in stable condition from the hospitals with bus tokens to shelters that do not even have beds. This is causing strain on the whole system. Some get arrested, get sick or end up back in emergency rooms. What we can do about helping people get stable so they do not get sick, put out on the street, end up incarcerated or worse?

Dr. Southard: First, if there are hospitals that are engaging in inappropriate discharge practices the Department and Patient's Rights need to be notified because it is illegal to do this. Second, sometimes hospitals discharge the least ill person they have in their inpatient or in their emergency room because there are more acute people walking in the door that need services. This is particularly the case where the person coming in the door exhibits a combination of mental illness and addiction. As the drug of addiction clears and the mental status improves, sometimes that person is discharged from the inpatient or the emergency room. Then upon reengaging in certain activities they were doing before they may end up back in the emergency room.

Q: Are there other issues the board is looking for help from us to help other departments do better with our community? Housing the

homeless and reaching people with mental health issues is also a big topic among the Board, could you talk more about that?

Dr. Southard: There are particular areas like sexually trafficked youth and other groups that we think of as a subset of the transition age youth project because most of them fit in that category. In the area of homelessness I have focused my comments specifically on the creation of this new integrative functionality within the CEO's office but there are many other efforts in and connected to DMH. For example, we are in the process of starting some additional outreach teams for various areas of the county and we are getting some additional contracts in the Skid Row area so we can focus on the particular needs there.

One of the things that we undertook even before the CEO adopted this is we wanted to have a look first within our own department then among other county entities as well for a smartest way of approaching the outreach issue. There are some kinds of outreach that frankly can be a waste of time and resources. Then there are some kinds of outreach that are really good, necessary, and focused but may be overly focused in one geography and should be dispersed to other areas of the county that do not get enough attention. The acute homeless issues in SPA 6 is at times overlooked. Look at the data it is apparent that the homeless issues in the non-Skid Row portions of service area 4 are considerable.

Response: Veterans suffer from great homelessness in our community when they come back from overseas. So maybe there is something we can do in concert with the federal government to address that issue.

Carl McKnight: We do have a high number of contracts with the VA. It started out with 50 vouchers and now we are up to 64 vouchers to house chronically homeless veterans. If that gets renewed for the next year, it can go up to 80 vouchers. We are also working with the City of Los Angeles Housing Authority. We have 50 vouchers to house those veterans who do not qualify for VA benefits, because there a lot of homeless veterans out there that do not qualify for VA. I control 25 vouchers and there are 25 vouchers for those veterans that do not qualify for VA who are spread out to our contracted agencies.

Q: On a call from the National Mental Health Consumers Self Help Clearing House, the Nathaniel Project was mentioned and a program called Cases. The purpose is to increase public safety, reduce incarceration, promote recovery, and create opportunities in the community. They hold court with individuals through cooperation with judges, district attorneys, and other criminal justice stakeholders. They provide court involved individuals with needed resources to achieve positive change and are involved in creating new programs and initiatives that respond to the needs of court involved individuals. Is there a program similar to that here in LA?

Dr. Southard: The district attorney's report on diversion contains many of the elements referenced. As you may know the department has sponsored, for several years now, a leadership program for consumers that is very robust and very well received by the participants.

Q: In regards to diversion you mentioned briefly Laura's Law. I have received questions from both sides of the consumers and the family members about applying for Laura's Law. It is a very small window of the population. Some of the consumers are concerned that they are just going to be abducted from the streets, which we know is not true. Family members are also asking how to apply.

Dr. Southard: One thing we are learning in implementation is a procedure where a qualifying individual, which could be law enforcement, a family member, or a medical professional can start the process. They make the referral, the team goes out to investigate, but a surprising number of individuals who meet 5150 criteria and are ending up in the hospitalization conservatorship process. They became known to us through the Laura's Law process but ended up being handled outside of Laura's Law. For those engaged in the Laura's Law process, one thing we are learning is that our experience is similar to other counties, people who are met by the team tend to choose to engage in voluntary services. I received a letter from a Kaiser professional that engaged the Laura's Law process and then sent back a testimonial on how well it had worked for that individual and their families.

The process is not an abrupt one and draconian things do not happen to people. Sometimes families have perceived needs as immediate and acute so this can be disappointing. On the other hand it does not meet the fears of the client community that people will be snatched up. The way it is working is the way that it is meant to work, a middle of the road approach that takes a measured approach to getting people into the care they need. As we have always spoken about it's primary strength is engagement.

Q: When you were talking about diversion and the ecology could we do a survey or other research on ecology for children that are not involved with protective services or juvenile justice and how we can engage them in preventative measures. I know we have services for them but there are not that many. I have a lot of parents that will ask me where to go for support but most places have waiting lists.

Dr. Southard: If they are Medicaid beneficiaries or EPSDT (Early and Periodic Screening, Diagnostic and Treatment) there cannot be a waiting list. If there is a waiting list let me know where and we will deal with it. We provided agencies with the funding to avoid waiting lists. Los Angeles leads the state by a wide margin with our services available for EPSDT youth. The difficulty is, similar to Laura's Law, for non-Medicaid kids and families with private insurance relying on systems that are not ours and may not be as robust in the service they provide. One thing we learned in the Laura's Law program is a surprising number of the people that we are engaging have private resources that include private insurance that may not want to pay for assertive community treatment which is necessary for these. Engaging in those kind of negotiations with the private health world is something that will become more and more important for us moving forward.

Q: The Cultural Competency Committee wants to know if the Board is considering addressing these issues with cultural competency in mind. If we are going to appropriately deal with these priorities knowing the culture of each of these populations is extremely important to make sure that culturally sensitive and relevant appropriate services are being provided. That is one of the main issues why we have these problems, accessing them and then keeping them in treatment. Cultural competency is vital and we want to know if that is on the radar or is it a sub-priority of the Board? If not, can we make it one?

Dr. Southard: For the board, as for DMH as a whole, cultural competence is a subset of general competency. In other words if you are not culturally competent you are just plain not clinically competent. You cannot do the work unless you are culturally competent. DMH nor any of our agencies can do the work unless we are culturally competent. I think we should take it as a fundamental precept of our work no matter what. I would add on top of that this Board may be advancing cultural competence to some new levels. They are asking us to consider more seriously the non-ethnic issues related to cultural competency. It is not that we have not done it before but the Board is asking us to be more robust. LGBT issues are coming up at a higher level through the direction of the Board than previously as are issues

related to persons with disabilities among others. The Board is in agreement with all of us here that we will never succeed in dealing with the mental health issues of our population unless we attend to the disabilities connected with addiction that afflict so many of the people that we are trying to help.

Q: Could you go deeper into the holdups and the benefits of the alignment with a robust substance abuse benefits? We make such a difference when those are lined up.

Dr. Southard: It is a federal, county and state process underway. The state is negotiating the final pieces of the waiver that will allow the substance abuse benefit to be put in place and is also working on their implementation plan. The plan is for it to be implemented in the summer in the Bay Area and the fall in Southern California though it is not implemented in the Bay Area yet. There are also issues related to the cost because initially the costs are all Federal for a variety of reasons but ultimately there will be a local share. Some counties are reluctant to commit to this because of the fear of what the future cost related to the local match might be. The scandals related to the drug Medicaid program have made the state very reluctant to hand off the certification process to counties the way they do for mental health. This means the directly operated programs the state certifies us, for all our contract agencies DMH does the certification. But they are reluctant to give that same delegated authority for alcohol and drug because they do not want to have issues in that process even though that certification process was centralized previously by the state.

Q: On some of the discussion around TAY and children and the issue of private insurance the private insurance has a real problem paying for a lot of the things that kids need because it is not in their plan. What we have not had at the state is any kind of adequate advocacy in the private sector. My organization is supposed to do that sort of stuff at the state level but there has not been much happening there because of the difficulty with how to make the crossover between the public sector and the private sector? It particularly crops up for kids who come out of foster care and are not in an AB12 program and age out of the system. Now with Medicaid and Medi-Cal expansion you may because they have no income and they are poor, they qualify. But the struggle is getting them on the program. We have a job which is not really the public sector's job but it can be. There are people on the SLT that could probably do that but I think that is an issue that we have not confronted. We need to confront it and we need the collaboration with LA County to get the connections going.

Q: When you were talking about diversion, is anyone trying to build a place for the people to be diverted such as substance abuse treatment instead of going to jail?

Dr. Southard: Yes, one of the reasons I have been pushing to get this alcohol and drug benefit in place is because, for example, there would be an entitlement to 90 days of residential drug treatment if needed. There is an entitlement in the plan for sober living facilities. If and when this benefit becomes available it really helps all our systems. To me this is the biggest ecological question, if we can solve that issue everything gets better. Foster care gets better, mental health treatment gets better, homelessness gets better. There is a whole bunch of things I think that are contingent on finally, in California, having a Medicaid benefit for alcohol and drug that makes sense. We already have one of the best mental health benefits in the country available to the public sector. We just need to make sure that it is available to people in a way that they are willing to accept it.

On the housing side we are doing a lot. Ruth Holman has some specific things that she has been doing for a while but it is a matter of matching. Locked facilities will remain a problem for some time. We have purchased all the locked beds that currently exist in LA County. We are looking at buying more outside of the county which is not something that we really like to do. We do not believe that it is the best outcome for most people anyway. So we are trying to create housing resources that do not depend on locked settings.

Q: What really is Laura's Law?

A: Laura's Law is a way of having the possibility for somebody who has had a mental illness that had impaired their life so much that they have had a certain number of hospitalizations or incarcerations and where that individual is not currently engaged in treatment and they are rejecting treatment, a family member, law enforcement or mental health professional, or a health professional can recommend a team engage that person and offer them a proposition. The proposition is, 'We want to offer you services but if you need services and do not accept them there is a possibility that a judge may order you to participate in services.' Jail is not a part of it, the judge can admonish somebody but he cannot incarcerate them.

Q: You had mentioned briefly DMH's involvement with human trafficking. From the board's perspective, could you elaborate a little on what exactly DMH is doing on this particular issue?

Dr. Southard: I will have Terri Boykins, who is leading the effort for the Department get in touch you and send the SLT the details.

MHSA-RELATED ITEMS

Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, Los Angeles County of Department of Mental Health

The FY 15/16 Annual Update that was approved by the Mental Health Commission at its meeting on June 25th. We are currently drafting the Board letter and briefing the Board offices about the Annual Update. We anticipate that the Board will adopt it in late August, early September.

The $84 million plan was publicly posted on July 7th. We are still in the public comment phase. So far we have received no public comments but that is on our website for you to review.

CSS regulations allow counties to do planning after an Annual Update or a three year plan has been adopted, so planning anytime during the year is what we have been starting to do a lot more of in the last year or so. Mid-year adjustments require approval by stakeholders and a 30 day public posting. Any public comments that are substantial have to be addressed. Then that becomes an amendment to the most recently approved plan.

Next steps for $84 million CSS plan; the plan is being divided into two components; the most urgent actions that will jointly be considered a mid-year adjustment of last year's MHSA 3 Year Program and Expenditure Plan. The majority of the actions, however, will be a mid-year

adjustment to the FY 15/16 Annual Update when it is adopted by the Board.

Regarding last month's request for the amount of funding expended on rental subsidies for our Full Service Partnership (FSP) program, that analysis is currently underway. What we are trying to do is use '14-15 as the base and we are just waiting for the one or two months to come in to make sure that we have got a full analysis. At our next meeting will be able to report that back out to you.

Finally, I just wanted to update you on a senate bill, SB 614 that Susan Rajlal reported on last month. That is the peer certification bill that is sponsored by the County Behavioral Health Directors Association (CBHDA). Senator Mark Leno is carrying the bill. SB 614 creates a certification process for peer providers that DHCS would administer. It would prescribe a training curriculum that would result in a certification that would allow certified peers to bill Medi-Cal for certain procedure codes within their defined scope. The elements of the certification, is consistent with the elements of training that exist in LA, as well as, other counties. It has passed both the senate and assembly committees and now is in appropriations.

I want to thank Wendy Wang of Pacific Clinics, Chad Costello of Mental Health America Los Angeles and Project Return, as well as a number of different people who weighed in to help support this bill get to where it is now. Once the Legislature comes back, in August or September, the next phase of this will go to appropriations. Given that it would be mostly Medi-Cal and MHSA funded, I do not think that appropriations will have any issues.

After appropriations, because there were some amendments to the bill, it would go back to the Senate and then hopefully to the Governor's desk for a signature.

MHSA THREE-YEAR PROGRAM AND EXPENDITURE PLAN

Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, Los Angeles County of Department of Mental Health

Our goal is to provide you with monthly updates on the implementation of the expansions associated with the MHSA 3 Year Plan, as well as the $84 million plan that you approved last month. Next month you will get an update on not only this but also the $84 million plan. And then, of course, any additional expansions that we do we will update you on a regular basis.

Part of this is related to accountability and making sure that you keep us accountable for the actions that you all have to approve and also get your feedback on not only how we are doing in terms of implementation but also whether this is a good reporting structure for this or whether you would recommend something else.

For full details on the presentation items please see handout.

Section 1

Laura's Law program, alternative crisis services and IMD step down facilities.

Questions and Discussion

Q: In these three priorities I do not see anything that is related to in any way for children. Are these beds also for children that go into the emergency ward and have to wait for a bed wherever?

Debbie Innes-Gomberg: These are adult priorities the SLT approved over a year ago. What is being reported is the status of implementation of what was approved.

Q: Because one of the step downs has not been implemented, would having them come and present by December be too early or should we wait until after January?

Debbie Innes-Gomberg: I will check with Mary Marx on that but my sense would be that we want to wait until they start implementing. We will get a better sense of that in the next couple of months. The alternative crisis service, we probably want to wait until 2016 for so they can all present at the same time.

Response: Yes, and we can get the group together to understand where they are going, are they hitting the mark, what is working, what is not, and what do you they recommend the change to improve it.

Facilitator: The SLT may need to talk at some point the process by which we want to engage these different areas so that it is done in way that is going to be most effective for all. We can come back to that process question.

Q: As we look at the Assisted Outpatient Treatment implementation parts of it are up and going, the directly operated team is together and money is being expended. As far as I know nobody yet is in a FSP or a step down program and it will still potentially take some time, I think, for that to happen. So I assume that a significant part of this budget will not be spent in this fiscal year. How does that get dealt with in terms of what happens with that money? Does it stay allocated to AOT? Does it come back into the pot? How do we deal with that?

Debbie Innes-Gomberg: It goes back into a general CSS pot, we believe, if it is not expended in a fiscal year.

Dennis Murata: When we presented on the three year plan they anticipated the ramp up period. The dollars that were allocated, some of them did not front load a lot of those dollars for the first share. They distributed them based on their estimate of when these things would be implemented. Whatever goes unspent goes back into the general MHSA unspent pot and then we discuss what we are going to do with those dollars.

Q: So the urgent care centers, for example, will take youth?

Debbie Innes-Gomberg: Yes, some of them do. I am not sure that these will be taking youth, the CHFA funded. But we will find out for you.

Section 2
Housing, family wellness and resource centers, and family crisis services or the respite care program.

Comment: I think it is a good idea to embed the self-help support groups in with the family wellness resource centers. I was wondering if there is a way to give evidence based best practices for the children self-help groups as part of the solicitation program process so that people are choosing the best practices and not trying to reinvent the wheel by having a staff run self-help group.

Debbie Innes-Gomberg: We have completed extensive research and came up with about 15 potential evidence based groups that could be used in the family wellness resource centers. We have come up with four that seem very promising. Two of them relate to parenting issues and two relate to children and TAY developing better social skills to prevent substance abuse or risky behavior. We are looking at those to see what the cost of training is, what the prequisites are for group leaders because if we are hoping to combine that with the family wellness center, we want to have parent partners and parent advocates be the first leaders, then be able to develop to maybe some young adults to lead those groups.

Response: You are no longer talking about self-help support groups as soon as you have a parent leading a child's group because everyone in the group is not a peer. The programs I would want you to definitely have there would be Rainbows, which starts from preschool and goes to 18 and deals with any trauma in children's lives and is evidence based. It is really inexpensive. How is a parenting group a support group for children? What you are doing is you have a support group for the parents. That is different than having the support group for peers.

Debbie Innes-Gomberg: Those are two of the groups that we are looking at. The other two groups are for kids but we would have to have sort out older kids.

Q: Will this include programs such as the Wellness Recovery Action Plan, the Intentional Peer Support?

Debbie Innes-Gomberg: Those are for adults and this is a children's investment. I think our department has invested in those. Next month we will have the $84 million update and there are a number of expansions of FSP and FCCS related to Katie A. implementation. I feel like I am painting a somewhat incomplete picture.

Response: I also want to complement that the certified peer specialist program will be implemented here. That is a program that has come from the east coast. I know that Maryland has a five-month training. We are going to start getting these programs going and have them be the same program that is universal.

Comment: The WRAP program and the children decision, we want to identify it in a different way only because we have wraparound. They use WRAP for wraparound and WRAP for the other one so we have to be careful how we say that.

Q: With Katie A. mentioned some of the programs are to help because of the lawsuit but not all the children have the Katie A. over them. What are we doing with that? I think that comes back to the question that I was asking Dr. Southard about getting them before they start

getting to the system, then dealing with them when they are already in the system. I think that is what it was.

Debbie Innes-Gomberg: It is an interesting process because Katie A. has provided us with the ability to think about services, the child and family team, the core practice model and approach to services that transcends the Katie A. subclass. The MHSA has allowed us to develop a structure to support the Katie A. initiated investments. FCCS and FSP in particular I think have created that structure.

Q: Regarding children's self-help support groups can we somehow push part of this really upstream into faith based communities so that we are working on developing a structure and the natural supports of the community?

Debbie Innes-Gomberg: This sounds like Innovation 2. Marta and others also have a program similar to this can take that back.

Section 3
TAY - FSP expansion, FCCS capacity, supported employment, and self help and support groups,

Q: I am not familiar with the TAY independent living program. Can you tell me what that is?

Debbie Innes-Gomberg: The independent living program works in conjunction with DCFS and probation to work with youth who are emancipating from DCFS or probation to provide independent living services. The mental health dollars that you see that were added to the three year plan were to really provide the intensive mental health services that were needed for these youth residing in these programs. The programs are located in Service Areas 2, 3 and 6. So it was a focused approach to add the limited number of FSP and FCCS slots.

Q: Self-help support groups do better when you have a diverse group of people in the group rather than everybody just in similar positions. You need to have the people who are now independent along with the people who are not. I am concerned with limiting the groups only to those who are in permanent supportive housing and not opening them up to the community. It does not cost any more to have another person in a self-help support group and as they get bigger they self-generate. We can seed them and getting them started, which is what you want to use your money for, not having one facilitator to x number of people. Why we are not including the community in the permanent supportive housing self-help support groups?

DMH: In late 2014 we did a survey of permanent supportive housing among all the TAY age range residents. We did see a full array functioning within the permanent supportive housing programs themselves. We saw TAY youth who were working part time, going to community colleges to those who were really isolated in their rooms all day. We asked the TAY what would help them engage in the community? They responded that what is really interesting is the arts, poetry, self-expression through the arts, etc. We are looking to engage the youth who are really isolated but as well as being open to those residents who have a natural talent for art who may be higher functioning. In addition, we only have $45,000 to do this program and really want to make the most impact for the dollars that we were allocated.

Response: Again, self-help support groups do not cost a lot of money and they are not arts programs. This is an evidence based best

practice that can help everyone and the idea is to get it started and to have places where the groups are meeting and to do outreach in terms of letting people know, and letting people self-select from everywhere, not saying we are only going to have target population there because of resources. It is somebody who is living with their family outside who is going to be able to provide a connection. We are trying to self-contain it and that is not the best way to be doing it.

Facilitator: I am hearing three things. One is, from a best practice standpoint, you want to have in the group a full spectrum of functioning youth. What Joo is stating is that to the extent you get that range within the youth that live in the TAY housing the first condition is satisfied. There is a second question about the ability to invite folks from the community that are not residing in TAY housing and a third question about resources.

Response: Having only TAY housing residents be in this support group is not how they work best. That is contrary to what you want because you want resources to be entering.

Facilitator: And that is what I heard also, the engagement piece, to be able to create that bridge of youth in the housing to a community.

Section 4
Adult – FSP expansion, wellness center expansion, adjunct services for clients and wellness centers and expanded client run centers
Two amendments/corrections noted.

Q: Looking at the $274,000 for the wellness client run centers. And you were talking about it all being directly operated. Can you clarify?

Facilitator: That is the one that was about Individual Placement and Support.

Q: I do not think that the Department has any client run centers that are directly operated. Or is there something that is for client run centers as well?

Debbie Innes-Gomberg: The name of the plan is wellness/client run center. There are family focus wellness centers. 'Client run' is there because it is a category.

Section 5
Older adult - FSP slots and FCCS services.

Q: Are they going to implement more?

DMH: Yes, we are in the process of amending the FSP contract and we are going to add an additional 30 slots for this fiscal year.

Section 6

Combined age groups - Community health worker/Promotoras, the COD conference and COD training and technical assistance.

Q: On the Promotoras or the community health workers, I assume the UREP will be taking the lead in terms of identifying what other ethnic language groups are involved. Will there be translation following to the respective languages?

Naga: Yes. For the translation we will be doing the appropriate translations for the different UREP programs.

Comment: I would like to put out a plea here that the community health workers and the Promotoras get at least some training in self help support groups in the community so that they can direct people in places to get support and help.

Facilitator: In terms of language I want to be clear that I do not see the word Promotoras here because we were clear that we wanted to change the language to community mental health workers or promoters.

Q: We went through this during meetings about Co-occurring Disorders, it was such a huge interest for all of this. I am sort of surprised that they are only just putting money out to fund the conference. It just seems to be that it is such a huge issue, to train in the field as well, the different mental health places that do not go to UCLA. It is a wonderful conference, I have attended in the past but there has to be something in between and more money needs to allocated and more study needs to be done on how to get best practices to make a difference in a timely manner.

Debbie Innes-Gomberg: You have raised a couple of issues. One is this investment only around the COD conference. We will get clarification on that. My understanding was that it was not just for the COD conference but it was also for ISAP related trainings. The second issue though I think relates to the investment that the department makes in co-occurring disorders, particularly around the drug Medi-Cal waiver and the things that are likely to happen in the county in the coming years.

Response: I think more money needs to be allocated because we have to have something ready when the waiver happens.

Facilitator: Today we are not advocating on more or less money because the decision was already made by all of us that these would be the allocations. We will note the question around whether it is accounting for other investments. This only shows you the $90 million that you all invested. It does not show the other MHSA investments that do focus on training, workforce investment, etc. We can provide the SLT the big picture of all of the MHSA related investments for COD and continue this conversation to get everybody on the same page around the investments if you want to propose a midyear adjustment or any other future additions.

Response: How did they come up with this money and how it is going to be spent?

Facilitator: If anybody has any questions around how this documents feel free to contact us.

Debbie Innes-Gomberg: Please go back and look at the three year plan, it is on our website, and particularly the appendices related to the three year plan because all the planning documents and agreements are included.

Facilitator: This is an open invitation to everyone else because we assume a lot background around these kinds of documents.

Q: From time to time we talk about a big overview of the budget process and evaluating not just individual programs but how the money is being spent in general. I think that is related to the question that was just raised and my question of where in the process do we do that?

Facilitator: On June 6th the SLT standing committee met where we talked about what we want to do for the next six (6) months. There were at least two (2) areas that were proposed based on what is going to come up—August 11th the Board motioned the consolidation motion—but what we did acknowledge is that there is the need to do another round of making sure the SLT members are on the same page with regards to how all of these decisions have been made. There is a lot of infrastructure that we need, including, for example, reviewing all of these assumptions with regards to the budgets, the formulas that we did for PEI, for CSS and so we need to come back to that. We are just sort of waiting for what is going to happen with the board, August 11th, to come back, reorganize ourselves and then really do some serious planning work around that. We do need to come back to that and we are just sort of in holding pattern until August 11th.

Debbie Innes-Gomberg: Dennis can work on the budget piece and I can work on the program piece. We can show you the overall, create a larger picture of, because we are doing this piecemeal and I understand how it can be confusing because there might be WET investments around COD. We will do a larger picture around the budget and the program so this all makes sense and can aid in our plan.

Comment: Regarding the health navigator, this will be a prime thing to have as we talk about where we go forward with that, with the UREP leadership groups, to make sure the cultural competency issue is met based on the communities, issues, and dynamics, so that we know that one size does not fit all and not everything you say in one language is respectful in another, nor is the cultural accepting. This would be one of those things we can meet on and go over to discuss this as a good foundation and the need to do these things to adapt for various cultures.

Facilitator: The UREP group also agreed that you would expand underserved cultural populations. So this term, UREP, is really one that will get revised to make sure that we go beyond ethnicity to make sure that we are serving the broad range. If we come back with a different term for that committee it will be because we are trying to make sure that it is inclusive of other culture groups.

Comment: With regards to the trainings Occidental College has Project Return.

Q: You have done a tremendous job trying to summarize the $90 million proposal that were approved many months ago. And I appreciate the implementation status that we are trying to get today. Earlier there was some discussion on unspent dollars reverting to a general CSS or MHSA bucket. For '14-15, which is already completed, you have got about $24-25 million showing for the fiscal year '14-15. Say there is already $6 million that has gone into this bucket. And then $24 million I am anticipating based on the status that a lot of these things, that money was not spent or is not going to be—does it rollover? What is this new bucket and what happens to the 30/30/30 overall plan when

all this money starts moving sideways?

Debbie Innes-Gomberg: It is not moving sideways.

Dennis Murata: The practice within the department is that those dollars that are unspent because of delayed due to implementation get put into a general bucket for unspent dollars. Every year there is always some other priority that we are being asked to fund. Which is why, we go through this whole process. As it is now the priority designated by the Board and by the CEO have to deal with homelessness, TAY, and diversion. These new initiatives come up and they are expecting that we use unspent dollars for that because, bottom line, there are no additional ongoing dollars. When we get a spike in our state allocation it is not something that stays at that level. In reality our ongoing dollars that we get, we have to treat also as onetime because they can go down the following year. That has been our dilemma. We also try to take a look at where those dollars came from and try to keep it within those age groups as well. But sometimes we just cannot manage it because the priorities that are given to us by the Board or by the CEO, and also that is vetted with the stakeholders, we have to find some way of funding it.

Response: That is very helpful. I would just want to see if I understand what is going on. We had 30/30/30. That was the general plan that everybody agreed on at some point. Although it does not seem like they necessarily agree from the comments that we are hearing today. But the $30 million for '14-15 is apparently down to $24 million if you just quickly add up everything in that column. I am just curious, how much more do you expect for that '14-15 column to decrease? Because it is already over with.

Dennis: We can show you the cash flow by CSS, PEI, what gets rolled over to the next year based on those funding categories. Keep in mind that certain things like PEI, what we have budgeted now is way over the amount we have in terms of an ongoing state allocation. What we have been doing with certain programs that we have been using, the leftovers or the unspent dollars, to keep things at that initial funding level. Kim and I at some point can walk through how this has been going on for each year and how we roll dollars forward and where those dollars end up going.

Facilitator: Just for everybody to know that are a couple of areas that I think we need to step back and do some capacity building in the group so we are all on the same page. One is to be familiar with the MHSA work groups, to have an opportunity to go deep into that because this program and expenditure plan to some degree modifies that but it also is on top of the ones that we approved a while ago. Second is the budget and the budgeting process, so that we are clear about how these budgets, onetime, ongoing funds, and some of the structural dilemmas that as a system are faced period. Third is around the outcomes and metrics that were raised around PEI but also metrics more broadly around how we are going to be holding ourselves accountable for the investments. There are also just some nuts and bolts, decision making, and conflict of interest. Every time we bring up conflict of interest we all have these questions. And then also, finally, remember Mitch came in and he challenged us and said, 'You know, you all are behind the curve on client and consumer inclusion,' so we have to come back on that and deal with the membership question.

We are not moving on those right now because there may be one big agency that can change the game plan. These questions are really crucial but they have a context that I want to make sure that we are all clear about. Over the next six months we need to cover these areas

to make sure that we get to a certain level where we can move more effectively and efficiently. Maybe we frontload the budget piece.

Dennis Murata: The other thing I forgot to mention, it not just delayed implementation. The implementation of the Medicaid expansion that is 100 percent federal revenue. So that means that there is no MHSA dollars that are required as a match. We do not have those expenditures as we see more MCE clients as well.

Q: I am seeing our discussions are changing and the world is changing around us and there are a lot of external forces that we cannot yet name. When Dr. Southard said, 'We are working to view all of the changes in a system's way rather than a program change,' I am going to ask the facilitator if you can somehow find a context for each meeting where we are looking at the whole of everything that we have got, where the outside pressures are coming and when we drop into the details because it could be really hard for us, we could focus on details and lose the context and therefore not make the best choice.

Facilitator: I would be happy to support this group on that and that the SLT Standing Committee, as it meets more regularly, after August 11th, to really be able to help me and this group identify the right context for the specific decisions as we are moving forward. We are doing both things at once with you, drawing upon your wisdom as well.

Q: Do we still have our WET program that we fund? I thought they had that kind of training in those WET funds.

Facilitator: WET stands for Workforce Education and Training Plan. There are some funds there.

Q: Are we still going to have a carve out?

Debbie Innes-Gomberg: The 1915b waiver will continue the services that we are currently providing and we will have to report on access and timeliness in a way that we are starting to through the External Quality Review Organization process but it is going to take that to a new level. Another important piece relates to context is that we have been reporting at either a MHSA component level or a program level, we need to think in larger terms because WET has a role in training, obviously PEI has a role in training, the CSS investments and we are giving a partial picture, so we will work on that.

PEI FUNDING PRIORITIES

Dr. Robin Kay, Chief Deputy Director, County of Los Angeles Department of Mental Health

We have reconvened the SLT Budget Committee (we are not calling it the Budget Mitigation Committee because we are not mitigating anything at this point).

Four months ago the committee began talking about the use of onetime PEI funding. The committee came up with a plan that was later presented to the SLT and approved. Last month the Committee developed a plan for the use of CSS funding that included extra homeless funding for downtown and for the Multidisciplinary Integrated Teams for the path entities in each service area. The plan included right sizing

the children's programs and had a number of items the Committee approved, mostly responsive to the three major priorities that Dr. Southard talked about this morning, jail diversion, homelessness and transition age youth, but in addition, following up on some of the promises that we made when we decided to do the transformation a number of years ago during the downturn.

The next major portion of MHSA funding that we will tackle will be the use of some additional small amounts of PEI ongoing funding. We will adopt the same approach: we will mobilize the SLT Budget Committee, we will present some of the areas that the department has been accumulating on a list that we know we need to address and then we will bring those issues here.

In the interim the department became aware of two programs that have been funded with onetime funding where there was no allocation of onetime funding. In truth these were programs that have been funded year after year after year. There was never intent to eliminate the programs but because of the way in which we are approaching the dedication of PEI funding the onetime funding for this program expires and we have not had the further discussion about sustaining the programs. This means they are out of sync with our planning process.

We are taking these two programs out of sequence because we believe that there is every likelihood that the stakeholders that you as an SLT group would not have the intent of eliminating the programs. We have vetted the programs in the Budget Workgroup with unanimous support for continuing the funding and are introducing it here for final approval so we can make a determination about whether or not to continue the funding.

The first one is a Latina youth program. This was a program that was established quite a number of years ago. The documents show fiscal year 13-14, but that is only the last year for which we have data. The program was established more than five years ago and is an effort in the service areas, mostly service area three and that portion of LA County, the San Gabriel Valley and East Los Angeles, to focus on the needs of a very vulnerable group of Latina young women and men. The program does two things. First, it provides outreach services to educate TAY and their families about suicide risk and vulnerability to encourage young people that have certain risk factors to get into treatment and to talk about those risk factors. Second it also delivers direct services to a number of young people. In fiscal year 13-14 the Latina Suicide Prevention Program did outreach and education to 2,664 young people. As a result of that outreach 142 students and their families, who were assessed as being at very high risk of suicide because they demonstrated those suicide risk factors, went into treatment. You can read the description in the handout but the risk factors that the programs screened for were substance use or abuse, suicidal ideation, past suicide attempts, running away, communication problems at home, poor school functioning, and difficulty regulating emotions. People were very upset, angry, anxious and involved with the legal system, had negative peer relations and issues related to sexual identity.

If the youth screened positive they went into the more in depth intervention component. They have had positive results as reported by Pacific Clinics. The Budget Workgroup asked the department to take a close look at the program because many of the outcomes are based on the report that the agency itself submitted to the department. The recommendation of the Budget Workgroup is to continue funding the program. This is only a piece of the picture. This program has ongoing funding of $375,000 a year. For last four or five years they have received an additional $375,000. And that is the piece that we are asking you to vote on today, the continuation of the additional $375,000 per year.

The second program is the Didi Hirsch warm line. When the state funding that was funneled through CalMHSA, the California Mental Health Services Authority was initiated. One of the programs that was funded was the Didi Hirsch suicide prevention line, the SBC line.

That took two forms, the Didi Hirsch hotline and the warm line. The warm line was initially operated through a subcontract that DMH with Didi Hirsch funded several positions in our access center. When that CalMHSA arrangement ended the department and Didi Hirsch looked at what the best strategy was for continuing the warm line and determined that Orange County, NAMI, had a warm line.

For a year the funding for the warm line, instead of being directed to the DMH was directed to the Orange County warm line very successfully. Even though the warm line is situated in Orange County the majority of their calls came from Los Angeles County. That warm line gets its referrals when the Didi Hirsch suicide prevention line takes a call from someone who may not be suicidal but is feeling estranged, disconnected, alienated and really needs a warm person to talk to often in the middle of the night.

When Didi Hirsch was here last month and did the presentation on the continued funding of the Didi Hirsch suicide prevention line they were intending to talk also about the warm line and we ran out of time so that part of the presentation was not done. They ask for the continued funding of the warm line is $275,000 annually. Both of these requests are for a period of five years. Pacific Clinic's Latina Suicide Prevention Programs is for a period of one year with four additional one year extensions assuming that the outcomes are positive. So there is no permanent commitment but there is intent to continue to fund it if we determine that in fact the program has the outcomes that we hope to see.

Questions and Discussion

Q: Is the funding that we are requesting still going to stay in Orange County or is there a plan to bring it back?

Dr. Robin Kay: Not, it would still stay in Orange County, but continue to serve people from LA.

Q: Are you aware that Project Return also has a warm line and that warm line works, I do not know about 24 hours a day, but it works several hours a day and they are also available for mental health consumers all over the county.

Dr. Robin Kay: We were looking to continue a 24-hour warm line. I am glad you raised the question because one of the comments made during the workgroup was that at this point there is a need and a desire to form a separate workgroup or task group to look at how all of a warm lines and hotlines in Los Angeles County fit together. We want to know in more detail what the relationship is between access suicide prevention center and the warm line. That will be done during this year.

Comment: I'd like my colleagues here on the SLT need to be aware that the relationship between what we are doing in LA County and what they are doing in Orange County is reciprocal. We take calls, at certain times that come from Orange County and other counties from all over the state sometime, that we are addressing. There is a reciprocal so we are both benefiting.

Q: Could you explain what the threshold or evaluation measurements we will be using in future funding for the Latina youth program?

A: The youth program is part of the array of PEI services that have required outcome measures. We need to take a look at the results reported by Pacific Clinics in their report that was generated and the outcomes that we collect from all PEI programs. And we have not had a chance to do that cross comparison yet.

Debbie Innes-Gomberg: I have talked with Luis Garcia because the outcomes that Robin was talking about have to conform to the PEI regulations around prevention, we are working on developing that.

Q: What is the telephone number of the warm line so we can spread the news?

Dr. Robin Kay: 855-952-9276

Facilitator: We are done with questions of clarification. We are now entering the second round to hear your opinion on the degree to which you support it, you do not or any friendly amendments.

Comment: I support both proposals and I really like that we are going to look at what we have. There are at least three different warm lines that operate at different times, sometimes overlapping each other. And I really like the idea that we are going to have a mechanism to have warm lines available hopefully 24/7 so that everybody gets served and we are not overlapping services.

Comment: I like how you want to have a task force to see how everything works together to make it even better.

Public Comment: This may be a question better suited for Debbie and Dennis but it is somewhat related to the commentary that Dr. Kay just provided, particularly in relation to what took place last month with the vote and we are preparing to take another vote on some more funding.

What I noticed is that in the meeting minutes from last month there was no articulation on how those dollars would be spent. I wanted to be careful that we at least have put on the department's website a summary of those programs and what anticipated outcomes we might expect. $90 million is quite a bit of money to approve and we would not want to look like we are issuing a blank check to DMH. So we should have some absolute figures before those dollars are allocated.

I think, Debbie, if you are going to provide a presentation maybe I will follow up because this information that I have to convey might better be suited for your presentation related to the PEI process, funding.

Debbie Innes-Gomberg: On our website under MHSA announcements is the $84 million allocation proposal. There is a fair amount of detail on the onetime section and the ongoing section. Take a look at that. We should have had that though for the SLT last month and we did not.

Voting Results: Unanimously approved.
A – 16 B – 6 C – 2 D – 0 E – 0

PUBLIC COMMENTS AND ANNOUNCEMENTS

Comment: We have had a lot of conversation today about use of one-time funds, PEI and new programs. In 2012-13, there was an RFP issued for $1 million for a special project in SPA 6. It was $250,000 each year for north and south PEI. I am trying to get some information on who was awarded that contract and what those outcomes were. Also there were 60 programs that were provided onetime prevention funding around the same time of 2012. To my understanding 12 of those programs received some ongoing support. I would like to also know which of those programs, organizations, agencies, received that money and what was the criteria for selecting those programs? Lastly, I am incredibly disheartened that as long as I have been coming to these meetings for about the past seven years, I may have missed three in that amount of time. Over the last couple years we have talked about the plight of African Americans and when I continually see focus on everyone but us it is really disheartening. I hope that as we continue to move forward that there is a little bit of light cast on the plight of African Americans and making certain that these public funds are equally distributed across these ethnic populations because I do not hear it being discussed here. I am hopeful, again, that this committee and the department will address the issues and needs of African Americans like everyone else.

Facilitator: We have captured the request that you made around the special programs for SPA 6 as well as these onetime PEI. We can ask Debbie to figure out how that information can get back to you.

In terms of the second item I think what I would ask if maybe the UREP group and the underserved cultural populations groups do another around of demographic analysis which we did several years ago around who is getting served by FSP, FCCS, by service and service area. We were able to do a cross sectional analysis in order to be able to then zoom in on the number and percent of African American folks that are being served as a basis for going deeper into that policy discussion around resource allocation. I think that is what I would suggest because that is also the resource that we have there with the underrepresented, underserved cultural populations.

Comment: There is a new foundation called the Struggle Foundation. They are looking for 120 TAY, 16 to 30 years old, to provide full, top of the line substance abuse treatment to. They previously paid for substance abuse treatment for worthy people and they discovered with Obamacare that they buy PPO insurance and 14 days later the person can go into treatment. They are particularly looking for people with trauma histories and that have mental health under control. This is for regular drug treatment with a major psychotherapy component to it. If you contact them please tell them that you heard about it from Ruth at SHARE.

SHARE also has just opened 17 houses, has immediate vacancies and can move anyone with SSI today or similar income. We have houses in service areas one, two, three, six, seven and eight. Some of them have swimming pools. All of them come with high speed internet and cable TV. For housing it is 877-SHARE-49. If you are calling for housing it is between 1:00 and 3:00 PM, Monday through Friday. If you want to show up in person you show up at either SHARE downtown or SHARE Culver City until 9:30 PM and we will house you.

Comment: Today there is a webinar on peer run communities by the National Mental Health Consumers Self Help Clearing House. Tomorrow there is a training called Women Unbarred and Supports for Women Involved with the Criminal Justice System through the Clearing House in Pennsylvania. These are being recorded so people can access them later. On August 24th there is a dignity march in San Francisco. The International Association of Peer Supporters have extended their deadline for registrations to July 31st. Peer supporter celebration on October 15th through the international Association of Peer Specialists.