County of Los Angeles - Department of Mental Health

Service Area Advisory Committee

SAAC

Manual

(Models are for illustrative purposes only)

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

How to Use The

Service Area Advisory Committee Manual

This manual provides an overview of the County of Los Angeles-Department of Mental Health operations and Service Area Advisory Committee (SAAC) guidelines. We hope this information will be helpful. Here are a few tips to help you get underway.

Let's get started with how to use this manual. You will notice colored tabs to assist with locating information with ease. Use these steps to get the best use of the guidebook:

1) Read the table of contents and become familiar with the various colored subdivisions and information located in each section.

Now that you are aware of the manual's outline, here is a step-by-step example to help you locate information about a specific service category like "**Veterans Services**". Just follow the instructions below:

1) First start with the table of contents located in the front of the manual
2) Go to the tab "**Part VI**"
3) Next choose the tab "**About the Department**"
4) Now find the tab "**Programs**"
5) Continue in the same section and find the tab "**Veterans Services**"

Congratulations you have successfully found one the wonderful resources made available to you in the SAAC Manual. You are on your way to becoming an important member of your local SAAC.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEE (SAAC) MANUAL

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
550 S. VERMONT AVE., LOS ANGELES, CA 90020 HTTP://DMH.LACOUNTY.GOV

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
Medical Director

Welcome!

We want to take the opportunity to welcome you as a Member of the Service Area Advisory Committee (SAAC). Your participation is genuinely appreciated in this capacity building partnership to strengthen lives, to enrich communities, and to support quality community living. Each individual is an important part of our stakeholder engagement system and are counted on to provide feedback and advise us on how well the County of Los Angeles-Department of Mental Health care system is operating. Your role is important to us in this process.

The Department is pleased to introduce our new SAAC Manual designed to be a general resource for our members. We are committed to improving communication and supporting our volunteers in the learning process of being a valued stakeholder on each SAAC committee. This Manual is intended to enhance your awareness and understanding of various departmental operations while supporting your capacity to serve. We support communication as a tool to effective services and believe this manual will aid in this process to increase quality operations, access to care, and improved outcomes.

To be a successful SAAC, we must create a supportive cooperative environment with our internal and external stakeholders which display true compassion through community service. I look forward to your continued interest and support to ensure we offer a mental health system which serves everyone who may be in need of services.

Sincerely,

SAAC District Chief

(12/01/14)

LA COUNTY BOARD OF SUPERVISORS
Hilda L. Solis I Mark Ridley-Thomas I Sheila Kuehl I Don Knabe I Michael D. Antonovich

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU

MHSA IMPLMENTATION AND OUTCOMES DIVISON

The MHSA Implementation and Outcomes Division is dedicated to the enhancement of the delivery of quality mental health services through the provision of excellent training, customer service and support services to Departmental bureaus and programs. Oversight and direction for all SAAC's will be provided by The MHSA Implementation and Outcomes Division.

This manual is being provided to the Service Area Advisory Committee's by the Department of Mental Health, The MHSA Implementation and Outcomes Division. The SAAC Manual is considered a "living" document, therefore yearly updates will be provided by The MHSA Implementation and Outcomes Division. If there is supplemental information to be included in the manual, please contact The MHSA Implementation and Outcomes Division for permission to do so. A SAAC may include information relevant to its SAAC under the SAAC index, located at the end of the manual. This may include SAAC minutes, membership rosters, sub-committee information and any information deemed important to the SAAC.

For questions or comments regarding this manual, please contact the SAAC Administrative team at **saacadmin@dmh.lacounty.gov** or Cheryl Peterson at (213) 251-6827.

If there are any additional concerns please contact Debbie Innes-Gomberg, District Chief at (213) 251-6817 or digomberg@dmh.lacounty.gov.

HISTORY OF THE SERVICE AREA ADVISORY COMMITTEES

The Service Area Advisory Committees (hereinafter SAAC) began as the Regional Community Liaison Committees (RCLC). In July of 1978, the Los Angeles County Board of Supervisors established the Department of Mental Health (DMH) as separate from the Department of Health. Back then, the County had designated five 'Regions' through which services were delivered. One of the very first acts of the newly formed DMH was to establish the RCLC system. The original RCLC was envisioned to serve as the community arm of the County of Los Angeles mental health system. Beginning on October 27, 1978, the RCLCs provided local providers and consumers a means to have their input heard with regard to the Department of Mental Health's programs, activities, and goals.

In 1985, the Board of Supervisors reexamined the delivery of services to the County's growing population and increasing diversity and reapportioned the five Regions into eight Service Areas. To increase planning among other county service agencies another reconfiguration occurred to Service Area boundaries in 1994 to what they are today. The RCLCs were thus transformed into the Service Area Advisory Committees (SAAC) and charged with a similar purpose within the Department. This purpose consists of four primary functions:

- as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;
- as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;
- as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;
- as a networking and advocacy body.

Like the RCLC system, the SAACs seek to involve the widest possible array of consumers, providers, family members, government representatives and interested citizens to share in the mission of the Department "to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency."

Without this representative diversity and their attendant voices, the Department of Mental Health simply could not provide the level of quality mental health services that the citizens of Los Angeles County deserve. Each Service Area District Chief is responsible for ensuring a SAAC is convened in their service area and is charged with being the conduit for the input of the SAAC to the Executive Management Team of DMH. Additionally, the SAAC is served by two members selected by the membership to serve as volunteer Co-Chairs. The Co-Chairs along with the District Chief voice the concerns and insights of their Committee to the Department.

In June of 2011, the Department's Program Support Bureau initiated an extensive project to rejuvenate the SAACs and improve the functioning of each SAAC to be equal across all eight Service Areas. The SAAC Manual you hold in your hand is the result of this effort.

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)

GUIDELINES FOR OPERATION

SAAC #1

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #1 (hereinafter 'SAAC'). The principle office of this committee is located at 2323-A East Palmdale Blvd., Palmdale, CA 93550, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #1 is to enhance the quality of mental health services in the Antelope Valley by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #1 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #1 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #1 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #1's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

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advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

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10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for ‘May Is Mental Health Month’;
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY ________________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ ________________
Name Title Date

Noted and Approved by:

______________________________ ________________
Analyst Date

Approved by:

______________________________ ________________
District Chief Signature Print Name

______________________________ ________________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #2

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #2 (hereinafter 'SAAC'). The principle office of this committee is located at 6800 Owensmouth Ave., Suite 160, Canoga Park, CA 91303, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #2 is to enhance the quality of mental health services in the San Fernando/Santa Clarita Valley by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #2 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #2 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee’s activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH’s Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #2 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #2's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

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Stakeholder Engagement System

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

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The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY _______________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

_______________________________ _______________
Name Title Date

Noted and Approved by:

_______________________________ _______________
Analyst Date

Approved by:

_______________________________ _______________
District Chief Signature Print Name

_______________________________ _______________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #3

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #3 (hereinafter 'SAAC'). The principle office of this committee is located at DMH Headquarters, 550 S. Vermont Ave., Los Angeles, CA 90020, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #3 is to enhance the quality of mental health services in the San Gabriel Valley by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #3 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #3 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #3 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #3's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for ‘May Is Mental Health Month’;
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

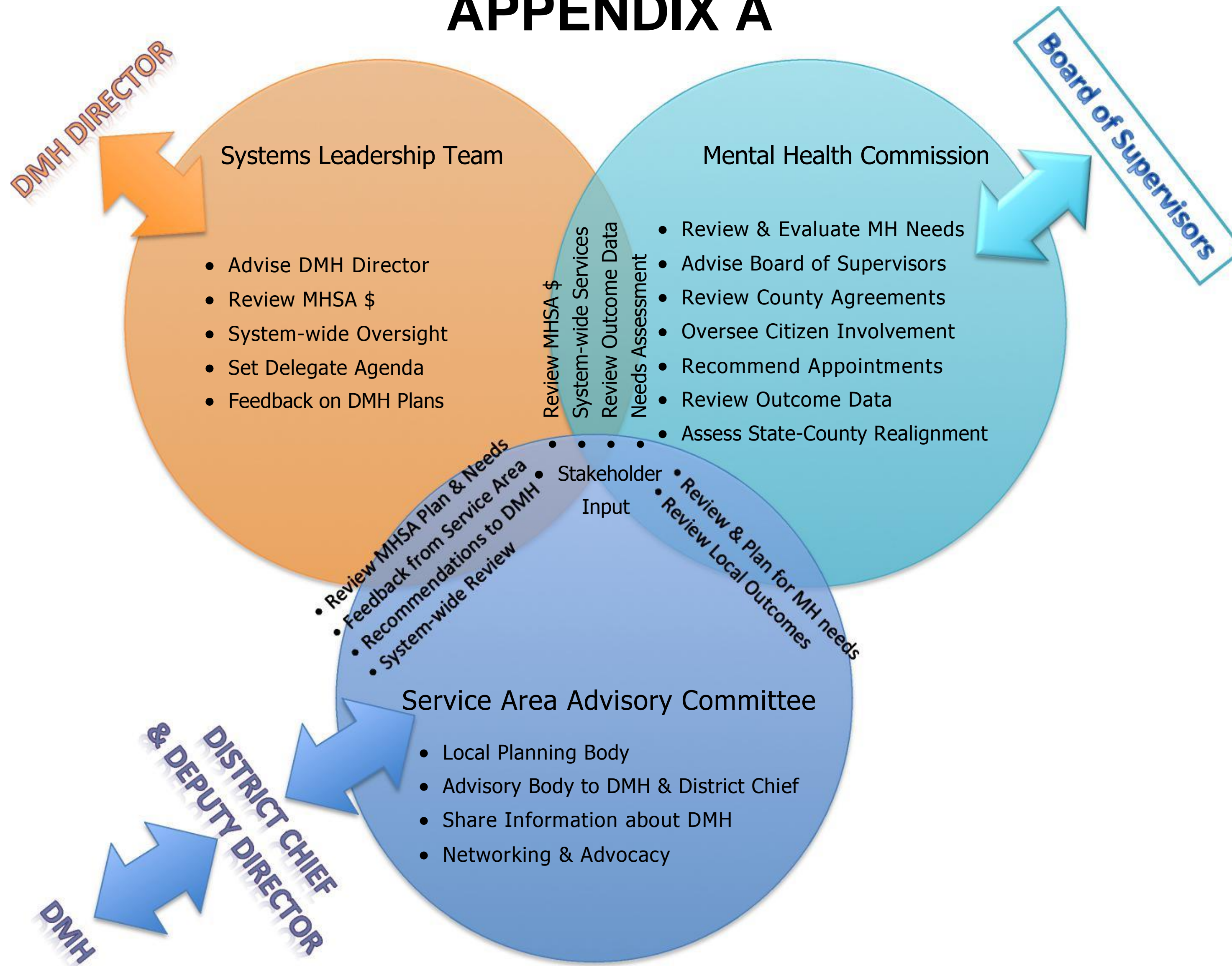
Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A



Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
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§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

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§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY ________________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ ______________
Name Title Date

Noted and Approved by:

______________________________ ______________
Analyst Date

Approved by:

______________________________ ______________
District Chief Signature Print Name

______________________________ ______________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #4

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #4 (hereinafter 'SAAC'). The principle office of this committee is located at DMH Headquarters, 550 S. Vermont Ave., Los Angeles, CA 90020, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #4 is to enhance the quality of mental health services in Los Angeles (Metro) by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #4 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #4 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee’s activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH’s Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #4 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #4's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for 'May Is Mental Health Month';
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentary inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY _______________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ _______________
Name Title Date

Noted and Approved by:

______________________________ _______________
Analyst Date

Approved by:

______________________________ _______________
District Chief Signature Print Name

______________________________ _______________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)

GUIDELINES FOR OPERATION

SAAC #5

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #5 (hereinafter 'SAAC'). The principle office of this committee is located at West Los Angeles Geographic Area Administrative Office, 11303 W. Washington Blvd., 2nd Floor, Los Angeles, CA 90064, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #5 is to enhance the quality of mental health services in Los Angeles (West) by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #5 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #5 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #5 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #5's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for ‘May Is Mental Health Month’;
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com Side 1

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY ________________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ ______________
Name Title Date

Noted and Approved by:

______________________________ ______________
Analyst Date

Approved by:

______________________________ ______________
District Chief Signature Print Name

______________________________ ______________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #6

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #6 (hereinafter 'SAAC'). The principle office of this committee is located at DMH Headquarters, 550 S. Vermont Ave., Los Angeles, CA 90020, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #6 is to enhance the quality of mental health services in Los Angeles (South) by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

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ARTICLE 5. MEMBERSHIP

5.1 SAAC #6 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	Demographically defined	Core
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #6 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #6 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #6's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for 'May Is Mental Health Month';
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

APPENDIX B

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
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Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY ________________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

____ ________________
Name Title Date

Noted and Approved by:

____ ________________
Analyst Date

Approved by:

____ ________________
District Chief Signature Print Name

____ ________________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #7

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #7 (hereinafter 'SAAC'). The principle office of this committee is located at DMH Headquarters, 550 S. Vermont Ave., Los Angeles, CA 90020, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #7 is to enhance the quality of mental health services in Los Angeles (East) by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #7 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

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5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

5.3.9 Maintaining a vibrant community of advocacy requires a commitment by SAAC members to attend meetings regularly and on time. Members shall request an absence when they cannot attend. In the event of unforeseen illness or circumstance that prevents attendance for an extended period of time, members are asked to communicate with the Co-Chairs or the District Chief. Members absent from three (3) consecutive meetings may be replaced; members absent from four (4) or more meetings annually may be replaced.

5.3.10 In circumstances where issues presented for vote are in conflict with the member's interest, either personally or as a representative of their employing agency, members are expected to voluntarily recuse themselves from voting. SAAC members who are also DMH employees will need to exercise an additional level of awareness and caution with regard to their competing interests. DMH employees should consult the official Department policy on material interest conflicts. If one is unsure whether a conflict of

interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

5.4.2 The term of office for the Membership Committee shall be two (2) years with a maximum of three (3) consecutive terms. (Initially, there will be three, three-year terms and two, two years terms in order to achieve a staggering of member's terms of office). A member who has served three terms must cycle off for one year before being eligible to serve additional terms.

5.4.3 The Membership Committee shall actively work to identify and recruit persons who may be eligible and should be considered as members. Consideration should be given to providers, community leaders, consumers and family members of consumers that can be of benefit to DMH programs and services and who support the vision and mission of DMH. The slate of candidates shall include any recommendations from the District Chief that the Membership Committee endorses.

5.4.4 The Membership Committee shall recommend candidates in each of the above categories to the entire SAAC for approval in June of each year. Terms begin and end by County of Los Angeles, Department of Mental Health fiscal year. The SAAC body at large, members and participants together, shall by majority vote approve the slate of candidates.

5.4.5 In June of each year, the Membership Committee shall nominate one Co-Chair for ratification by the voting membership and subject to acceptance by the Mental Health District Chief.

5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #7 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #7 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #7's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for 'May Is Mental Health Month';
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentar y inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY _______________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ ______________
Name Title Date

Noted and Approved by:

______________________________ ______________
Analyst Date

Approved by:

______________________________ ______________
District Chief Signature Print Name

______________________________ ______________
Service Area Date

COUNTY OF LOS ANGELES - DEPARTMENT OF MENTAL HEALTH

SERVICE AREA ADVISORY COMMITTEES (SAAC)
GUIDELINES FOR OPERATION
SAAC #8

PURPOSE

The purpose of these guidelines is to establish the mission, role, and function of Service Area Advisory Committees (SAAC) within the County of Los Angeles-Department of Mental Health (DMH) and to provide guidelines for its operations.

ARTICLE 1. NAME

1.1 The name of this organization will be Service Area Advisory Committee #8 (hereinafter 'SAAC'). The principle office of this committee is located at 100 Oceangate, Suite 550, Long Beach, CA 90802, or as otherwise designated by the Department of Mental Health of Los Angeles County.

ARTICLE 2. MISSION

2.1 The mission of the Department of Mental Health is to enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

2.2 Functioning in concert with this larger purpose, the general mission of the Service Area Advisory Committees is to enhance the quality of mental health services by collaborating with stakeholders and the Department of Mental Health in an advisory capacity, identifying, planning for and addressing current and emerging mental health needs in each service area to strengthen recovery, wellness, and resiliency.

2.2.1 More specifically, the objective of SAAC #8 is to enhance the quality of mental health services in Long Beach/South Bay by providing an open dialogue between the Department of Mental Health and its stakeholders on policy development, program planning, and procedural guidelines to ensure that the needs of the consumers and family members are met.

2.2.2 The Department of Mental Health simply cannot fulfill its mandate to "enrich lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency" without the involvement of a wide representation of stakeholders. Three intertwined entities help the Department in achieving this goal: 1) the Los Angeles County Mental Health Commission; 2) the Service Area Advisory Committees (SAACs), and, 3) the System Leadership Team (SLT). Together these three bodies form a

Stakeholder Engagement System (see Appendix A for diagram) with each serving both unique and overlapping functions.

ARTICLE 3. VISION

3.1 The vision for the Department of Mental Health is to partner with clients, families, and communities to create hope, wellness, and recovery.

3.2 Each of the designated eight (8) service areas will have a Service Area Advisory Committee (SAAC) which exists to function in the following manner:

3.2.1 as a local planning body to partner and gather community input, analyze information, prioritize programs, and integrate services tailored to the service area;

3.2.2 as an advisory body to provide DMH with ongoing feedback on existing or proposed programs including modification of programs, policies, and budgets for the service area;

3.2.3 as an information body to provide DMH with a vehicle to support and assist with the coordination of mental health programs and services within the service area;

3.2.4 as a networking and advocacy body.

ARTICLE 4. VALUES

4.1 The core values that guide the Department of Mental Health are:

- **Integrity:** We conduct ourselves professionally according to the highest ethical standards.
- **Respect:** We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.
- **Accountability:** We take responsibility for our choices and their outcomes.
- **Collaboration:** We work together toward common goals by partnering with the whole community, sharing knowledge, building consensus, and sharing decision-making.
- **Dedication:** We will do whatever it takes to improve the lives of our clients and communities.
- **Transparency:** We openly convey our ideas, decision, and outcomes to ensure trust in our organization.
- **Quality and Excellence:** We identify the highest personal, organizational, professional, and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

ARTICLE 5. MEMBERSHIP

5.1 SAAC #8 is comprised of interested mental health service providers and consumers who operate or reside within this service area of Los Angeles County. The Department of Mental Health seeks the involvement of the larger community and thereby invites any interested party to become an active participant in this SAAC. The input and advocacy of all participants is eagerly sought and highly valued.

5.2 There are some matters that require an official action on the part of the SAAC. To expedite this in a democratic fashion, the SAAC will select between twenty-six (26) and thirty-one (31) persons to serve as voting members. To ensure that those groups and persons with knowledge, experience and a stake in the mental health network are represented several categories of membership are to be represented in the example following:

Core	**Demographically defined**	**Core**
Prenatal to 5 - (1) Children (6-15) - (1) TAY (16-25) – (1) Adults (25-59) - (1) Older Adult (60+) - (1) Parent/Caregiver of Child/Youth in MH System - (1)	**Underserved Communities- (7)** African American/Africa Asian/Pacific Islander American Indian Middle Eastern/Eastern European Latino LGBTQ Visual Impaired/Hearing Limited Co-Occurring Other **At-Large (2)**	Consumers (2) Family Members (2) MH Provider (2) Education Representative (1 or 2) Law Enforcement (1 or 2) Social Services (1 or 2) Physical Health (1 or 2) Faith-Based (1 or 2)
6	9	11 - 16

5.3 Members

5.3.1 Each SAACs membership goal will reflect the ever-changing geographic area's demographics in terms of cultural diversity and racial, ethnic, gender, and age distribution.

5.3.2 All SAAC members shall be elected by the general SAAC membership but shall be officially appointed by the DMH Director for terms of two (2) years. (Initial appointments for SAAC memberships shall be staggered with half the member terms set for two-years (2) and the other half for three (3)

years. Staggering the initial terms will allow for a rotation in membership appointments).

5.3.3 Members may serve a maximum of three (3) consecutive terms with a one-year waiting period before serving additional terms. All member terms begin on July 1st.

5.3.4 When SAAC members serve additional terms they may represent another constituency group. Except on rare occasions such as when a public agency has one representative for several Service Areas, a person may not hold multiple SAAC memberships.

5.3.5 SAAC members should live, work, and/or volunteer in the area.

5.3.6 Voting. A simple majority of voting members shall constitute the input of the SAAC to the Department's Executive Management Team. All input shall be advisory to the Department.

5.3.6.1 Voting by proxy or absentee ballot will not be permitted.

5.3.6.2 Voting actions may not be taken during a conference telephone call, by mail, or by electronic vote. All actions requiring a vote of the official membership shall be undertaken in public only during in-person SAAC meetings.

5.3.7 The Mental Health District Chief of this Service Area will serve as an ex-officio, non-voting member of the SAAC. The SAAC Co-Chairs will vote only in the event of a tie.

5.3.8 The County of Los Angeles - Department of Mental Health Program Support Bureau – Administration shall offer appropriate orientation, training, and preparation regarding the Department's goals, strategies, objectives, policies, and programs to new SAAC members. Training will be offered to SAAC members to assist in further development of communication, negotiation, decision-making, and leadership skills.

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interest requires recusal, members are encouraged to request guidance from the SAAC as a whole.

5.3.11 If unable to continue to function as a voting member of the SAAC, the member shall submit, in writing, official notification of resignation to the Co-Chairs.

5.4 Membership Committee.

5.4.1 Each SAAC shall have a standing Membership Committee composed of five (5) persons: one Co-Chair, one provider, the Service Area District Chief, and two (2) consumers, and/or family member of a consumer.

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5.4.6 Should a vacancy of a member or a Co-Chair occur during the term, the Membership Committee shall reconvene to select a replacement to present to the next SAAC meeting for approval.

ARTICLE 6. LEADERSHIP

6.1 Co-Chair.

6.1.1 The Co-Chair is a member of the Executive Committee and has full voting privileges, voting in the event of a tie.

6.1.2 Each SAAC will have Co-Chairs as elected by the SAAC members. In order to maintain productivity and ensure effectiveness, these persons will function as a team, dividing responsibilities and activities in a

complementary manner to promote full and complete discussion and deliberation in the SAAC meetings.

6.1.3 The tenure of the Co-Chairs shall be two-year terms (2) with a maximum of three consecutive terms. The terms of the two Co-Chairs will be staggered with respect to one another to allow for continuity of leadership. Persons may become eligible to serve additional terms after a waiting period of one year. There will be no other standing officers.

6.1.4 SAAC Co-Chairs are encouraged to provide mentorship to other SAAC members to ensure and support succession in leadership within the SAAC.

6.2 Co-Chair Expectations and Qualifications.

6.2.1 Attend at least 75% of monthly SAAC meetings during each calendar year.

6.2.2 Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.

6.2.3 Be familiar with the Service Area.

6.2.4 Be open-minded, respectful, and collaborative.

6.2.5 Keep the best of the whole Service Area in mind.

6.2.6 Adhere to the SAAC vision and mission and DMH Recovery Policy.

6.3 Co-Chair Roles and Responsibilities.

6.3.1 Co-Chairs shall work collaboratively with the DMH District Chief to set the monthly meeting agenda.

6.3.2 Facilitate the monthly SAAC meetings so as to meet the four (4) functions of the SAAC (see 3.2.1 through 3.2.4).

6.3.3 Assist in identifying the needs of the service area communities.

6.3.4 Serve, in concert with the Service Area District Chief, as a liaison between the SAAC and the Department of Mental Health.

6.3.5 Adhere to the SAAC vision and mission and DMH Recovery policy.

6.3.6 Communicate mental health needs and gaps in services with the community at large and provide advocacy and support for mental health issues and programs that support the mission and vision of the Department of Mental Health.

6.4 Responsibilities of the District Chief.

6.4.1 Be responsible for working with SAAC liaison and the Co-Chairs to plan, prepare, and conduct monthly meetings.

6.4.2 Provide the SAAC with technical as well as tangible support related to preparing agenda, sign-in sheet, minutes and hand-outs.

6.4.3 Provide informational materials on DMH.

6.4.4 Schedule presentations of special interests to the service area community.

6.4.5 Assist SAAC members with needed information such as available services.

6.4.6 Act as a link between the DMH Executive Management Team and the SAAC. On the one hand, the District Chief shall represent the Department to ensure that SAAC members are well informed on DMH and service area issues, while on the other hand the District Chief shall consistently advocate the needs of the Service Area to the Executive Management Team.

6.4.7 Work to recruit members to ensure that SAAC is well represented with providers, service recipients, and other community entities in the service area.

6.4.8 Provide DMH with community input and other pertinent concerns raised by SAAC.

6.4.9 Be responsible for thirty-day (30) advance requests of Translation Services for the SAAC meetings from the Program Support Bureau – Administration unit. The District Chief, or designee, will attempt to determine if persons needing translation services plan to attend the next meeting and thereby require translation services.

6.5 Executive Committee.

6.5.1 In order to effectively lead the SAAC, an Executive Committee shall be constituted. The Executive Committee shall be made up of the SAAC Co-Chairs, the District Chief, and at least three (3) other members as designated in the Service Area.

6.5.2 The Executive Committee is strongly encouraged to select one member who is a potential future Co-Chair and one who is a past Co-Chair in order to apprentice new leaders and ensuring maintenance of institutional memory.

6.5.3 The Executive Committee will attend to the development of the next generation of leadership of SAAC by continually seeking out persons with leadership potential and then nurturing that potential in those individuals.

ARTICLE 7. INDIVIDUAL RESPONSIBILITIES

7.1 Representation. Every participant of the SAAC #8 is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within the SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participant represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

7.2 Authority.

7.2.1 The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

7.2.2 The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings

are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

7.3 Participation.

7.3.1 Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

7.3.2 Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

7.3.3 It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

7.4 Countywide Client Activity Fund (CCAF) Reimbursement. CCAF participants are reimbursed twenty-five (25) dollars for attending and actively participating at a SAAC meeting. CCAF participants are consumers or family members. To be reimbursed for attending a meeting the participant must submit a completed invoice to the MHSA Implementation & Outcomes Division. The invoice should include the date, time, and location of the meeting, along with the signature of the facilitator and a copy of the agenda in order to confirm attendance.

ARTICLE 8. PRINCIPLES OF SAAC FORMATION AND OPERATION

8.1 Each SAAC shall establish the membership from the categories of membership listed above. Recruitment shall be a continuous process.

8.2 Each SAAC should present an annual report to the Mental Health Director with particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed. The Annual Report shall be coordinated through the Department of Mental Health Program Support Bureau – Administration.

8.3 Subcommittees and Task Forces. Each SAAC shall form sub-committees and task forces as appropriate and necessary each year to conduct business. The number and types of such groups may vary from one SAAC to another.

8.4 Each SAAC shall adopt the basic Department of Mental Health SAAC guidelines, however, additional pertinent policies particular to a specific SAAC may supplement these guidelines, as long as there is no conflict with Departmental policy, County/State statutes, regulations, and policies. Approval should be sought from DMH's Program Support Bureau - Administration to ensure no conflicts exist.

8.5 Each SAAC shall provide input to the SAAC Liaison to the System Leadership Team (SLT) as well as offer directions to DMH in the various initiatives. DMH shall identify this Liaison to the SAAC Co-Chairs.

ARTICLE 9. SAAC MEETINGS

9.1 Meetings.

9.1.1 Meetings will occur during the year on regular bases, at places and times to be determined by the SAACs based on their objectives, issues to be addressed, and tasks to be accomplished. There shall be, at the minimum, at least nine (9) meetings per year.

9.1.2 All of the SAAC general meetings are to be open to the public. Notification of meeting dates, times, and agendas shall be published for the general public by the Department of Mental Health, Program Support Bureau – Administration.

9.1.3 Between SAAC meetings, the Executive Committee may meet in order to facilitate the functioning of the SAAC. Delegated responsibilities to participants and subcommittees may be carried out. For example, SAAC participants may call upon those who have not attended in recent months or they may be tasked to invite participation from underrepresented groups as delegated by the SAAC leadership. SAAC members who serve on subcommittees may participate in conference calls or meetings to transact committee business between regular SAAC meetings. Also, SAAC members may be requested to represent the committee at other meetings.

9.1.4 Discussions that inform DMH on various perspectives on issues are encouraged. Each SAAC strives toward a culture that encourages diversity of opinion. Challenging questions and candid deliberation is valued. SAAC #8 wishes to hear the broadest range of opinion from all its participants regardless of whether they are voting members or not. Ultimately, official actions will be limited only to official voting members but this shall not be construed as invalidating the input of SAAC #8's general participants. Consideration of many viewpoints on an issue and then coming to final agreement on a single position is a sign of a healthy functioning advisory body.

9.1.5 All SAAC participants and voting members are expected to interact with DMH staff, Co-Chairs, special guests, and each other in a manner that conveys respect, fair play, ethical standards, and straightforward communication.

9.1.6 The Co-Chairs and the District Chiefs are partners in the leadership of this SAAC so that the purposes are fully achieved. This is accomplished both in the shaping of the official agenda and in keeping internal discussions focused and on track. SAAC participants are partners with the official leadership in helping maintain the focus by keeping our purposes fully in mind. Therefore each SAAC shall make the maximum use of the time allowed for the meeting.

9.1.7 Generally, SAAC discussions are handled informally and allow for culturally diverse styles of decision-making. In some instances, matters presented for discussion by the SAAC shall be made by consensus; in some cases however, when the SAAC deems it needs an official action, a majority vote will be used to make a final recommendation. While reaching consensus is a valued goal, *Robert's Rules of Order* will be employed in the formal decision-making process. The ultimate purpose of *Robert's Rules of Order* is to ensure that everyone is heard and that no one is overpowered. It is most helpful to smooth committee functioning for members to brush up on the basics of *Robert's Rules of Order* (see appendix B).

9.1.8 Decisions are to be made within the limits of the SAAC purposes and within the criteria established by the Executive Management Team of DMH. The District Chief will refer SAAC decisions to the Executive Management Team for further deliberation and consideration. The SAAC and its participants convey its decisions with a unified voice to the leadership of the Department of Mental Health.

9.1.9 Electronic Meetings. Only subcommittees or official task forces of the SAAC business may conduct their business via electronic communication if all members have access to such communication. The entire SAAC shall operate only via in-person meetings.

9.2 Quorum. The meeting quorum shall be 1/2 of the membership plus one. No business may be conducted in the absence of a quorum.

9.3 Brief action minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the SAACs. Copies of the action minutes should be maintained in the Service Area and forwarded to the Program Support Bureau – Administration. Minutes shall be distributed to the members and other Management staff, Co-Chairs of each SAAC, the Los Angeles County Mental Health Commission, and other staff as appropriate in a timely manner. Each District Chief shall support the coordination of the SAAC meetings, maintain and take minutes, and support other SAAC activities as needed by assigning the necessary staff.

9.4 The Administrator of the Program Support Bureau – Administration will take responsibility for providing each SAAC with a range of appropriate, informational materials concerning DMH, County and State guidelines, policies, procedures, evaluations, and programs. The Program Support Bureau Administration will endeavor to assure that these and other materials are received by SAACs and distributed to members in a timely manner.

9.4.1 SAAC Manual. A SAAC Manual, which specifies in detail the function of the SAAC with respect to the leadership of the SAAC, will be maintained at all times.

9.5 Elections. Each SAAC will approve, by a majority vote, the slate of candidates presented at the June meeting.

9.6 Translation Services. The District Chief will be responsible for requesting Translation Services from the Program Support Bureau – Administration. In

advance of the SAAC meeting, the District Chief will submit a request for the specific language translation services needed and where and when the SAAC meeting will be held.

ARTICLE 10. SPECIAL TOPICS

10.1 Replacement of a Chair. In the event of the need to replace a Co-Chair, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the Co-Chair directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the Chair.

10.2 Replacement of a Member. In the event of the need to replace a member, due to incapacitation, dereliction of duty, malfeasance, or misconduct, concerned members of the SAAC will address the issues with the member directly. If this does not resolve the problem, they will then consult with Service Area District Chief. If this does not resolve the problem, the SAAC may vote by 2/3 majority to recommend the replacement of the member.

10.3 Annual Expenditures. To ensure each Service Area Advisory Committee (SAAC) has the necessary funds to operate and to encourage increased participation, $5000 per year has been allocated for the following purposes:

A. Refreshments for each meeting;
B. Translation services as needed for the meetings;
C. Honorariums for Speakers and/or a specialized consultant(s);
D. Fees for facilitates for special meetings and/or events;
E. Events for 'May Is Mental Health Month';
F. Cost for plaques, trophies, etc.;
G. Other (please specify).

In conjunction with the District Chief, the SAACs shall submit an annual budget that includes a proposed plan for how the monies will be spent. The plan shall be submitted by June 1st for the next fiscal year (July 1 through June 30th). It should be signed and approved by the Service Area District Chief. It may be updated as needs change throughout the year.

The spending plan shall be submitted, see appendix C.

The plans shall be submitted to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

ARTICLE 11. CONTINUING RESOLUTIONS

11.1. Continuing Resolutions. Each SAAC may establish continuing resolutions as deemed necessary. These continuing resolutions may not conflict with these Guidelines.

11.2 Adoption of Continuing Resolutions. Adoption of continuing resolution will be made by a 2/3 vote of each SAAC and will remain in effect until rescinded by a 2/3 vote of the SAAC.

APPENDIX A

Stakeholder Engagement System

Parliamentary Motions Guide

APPENDIX B

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com Side 1

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentary inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com Side 2

APPENDIX C

SAAC ANNUAL SPENDING PLAN

FY ________________

(enter Fiscal Year)

Date(s) (specify if a monthly expense)	Program	Purpose	Amount

Submit to:

Cheryl Peterson
MHSA Implementation & Outcomes Division
695 S. Vermont Avenue, 8th Floor
Los Angeles, CA 90005

Submitted by:

______________________________ ______________
Name Title Date

Noted and Approved by:

______________________________ ______________
Analyst Date

Approved by:

______________________________ ______________
District Chief Signature Print Name

______________________________ ______________
Service Area Date

COUNTY OF LOS ANGELES – DEPARTMENTOF MENTAL HEALTH

SAAC CONTACT AND MEETING INFORMATION

SERVICE AREA 1
3:00 pm – 5:00 pm

3rd Thursday of every month
Antelope Valley Transit Authority
42210 6th Street West, Lancaster, CA 93534
Contact:* *JoEllen Perkins (661) 223-3827
jperkins@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 2
9:30 am - 11:30 am

2nd Thursday of every month
Greig Smith LAPD Devonshire Youth Center
8721 Wilbur Ave., Northridge, CA 91324
Contact:* *James Randall (818) 610-6732
jrandall@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 3
2:00 pm – 4:00 pm

2nd Thursday of every month
San Gabriel Valley Service Center
1441 Santa Anita Avenue, South El Monte, CA 91733
Contact:* *Alfredo Larios (213) 739-5455
alarios@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 4
1:30 pm – 3:30 pm

3rd Thursday of every month
Department of Mental Health (DMH) Headquarters
550 S. Vermont Avenue, Los Angeles, CA 90005
Contact:* *Ed Vidaurri (213) 738-3765
evidaurri@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 5
3:00 pm – 5:00 pm

4th Tuesday of every month
Meeting held at various locations.
Contact:* *Anahid Markarian-Aghaniantz (310) 482-6601
AMarkarianAghaniantz@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 6
10:00 am – 12:00 pm

3rd Thursday of every month
MLK-Multi Service Ambulatory Care Center (MACC)
12021 S. Wilmington Ave., Los Angeles, CA 90059
Contact:* *Yolanda Whittington (213) 738-3779
ywhittington@dmh.lacounty.gov
Contact:* *Elena Farias (310) 668-3962
efarias@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

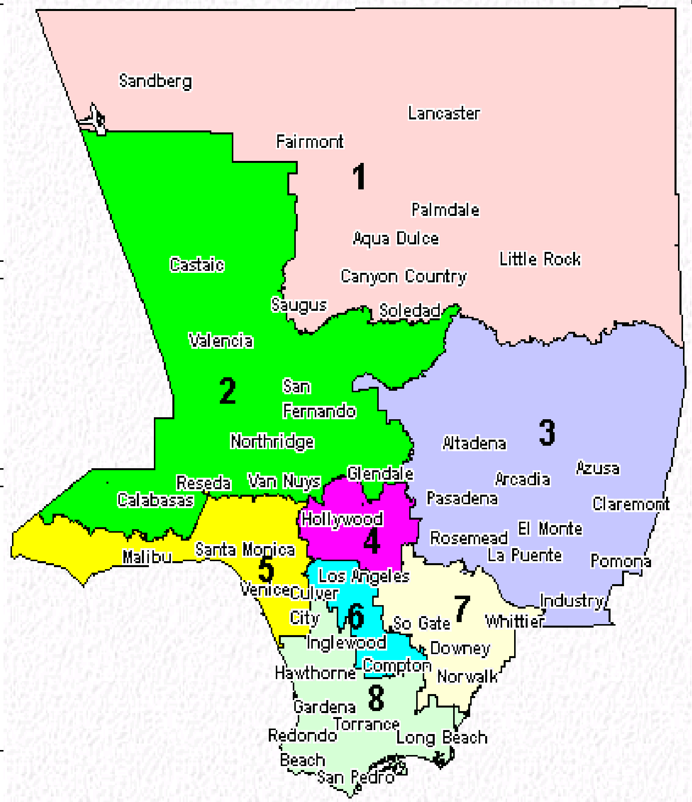
SERVICE AREA 7
10:30 am – 12:00 pm

2nd Friday of every month
ABC Unified School District - Boardroom
16700 Norwalk Blvd., Cerritos, CA 90703
Contact:* *Susan Donner (213) 738-3195
sdonner@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

SERVICE AREA 8
10:30 am – 12:00 pm

1st Friday of every month
Department of Children & Family Services (DCFS)
2325 Crenshaw Blvd., Torrance, CA 90501
Contact:* *Youngsook Kim-Sasaki (562) 435-3037
ykimsasaki@dmh.lacounty.gov
****call in advance to determine exact location of meetings***

Liaison:* *Ann Lee (562) 435-3027
alee@dmh.lacounty.gov



April 6, 2015

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Service Area Advisory Committees

Frequently Asked Questions

Q: What is a SAAC (purpose)?

The Service Area Advisory Committees (SAAC) are local planning, advisory, networking, advocacy, and informational groups geographically defined by Los Angeles County Service Planning Areas (SPA) that meet monthly to discuss issues related to mental health and mental health services in those areas. The SAACs are a part of the larger Stakeholder Engagement System in the Los Angeles County Department of Mental Health (DMH).

Q: Who can come to a SAAC meeting?

Anyone can attend a SAAC meeting.

Q: How do I locate my Service Area?

You can locate your Service Area by going to tab ***Part VI***, then tab ***Service Area Maps by Zip Code*** of the manual and look for your zip code to find the name of the community in which you live.

Q: What SAAC do I belong to?

You can attend any SAAC meeting across the County of Los Angeles, however, you can only become a member of a SAAC in a particular community (SPA) if you live, work, or volunteer in that community and have an interest in the mental health needs of the persons in that community.

Q: What is the role of members in the SAAC? What is the role of general participants in the SAAC?

The SAAC members are a body of diverse persons who are interested in advocating, advising, networking, and planning for mental health services in a particular community.

Q: In what ways does the SAAC influence and/or impact the needs of the mental health system?

The SAACs may help DMH plan for services, advise them about the best services in a particular community, and give feedback about how the current services are working or not working.

Q: What assistance can the SAAC provide in accessing the appropriate mental health program for my family and/or loved one?

The SAACs are a place for networking and informational sharing about services in a particular community. This may be a way for you to learn about mental health services.

Q: How do I obtain more information about my SAAC?

Information is available on the DMH website http://dmh.lacounty.gov about the SAACs, where they meet, and who the contact persons are.

Q: How can I benefit from being a member?

If you are interested in mental health services in Los Angeles County or want to advocate for more, better, or different mental health services you can benefit by being a part of group who share your interests and concerns.

Q: Can I present my Agency at the SAAC?

The SAACs welcome all agencies and information about various agencies in their community. They recognize that it takes a "village" to ensure all needs of those with mental illness are addressed.

Q: What does the Executive Committee do and can I join?

The Executive Committee is a small group of individuals in the SAAC that form the "leadership cooperative" of the SAACs. They are always looking for individuals who are willing to invest their talents as a leader in the SAAC. Please let the SAAC Co-Chairs know of your interest once you have spent some time with the SAACs and are certain of your interest.

Q: What does the Membership Committee do and can I join?

The Membership Committee is a small group of individuals in the SAAC that perform the nominating function of the SAACs. They recruit and nominate potential Co-Chairs and members for election each June. In the event of a member vacancy, the Membership Committee recruits and nominates persons to fill the vacancy until the next election.

Q: What are the boundaries of the different SAAC?

The boundaries for the various Service Planning Areas (SPA) and therefore the SAACs can be found on the Los Angeles County website http://lacounty.gov.

Q: Can I attend other area SAAC meetings?

You are welcome to attend any SAAC meeting of your choosing.

Q: What do I do when I have a specific question on how to get help from DMH or the mental health system in general?

The Department of Mental Health maintains a website http://dmh.lacounty.gov where information is readily available, or you can call 1-800-854-7771 to speak to a live person about needed services.

Q: How can I become involved with the work of the SAAC?

You can attend the SAAC meeting where you live, work, or volunteer and apply for membership. We recommend you attend the meetings a few times to meet people and learn about the SAAC.

Q: How can I be nominated to become a voting member of the SAAC?

There is a simple membership application and the Membership Committee will accept that application. Members are voted in by the general body at least once a year as membership terms are two years, with renewability for up to three consecutive terms.

Q: How does one become a SAAC Co-Chair?

You can become a SAAC Co-Chair by actively participating in the SAAC, and by expressing your interest to the current SAAC Co-Chairs and/or Service Area District Chief responsible for the SAAC in joining the Executive Committee. It is advisable to first serve on the Executive Committee for at least a year to come to learn what it involved in leading a SAAC.

Q: What other leadership opportunities are available?

By attending the SAAC meetings regularly you will see what other opportunities are available for leadership. This is important for each SAAC, as each may be different. Make your interest known and your participation will be welcomed.

Q: I have something I'd like to share. How do I get on the Agenda?

Please let the SAAC Co-Chairs know in advance your wish to add something to the agenda. Also, there is a designation on the Agenda for public comments, which allows anyone from the public to speak.

Q: How do I propose a topic or speaker for an upcoming SAAC meeting?

Again, let your SAAC Co-Chairs know you are interested in proposing an agenda topic.

County of Los Angeles – Department of Mental Health

Service Area Advisory Committee (SAAC)
Membership Application

Name: ______________________________ Phone: ________________________

E-Mail Address: _______________ Address: ___________________________________

Age group(s) you represent (please "X" the age group(s) you represent):	____Prenatal to Five (Ages 0-5) ____Children (Ages 6-15) ____TAY (Ages 16-25) ____Adults (Ages 26-59) ____Older Adults (Ages 59+) ____Parent/Caregiver of Child/Youth in MH System
Demographically defined State defined Underrepresented groups (self identified)	____African-American/African ____Asian/Pacific Islander ____American Indian ____Middle Eastern/Eastern European ____Latino ____LGBTQ ____Visual Impaired/Hearing Limited ____Co-Occurring ____Other
Primary Sector	____Consumer ____Family Member ____Education Representative ____Law Enforcement ____ Social Services ____ Physical Health ____Faith Based ____Mental Health ____Veterans ____Other

If you represent more than one sector, please write in the additional sectors here:

Additional Sector 1: _________________________ Additional Sector 2: __________________________

Additional information – Why would you be a good candidate for the Service Area Advisory Committee?

Language/Translation Needs other than English_____________________________

SERVICE AREA _____

10/29/14

SERVICE AREA ADVISORY COMMITTEE
MEMBER JOB DESCRIPTION

INDIVIDUAL RESPONSIBILITIES

Representation.

Every participant of SAAC is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participants represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

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The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

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Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

County of Los Angeles – Department of Mental Health

Service Area Advisory Committee (SAAC)
Non- Member Application for SAAC Manual

In order to provide you with valuable updates to this SAAC Manual, the Department wishes to maintain a listing of those persons and agencies that have been issued a copy. We ask that you kindly complete this form enabling us to provide you with these updates as they become available.

Name: ____

Agency (*if applicable*): ______________________________________

Phone: (   ) ________ – ______________________________

Address: ____

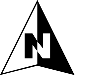
____

E-Mail Address: ______________________________________

Age group(s) you represent (please "X" the age group(s) you represent):	____Prenatal to Five (Ages 0-5) ____Children (Ages 6-15) ____TAY (Ages 16-25) ____Adults (Ages 26-59) ____Older Adults (Ages 59+) ____Parent/Caregiver of Child/Youth in MH System
Demographically defined State defined Underrepresented groups (self identified)	____African-American/African ____Asian/Pacific Islander ____American Indian ____Middle Eastern/Eastern European ____Latino ____LGBTQ ____Visual Impaired/Hearing Limited ____Co-Occurring ____Other
Primary Sector	____Consumer ____Family Member ____Education Representative ____Law Enforcement ____ Social Services ____ Physical Health ____Faith Based ____Mental Health ____Veterans ____Other

SERVICE AREA _____

Supervisorial Districts and Service Areas with City and Community Names
County of Los Angeles
Department of Mental Health



Del Sur
North Lancaster
Roosevelt
Hi Vista
Lancaster
Lake Hughes
Castaic/Lake Hughes
Leona Valley
Quartz Hill
Lake Los Angeles
Littlerock
Palmdale
SA 1
South Antelope Valley
Pearblossom
Castaic/Val Verde
Agua Dulce
Acton
Llano
Canyon Country
Santa Clarita
District 5
Stevenson Ranch
Chatsworth
SA 2
Angeles National Forest
Sylmar
Granada Hills
Lake View Terrace
Tujunga
Porter Ranch
Pacoima
Northridge
North Hills
Winnetka
Sun Valley
Shadow Hills
La Canada Flintridge
SA 3
West Hills
Canoga Park
Reseda
Van Nuys
Valley Glen
Altadena
Duarte
Hidden Hills
Woodland Hills
Burbank
Glendale
Sierra Madre
Monrovia
Agoura Hills
Tarzana
Sherman Oaks
North Hollywood
Pasadena
Bradbury
Azusa
Glendora
Westlake Village
Calabasas
Encino
Studio City
Los Feliz
Eagle Rock/Glassell
Arcadia
San Marino
Triunfo Canyon
Calabasas
Topanga Canyon
Beverly Crest
Bel Air
Hollywood
Los Angeles
Claremont
San Gabriel
Irwindale
La Verne
SA 5
SA 4
El Sereno
Temple City
Malibu
District 3
Silverlake
El Monte
Baldwin Park
Covina
San Dimas
Pacific Palisades
Boyle Heights
Monterey Park
South El Monte
West Covina
Pomona
Miracle Mile
District 1
West LA
Santa Monica
Palms
East Los Angeles
Walnut
Malibu
Adams/La Brea
Crenshaw
Montebello
Commerce
La Puente
Culver City
SA 6
South Park
Whittier
Industry
Diamond Bar
SA 7
Hacienda Heights
Rowland Heights
Bell
South Vermont
Pico Rivera
Whittier
La Habra Heights
Westchester
District 2
South Gate
Santa Fe Springs
South Whittier
El Segundo
Downey
Hawthorne
Gardena
Lynwood
Norwalk
La Mirada
Manhattan Beach
Compton
Bellflower
Cerritos
Artesia
Hermosa Beach
SA 8
Pacific Ocean
Lakewood
Carson
Torrance
District 4
Hawaiian Gardens
Harbor City
Wilmington
Signal Hill
Palos Verdes Estates
Lomita
Rolling Hills Estates
Long Beach
Rancho Palos Verdes
San Pedro

Santa Catalina Island
Pacific Ocean
SA 8
Santa Catalina Island
Avalon
SD 4
Note: Not in scale and not in true location.

Supervisorial Districts

District 1: Gloria Molina
District 2: Mark Ridley-Thomas
District 3: Zev Yaroslavsky
District 4: Don Knabe
District 5: Michael D. Antonovich

Note: City names in black
Community names in blue

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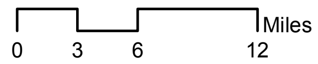


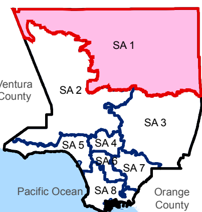
Freeways
Highways
Supervisorial Disatrict Boundaries

Service Areas

SA 1: Antelope Valley
SA 2: San Fernando
SA 3: San Gabriel
SA 4: Metro
SA 5: West
SA 6: South
SA 7: East
SA 8: South Bay

Mental Health Clinics - Service Area 1
County of Los Angeles
Department of Mental Health

Lancaster
Palmdale
North Lancaster
Roosevelt
Hi Vista
Del Sur
Lake Hughes
Lake Los Angeles
Leona Valley
Agua Dulce
Littlerock
Pearblossom
South Antelope Valley
Acton
Llano
Angeles National Forest



Note: City names in black
Community names in blue

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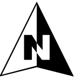
National Forest
Unincorporated Areas

Mental Health Clinics
Directly Operated
Contract Providers

Mental Health Clinics - Service Area 2
County of Los Angeles
Department of Mental Health



Castaic/Lake Hughes
Castaic/Val Verde
Agua Dulce
Ridge Route Rd
The Old Rd
Bouquet Canyon Rd
Copper Hill Dr
Mcbean Pkwy
Sierra Hwy
Sand Canyon Rd
Henry Mayo Dr
Valencia Blvd
Santa Clarita
Stevenson Ranch
Lyons Ave
Placerita Canyon Rd
Angeles National Forest
Chatsworth
Sesnon Blvd
Granada Hills
Sylmar
Glenoaks Blvd
Tujunga
Balboa Blvd
Chatsworth
Devonshire St
Plummer St
Nordhoff St
Wentworth St
Foothill Blvd
Foothill Frwy
Day St
Shadow Hills
San Fernando Rd
Laurel Canyon Blvd
Sun Valley
La Cañada Flintridge
Burbank
Glendale
Roscoe Blvd
Sherman Way
Victory Blvd
Burbank Blvd
Van Nuys Blvd
Lankershim Blvd
Tujunga Ave
Vineland Ave
W Olive Ave
Canada Blvd
Fallbrook Ave
Platt Ave
Canoga Ave
De Soto Ave
Winnetka Ave
Corbin Ave
Tampa Ave
Reseda Blvd
White Oak Ave
Woodland Hills
Tarzana
Ventura Blvd
Encino
Sherman Oaks
Agoura Hills
Triunfo Canyon
Agoura Rd
Calabasas
Las Virgenes Rd
Topanga Canyon
Topanga Canyon Hwy
Calabasas
Mulholland
5
14
118
126
134
170
210
405
101

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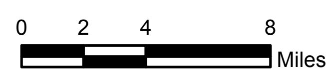
Note: City names in black
Community names in blue



National Forest
City of Los Angeles
Unincorporated Areas

Mental Health Clinics
Directly Operated
Contract Providers

Mental Health Clinics
Service Area 3
County of Los Angeles
Department of Mental Health

Angeles National Forest

Upper Big Tujunga Canyon Rd

Angeles Crest Hwy

E East Fork Rd

Glendora Ridge Rd

Mount Baldy Rd

Altadena

Pasadena

Monrovia

Duarte

Glendora

Azusa

Claremont

Arcadia

Irwindale

La Verne

Covina

San Dimas

Alhambra

El Monte

Baldwin Park

Rosemead

West Covina

Monterey Park

Pomona

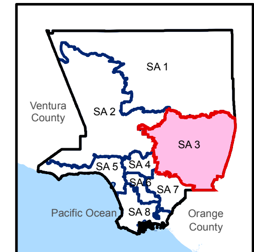
Walnut

Industry

Diamond Bar

Hacienda Heights

Rowland Heights



Mental Health Clinics

- Directly Operated
- Contract Providers

- National Forest
- Unincorporated Areas

Note:
City names in black
Community names in blue

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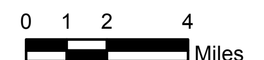
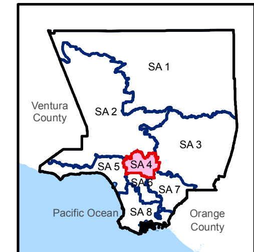


Mental Health Clinics
Service Area 4
County of Los Angeles
Department of Mental Health

Los Angeles
West Hollywood
Los Feliz
Hollywood
Atwater Village
Eagle Rock/Glassell
Highland Park
El Sereno
Silverlake
Lincoln Heights
Fairfax
Hancock Park
Westlake
Miracle Mile
Boyle Heights
Downtown
Wholesale
Los Angeles



Mental Health Clinics

- Directly Operated
- Contract Providers

- City of Los Angeles
- Unincorporated Areas

Note:
City names in black
Community names in blue

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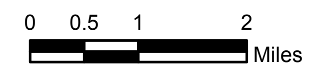
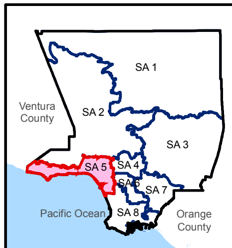


Mental Health Clinics - Service Area 5
County of Los Angeles
Department of Mental Health

Malibu
Malibu
Pacific Palisades
Brentwood
Bel Air
Beverly Crest
Los Angeles
Westwood
Beverly Hills
West LA
Palms
Santa Monica
Mar Vista
Culver City
Venice
Ladera
Inglewood
Westchester
Los Angeles



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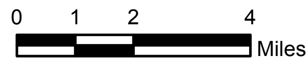
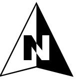
Community names in blue



City of Los Angeles
Unincorporated Areas

Mental Health Clinics
Directly Operated
Contract Providers

Mental Health Clinics - Service Area 6
County of Los Angeles
Department of Mental Health



West Adams/Exposition Park
Los Angeles
Adams/La Brea
Crenshaw
View Park/Windsor Hills
Vermont Square
South Park
South Vermont
Florence/Firestone
Green Meadows
Watts
Los Angeles
Willowbrook
Lynwood
Paramount
Rosewood/West Rancho Dominguez
Compton
Carson

10
W Adams Blvd
Hauser Blvd
W Jefferson Blvd
Rodeo Rd
Exposition Blvd
Coliseum St
Exposition Blvd
W Martin Luther King Blvd
W Martin Luther King Jr Blvd
Leimert Blvd
Stocker St
W Vernon Ave
W 48Th St
W 54Th St
W Slauson Ave
West Blvd
8Th Ave
W Florence Ave
S Normandie Ave
S Hoover St
S Hoover St
S Figueroa St
Harbor Frwy
S Broadway
110
S Hill St
E Jefferson Blvd
Hooper Ave
E 41St St
Long Beach Ave West
E 54Th St
E 55Th St
S San Pedro St
Avalon Blvd
E Florence Ave
Nadeau St
E Firestone Blvd
E 92Nd St
Clovis Ave
E 103Rd St
E 103Rd St
E 108Th St
Santa Ana Blvd South
Compton Ave
Wilmington Ave
105
E 119Th St
S Mona Blvd
Martin Luther King Jr Blvd
Abbott Rd
E Imperial Hwy
Fernwood Ave
Wright Rd
Long Beach Blvd
N Santa Fe Ave
Atlantic Ave
Century Frwy
S Main St
S San Pedro St
S Avalon Blvd
N Wilmington Ave
W Rosecrans Ave
E Rosecrans Ave
E Compton Blvd
S Willowbrook Ave
S Alameda St
E Alondra Blvd
S Atlantic Ave
W Alondra Blvd
W Artesia Blvd
710
Rosecrans Ave
Orange Ave
Garfield Ave
Paramount Blvd
Downey Ave
Alondra Blvd

Note: City names in black
Community names in blue

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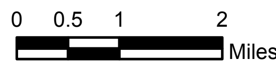

City of Los Angeles
Unincorporated Areas

Mental Health Clinics
Directly Operated
Contract Providers

Mental Health Clinics - Service Area 7
County of Los Angeles
Department of Mental Health

East Los Angeles
Montebello
Commerce
Vernon
Bell
Huntington Park
Florence/Firestone
Bell Gardens
Pico Rivera
West Whittier/Los Nietos
Whittier
La Habra Heights
Santa Fe Springs
South Whittier
East La Mirada
La Mirada
South Gate
Downey
Norwalk
Bellflower
Artesia
Cerritos
Lakewood

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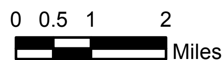
Community names in blue



City of Los Angeles
Unincorporated Areas

Mental Health Clinics
Directly Operated
Contract Providers

Mental Health Clinics - Service Area 8
County of Los Angeles
Department of Mental Health

Inglewood
El Segundo
Athens/Westmont
Hawthorne
Manhattan Beach
Gardena
Lawndale
Redondo Beach
Harbor Gateway
Rancho Dominguez
Carson
West Carson
Torrance
Long Beach
Lomita
Harbor City
Rolling Hills Estates
Los Angeles
Rancho Palos Verdes
San Pedro

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Community names in blue

Mental Health Clinics

- Directly Operated
- Contract Providers

0 1 2 4 Miles

- City of Los Angeles
- Unincorporated Areas

HOW TO BE AN ADVOCATE

The word advocate is meant "to summon to" or "to call one's attention to" something or someone. To be an advocate, in the modern sense of the word, is to stand in place of someone and speak out on his or her behalf. It means to be the voice of another, to cry out for those who are unheard by the powers of society, to lift up the plight of the marginalized and bring their cause into the light of day so that justice may be done.

To be a participant in this Service Area Advisory Committee is to be an advocate in this fullest sense of the word. Persons suffering from mental illness and their family members need you to advocate on their behalf. They are counting on you to continually promote for more and better mental health services, for increased funding, as well as for just distribution of those services across the vastness of Los Angeles County.

The Los Angeles County Department of Mental Health, for their part, also needs your advocacy. Any organization, if it does not regularly and faithfully bend its collective ear to listen to those it serves will eventually grow out of touch and ineffective. DMH cannot be successful without a continuous feedback loop of information being shared on how efficient and effective its offerings are. This is as true of the State and Federal governments as it is of Los Angeles County.

So, you are an advocate. No doubt about it. You bear a tremendous responsibility to speak out for yourself, your community, and for those who cannot speak for themselves. Now, the question becomes, "How does one do that? How does a person become a truly effective advocate?"

Will I be heard?

The cultural anthropologist Margaret Mead famously said, "Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it is the only thing that ever has." With the rise of the Internet, social media, and rapid communication, Mead's insight is ever more true today than when she first spoke it. Your advocacy is essential. It is important and your voice will be heard. You will make a difference.

But, to be heard, you must speak out. Hockey legend Wayne Gretzy once said, "You miss 100% of the shots you never take." Therefore, be bold. Do not fear those in power. We all deserve respect and fair treatment. Advocate for yourself and others. Think of advocacy as a grand adventure of working to change even one small corner of the world for the better.

How to be Heard

Listen

The first, and maybe the most important, element of being an advocate is to listen. Listen to consumers of mental health services, to providers, to program managers, to government employees, and even to politicians. Seek out those who cannot or will not speak out and ask them for their point of view. An advocate is someone who voluntarily stands in that person's place and becomes their voice speaking on their behalf. This is a most noble pursuit indeed. It is the first step in fashioning a just society wherein all persons are important and everyone's perspective matters.

Listening as an advocate however also entails listening to your opponent. Listening only to one side of any debate is always self-defeating. The most effective way to get your message across comes by understanding the other party's position and interests. In other words, what precisely is their position? What evidence do they use to support that position? By what logic or set of values do they arrive at their beliefs? Francis of Assisi gave wise counsel to all advocates when he admonished: "Seek first to understand, then to be understood."

Do your homework

Life is just like school predicted it would be: do your homework and you are likely to come out all right. This is as true in advocacy work as it was in high school. Successful advocates know what they are talking about before they speak up. They have visited the library and read whatever they can get their hands on about the topic. They have sought out key people, on both sides of the issue, to ask their perspective. They have sat down and written out their arguments and the evidence that leads them to that position so that when the time comes they can speak clearly.

Doing your homework as an advocate also means fully understanding the other side's viewpoint. What arguments do they make and why? Why do they see things in that way, instead of how you see matters? In doing your homework on the opposing point of view you will undoubtedly find several places where you agree. This offers an excellent entry point into a conversation where you seek to influence the other party. Begin with your common agreement that you have uncovered in doing your homework. You are much more likely to move the other party towards your position if you begin the dialogue in a positive, rather than a negative way.

Know how the system works

In order for human beings to live in complex societies, they have created large, structured ways of accomplishing mutually agreed upon goals. These "systems" are the means by which groups come to a decision and move forward. The

advocate standing on the street corner all alone screaming from the sidewalk rarely achieves very much other than creating a spectacle (there are exceptions to this of course, but they are rare). The very best way to advocate for your position is to fully understand the system. In other words, how are decisions made? Who makes them? Are there public hearings? How do decisions get reversed? Who has influence and who does not?

Speak out
When the time comes when the system bends its ear to listen to the voices of its constituents, do not be afraid to speak out all that you have heard and have come to believe. The manner in which you do speak out however, is essential to your success. Negative, rage-filled speech dripping with vindictiveness and name-calling persuades no one. The well-spoken, thoroughly present argument that understands that there are many perspectives on the issue but stands firmly grounded in its advocacy for its unique perspective generally has the best chance of changing things. The well-reasoned argument, even if it contains tempered, justifiable anger, can change minds and move mountains.

Write letters
Too often people deny the effect they might have in effecting change by saying to themselves: What difference will it make if I speak out or write a letter? The truth of the matter is quite the opposite, speaking out and writing letters does indeed make a difference. One more letter does carry weight. It is always of value.

As any politician can tell you, the letters and emails sent to them are carefully counted and analyzed as indicators of prevailing opinion. Our leaders understand that they must attune themselves to what their constituents are thinking and the letters that are sent to them are a very strong indication of such positions. Advocates who stop and take the time to write their representatives give added weight to their position by forcing political and government leaders to evaluate these submitted perspectives. Each letter or email received by politicians gets crunched using a statistical formula as a gauge of how many others feel as you do. Thus, when you write even a single letter or email the effect is multiplied.

Attend meetings
It has been said that “the world is run by those who show up.” This is more true than most Americans realize. Just showing up to meetings, hearings, congressional sessions, corporate board meetings, local school board meetings, etc. has profound implications. Those who show up consistently find themselves being nominated for positions of influence, they are invited to speak, and they come to understand who the players are and how things really get done. Showing up

makes all the difference in the world because it tells those in power that people care, that citizens are watching, and that there are other perspectives and arguments that need to be heard.

Volunteer
If you were to interview some of your most admired leaders and ask them how they got started on the path to becoming a person of influence, no doubt they would tell you that they were in the right place at the right time. Volunteering is one significant way to become a leading advocate in the manner of your leadership heroes. Volunteer. Offer to roll up your sleeves and work. Help out in any way that you can. You will make a difference and you will earn the right to be heard.

Build Relationships
Advocates are focused on building genuine, caring, quality relationships. The most successful advocates work especially hard at building compassionate relationships even with their most ardent opponents. Vilifying the other only serves to lessen your influence and your chance to prevail. We are all human beings even if we vehemently disagree on what to value, what policy to enact, or what decision to make. The most persuasive advocates work hard to find common ground in our shared humanity. Superior advocates build strong, even if complicated, relationships with those who oppose them.

Make Allies
Building relationships will inevitably lead to finding allies who can fight alongside you. Such allies will be arrayed along a spectrum: some will agree with a vast majority of your position and opinions while others will share in common with you only a fraction of what you believe. Regardless of how much your mutual affinity is with your allies, joining together with others as allies is a strategic necessity in successful advocacy.

Practical Tips
Beyond the bigger principles and guidelines for advocates lie several practical how-tos that will increase your impact as an advocate.

Contact lists
In keeping with the “Build Relationships” admonition above, it is a wise idea to maintain a detailed list of all the people and agencies you come in contact with. Get a special address book or use a digital contact information software application and diligently record names, addresses, phone numbers, etc. Build your system to delve even further. Record the name of an influential person’s administrative assistant. Write down some notes about their children that they mentioned in a

conversation with you. Make a note about their favorite hobby or most recent book read that they talked about with you. These practical reminders will help you to build relationships, find common ground, and break the ice with the people you want to influence. Remember, however, to be genuinely interested in the other person. If you use your notations in your contact record keeping system in a manipulative way you will undoubtedly be seen as disingenuous and your message will be devalued or even dismissed outright. Genuine concern, even for your most ardent opponent, will go a long way to building trust that allows you to get your message across.

Keep Records

Faithfully maintain a written record that lists in chronological order everything you have done in your advocacy efforts. Being able to accurately recall the history of what you have done often has tremendous power. "I spoke before this committee on April 3, sent you a follow-up letter on May 1, called your office six times in the past three weeks, and met with your assistant last Tuesday," is a very persuasive position to take largely due to its specific detail.

Leadership

Who me? A leader?

The truth is that there are many types of leaders: some are quiet, supportive leaders, others come alongside to lead by example, and yes, some are the 'up-front' kind of leaders we so readily recognize.

Let's define what exactly "leadership." is. And, what kind of leader it takes to be involved in the Service Area Advisory Committee. The following are a few of the better attempts at defining the essence of leadership:

"Leadership is a relationship, one between constituent and leader that is based on mutual needs and interests."

"The art of mobilizing others to want to struggle for shared aspirations."

"The process of persuasion or example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his or her followers."

"The first responsibility of a leader is to define reality. The last is to say thank you. In between the two, the leader must become a servant and a debtor."

Leadership is painfully hard to pin down because, despite contemporary myths of the charismatic leader, leadership is as unique as any individual. Some notable leaders are indeed charismatic dynamos who can boldly stand before thousands to paint a grand persuasive picture of the future of the group. Other leaders are of the gentle, quiet variety who readily comes alongside another to offer wisdom and guidance. Still other

leaders are the supportive type who much prefer to remain in the background but who nevertheless have such profound influence that people look to them for their opinions.

Leadership is as unique as you are. This is why no one definition works to describe all forms of leadership. This is why you too are a leader in your own way, in your own relationships. Just being who you are changes people around you, and changes your community. That is leadership we are looking for, someone who is willing to be themselves and represent their community. You are a leader in your community.

As you take on this leadership role in your Service Area Advisory Committee let us review the expectation of your role:

Representation

Every participant of SAAC is an important voice for countless others who cannot or are not able to speak out. It is imperative that all participants focus their work within SAAC through the lens of the larger mission of the Department of Mental Health's mission to serve the citizens of Los Angeles County. As SAAC members, we must always be aware that we represent the community or constituency and for this reason we must always be aware to ensure the committee pursues any other goal than its stated mission. Each SAAC participants represents the whole of the Service Area. Our actions and decisions are always made with the welfare of all in mind.

Authority

The strength and vitality of our SAAC comes from the combined wisdom, ability, and diversity of our participants.

The SAAC exercises its responsibilities as a whole, not as individuals outside the context of meetings. SAAC meetings and committee meetings are places for discussion and debate. Once a SAAC vote is taken or a decision made, the SAAC speaks with one voice.

Participation

Prior to SAAC meetings, participants may receive information that is related to that meeting. To prepare adequately for the meeting, participants are expected to read the material, formulate questions and ideas, and reflect on the decisions they will be asked to make in the meeting. SAAC participants are encouraged to fully engage in discussions and request information as necessary to influence deliberations.

Since full participation of participants is vital to effective governance, attendance at SAAC meetings is expected. Meeting dates are scheduled well in advance to allow members to plan for their attendance and participation.

It is vital that SAAC participants exercise discretion and respect confidentiality in handling materials and engaging in discussion of sensitive matters to help ensure the degree of privacy necessary for the SAAC to perform its responsibilities as assigned.

Best Ideas

Service Area Advisory Committees

The following document is a compilation of some of the best practice ideas gleaned from the eight Service Area Advisory Committees. While there is a need to impose some level of uniformity of function across the eight Service Areas, there is also latitude for uniqueness. The practices below have been judged as worthy to be shared, even encouraged, without being mandated across the board.

Volunteer Leadership Positions

In the interests of growing leaders by offering opportunities to serve, the SAAC leadership could choose to implement several "volunteer leadership positions" including the following:

Follow-Up – calls those who have missed a meeting to let them know they were missed, when the next meeting will be held, and listen for any concerns, answer any questions, etc.

Set Up Leader – arrives 20 minutes before the meeting to set up the room and lay out the resource table. This person(s) helps to set up presentation equipment also.

Greeter – welcomes participants as they arrive, hands them a nametag, and answers any questions they might have.

Capacity Builder – seeks to increase the capacity of the SAAC by actively recruiting community members, especially underrepresented groups and constituencies, to become involved with the work of the SAAC.

Leadership Development

Leaders rarely appear from out of nowhere. Instead, great organizations intentionally grow their future leaders from within. Much like a major league baseball team grooms future players through a farm system of A, AA, and AAA farm teams, so, too, are leaders developed throughout an organization. The key to leadership success is to

define a series of leadership roles with increasing responsibilities and give these roles to potential leadership. When a person proves capable in one role, offer them a chance to lead at a higher level, and so on. In this way, a perpetual supply of trusted, proven leaders is readily available to achieve the organization's mission and vision.

Within the arena of the SAACs, it is advisable to carve out small, definable volunteer leadership positions beginning perhaps with one of those discussed above. When a leader proves competent in such a role, invite them to serve on the Membership Committee, and then once successful here, to serve on the Executive Committee. Service on the Executive Committee, wherein a leader can see from behind the scenes how the SAAC is organized, will qualify that person to be a good choice to one day be elected as a Co-Chair.

Capacity Building

It appears that each SAAC has a perpetual struggle to involve certain element of their communities in this work. Engaging the law enforcement community, or the education community, or parents and family members for example is especially difficult. Here are several ideas that might assist the SAAC to incorporate under-involved group such as these.

Visit – send SAAC volunteers to visit under-involved groups with the goal of listening to the needs with regard to mental health services.

Invite – extend an invitation to representatives of under-involved groups to present at an upcoming SAAC meeting.

Involve – ask a member of an under-involved organization if they will assist with some tangible SAAC project or initiative.

Capacity building, by its very nature, requires an intentional, active effort. Discuss within your SAAC how your organization might strategize to build the capacity of the SAAC by incorporating under-involved agencies and/or people groups.

A LEADERSHIP FARM SYSTEM FOR

THE SERVICE AREA ADVISORY COMMITTEES

Just as in baseball wherein a player with aspirations of playing in the Major Leagues hones his skills through a system of A, AA, and AAA farm teams, so too are future leaders best groomed. This same graduated methodology is ideal for use by the Service Area Advisory Committees to train up leaders who can be counted on to enhance, even expand, the work of the SAACs.

This “leadership farm system” works like this:

These leadership opportunities provide community members with the chance to grow in their service to the Service Area by gaining confidence in their abilities to lead. As leaders move from one level to the next higher level they will bring with them greater knowledge of the inner workings of the SAAC and stronger trust earned by their earlier service.

Volunteer Positions

Hospitality Team

Setup / Takedown Team

Capacity Building Team

Historian

Membership or Executive Committee

Membership Committee

Executive Committee

Co-Chair of SAAC

Co-Chair

The next few pages outline the basic job descriptions for each of the above positions.

HOSPITALITY TEAM JOB DESCRIPTION

Hospitality Team Greeter

Greeters welcome at the door SAAC participants and guests and offer any assistance that might be needed. Greeters educate visitors on the goals of the SAAC and what the day's agenda will entail. Furthermore, they direct those arriving to the sign-in and information tables. Above all else, greeters make everyone feel welcome, comfortable, and excited about the SAAC.

Qualifications

To become a Greeter, you must enjoy meeting and talking with all kinds of people. You also need to be familiar with and enthusiastic about the SAAC. We especially need people with foreign language skills, American Sign Language, and those who are sensitive a wide variety of cultures.

Time and Place

Greeters should arrive at the SAAC meeting or event one half-hour in advance to familiarize themselves with the day's agenda and to greet those arriving early.

Benefits of Becoming a Hospitality Team Greeter

Greeters have the opportunity to lead in the work of the SAAC by expanding its participation as well as the energy level and commitment of those attending. If you speak a foreign language, you'll have the opportunity to use it. Plus, making new friends is exciting!

SET UP AND TAKE DOWN TEAM

Set up and Take Down Team

Some leaders prefer active tasks. This team offers the opportunity to actively support the SAAC by arriving early to set up the room for the meeting or event and to stay late to return everything as it was. Team members will also assist special guest presenters to set up their audio-visual presentations.

Qualifications

To become a Set up/Take down team member, you must be physically able to move chairs, carry boxes (none are very heavy), and to set up the audio-visual systems. You need some familiarity with laptop computers and projectors and ancillary presentation equipment.

Time and Place

Set up/Take down team members should arrive at the SAAC meeting or event one half-hour in advance to familiarize themselves with the day's agenda and to set the room up as directed by someone from the Executive Committee.

Benefits of Becoming a Set up/Take down Team Member

Set up/Take down team members have the opportunity to become leaders in the work of the SAAC by making the SAAC accessible and comfortable to all who attend and by reducing the workload of the Executive Committee and the Co-Chairs. This team also ensures the SAAC remains welcome in the rented or borrowed space provided by outside groups through carefully returning the room to the condition the SAAC found it upon arrival.

CAPACITY BUILDING TEAM

Capacity Building Team

Without active representation from a broad array of community organizations and sectors, the SAAC will not be able to achieve its intended purpose. The job of the Capacity Building Team is to continuously reach out to various community groups and leaders and invite them to participation and fellowship in the SAAC.

Qualifications

To become a Capacity Building Team, you need to be able to warmly and gracious meet people and make them feel comfortable and welcome. Capacity Building Team members are people who find it easy to phone or visit potential participants and share with them the vision of the SAAC.

Time and Place

The work of the Capacity Building Team will largely take place outside of the general meeting and event schedule. Phone calls, emails, and personal visits will be the primary means by which the Capacity Building Team seeks to incorporate more voices in the work of expanding mental health services and advocacy via the SAA.

Benefits of Becoming a Capacity Building Team Member

Capacity Building Team members lead by finding important new connections for the SAAC. Their leadership is vital to ensuring that all sectors of the Service Area are fully represented and are heard. This Team works hand-in-hand with the Hospitality Team to include more and more people and organizations.

HISTORIAN

Historian

Community social organizations like the SAACs rely heavily on institutional memory to succeed. The job of the Historian is to maintain the oral and written history of the SAAC so as to learn from the past and achieve more in the future.

Qualifications

To become a Historian, you need to have a long and steady history of personal participation and leadership in the SAAC. Historians will be persons who enjoy capturing the story of the group in via both photography and in writing.

Time and Place

The work of the Capacity Building Team will occur both within and without the general SAAC meetings and events. Faithful attendance is essential to document what the SAAC has accomplishing. Outside of the general membership meetings, the Historian will spend time cataloguing the minutes and stories and photographs of the SAAC's accomplishments.

Benefits of Becoming a Capacity Building Team Member

The Historian will lead by reminding the SAAC where it has been and what it has accomplished. Historians will also guide the future by recalling past events that did not succeed as hoped.

MEMBERSHIP COMMITTEE

Membership Committee

The SAACs strive for an artful blend of formal and informal leadership structures. When the Department of Mental Health has need for formal votes the approved members will cast official ballots. Even so, however, a wider sense of stakeholder engagement is desired from the community. The Membership Committee is charged with filling the official membership roster as set forth in the SAAC guidelines while maintaining the overall participation of all interested parties. Once per year, the Membership Committee selects and presents a slate of member candidates for approval by the body as a whole as well as filling vacancies as needed.

Qualifications

Membership Committee leaders should have a broad acquaintanceship with as many participants as possible so as to inform their selections of a potential slate of candidates.

Time and Place

The work of the Membership Committee will mostly occur with meetings beginning in February through March of each year as the Committee prepares its slate of nominees for the June SAAC meeting. Other meetings may be held throughout the year as the need arises to fill vacancies.

Benefits of Becoming a Membership Committee Leader

The Membership Committee expands SAAC capacity and ensures its widest possible diversity as it selects the official members who will express the will of the SAAC participants via balloting.

EXECUTIVE COMMITTEE

Executive Committee

The job of the Executive Committee is to plan the work of the SAAC between meetings of the general membership. The Executive Committee is comprised of the District Chief, the two Co-Chairs, and three SAAC members-at-large. Ideally, one of these members-at-large is a potential future Co-Chair and at least one is a past Co-Chair. This will enhance institutional memory and facilitate excellent leadership.

Qualifications

It is hoped that Executive Committee members have demonstrated a long and steady history of personal participation and leadership in the SAAC and/or the Service Area. Executive Committee members will be persons who are looked upon by the general SAAC membership as persons who are committed to the work of the Department and to the provision of mental health services.

Time and Place

The Executive Committee meets monthly, approximately two weeks prior to the general SAAC meetings and events. These meetings most often are one hour in length, but may be longer as needs present.

Benefits of Becoming an Executive Committee Member

The Executive Committee is a supreme importance as the central guide to the work and advocacy of the SAAC.

CO-CHAIRS

Co-Chairs

Other than the Service Area District Chief, the Co-Chair is the highest leadership position within the SAAC. Co-Chairs serve two-year terms with a maximum of three consecutive terms possible.

Qualifications

To become a Co-Chair, it is hoped that you have exhibited leadership in the SAAC in previous capacities or that you have demonstrated exceptional ability to lead in the Service Area. The qualifications for the Co-Chair are as follows:

- Attend at least 75% of monthly SAAC meetings during each calendar year.
- Be able to commit to serving as Co-Chair for a minimum of twelve (12) months.
- Be familiar with the Service Area.
- Be open-minded, respectful, and collaborative.
- Keep the best of the whole Service Area in mind.
- Adhere to the SAAC vision and mission and DMH Recovery Policy.

Time and Place

The work of the Co-Chairs will occur both within and without the general SAAC meetings and events. Co-Chair automatically is a member of the Executive Committee and as such serve alongside the Mental Health District Chief to plan meetings and execute SAAC business. Co-Chairs also, as the position's name so implies, chair the general SAAC meeting itself.

Benefits of Becoming a Co-Chair

The Co-Chairs are vital leaders of the mental health community of your particular Service Area. They guide, direct, and facilitate the work of the SAAC in conjunction with the District Chief. It is hoped that Co-Chairs arise from the ranks of not only Service Area providers, but from consumers, family members, and concerned citizens alike.

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

The motions below are listed in order of precedence. Any motion can be introduced if it is higher on the chart than the pending motion.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§21 Close meeting	I move to **adjourn**	No	Yes	No	No	Majority
§20 Take break	I move to **recess** for	No	Yes	No	Yes	Majority
§19 Register complaint	I rise to a **question of privilege**	Yes	No	No	No	None
§18 Make follow agenda	I call for the **orders of the day**	Yes	No	No	No	None
§17 Lay aside temporarily	I move to **lay** the question **on the table**	No	Yes	No	No	Majority
§16 Close debate	I move the **previous question**	No	Yes	No	No	2/3
§15 **Limit or extend debate**	I move that debate be limited to ...	No	Yes	No	Yes	2/3
§14 **Postpone to a certain time**	I move to postpone the motion to ...	No	Yes	Yes	Yes	Majority
§13 **Refer** to committee	I move to refer the motion to ...	No	Yes	Yes	Yes	Majority
§12 Modify wording of motion	I move to **amend** the motion by ...	No	Yes	Yes	Yes	Majority
§11 Kill main motion	I move that the motion be **postponed indefinitely**	No	Yes	Yes	No	Majority
§10 Bring business before assembly (a **main motion**)	I move that [or "to"] ...	No	Yes	Yes	Yes	Majority

Jim Slaughter, Certified Professional Parliamentarian-Teacher & Professional Registered Parliamentarian
336-378-1899(W) 336-378-1850(F) P.O. Box 41027, Greensboro 27404 web site: www.jimslaughter.com

Parliamentary Motions Guide

Based on *Robert's Rules of Order Newly Revised (11th Edition)*

Incidental Motions - No order of precedence. Arise incidentally and decided immediately.

YOU WANT TO:	YOU SAY:	INTERRUPT?	2ND?	DEBATE?	AMEND?	VOTE?
§23 Enforce rules	**Point of order**	Yes	No	No	No	None
§24 Submit matter to assembly	I **appeal** from the decision of the chair	Yes	Yes	Varies	No	Majority
§25 Suspend rules	I move to **suspend the rules** which ...	No	Yes	No	No	2/3
§26 Avoid main motion altogether	I **object to the consideration** of the question	Yes	No	No	No	2/3
§27 Divide motion	I move to **divide the question**	No	Yes	No	Yes	Majority
§29 Demand rising vote	I call for a **division**	Yes	No	No	No	None
§33 Parliamentary law question	**Parliamentary inquiry**	Yes (if urgent)	No	No	No	None
§33 Request information	**Request for information**	Yes (if urgent)	No	No	No	None

Motions That Bring a Question Again Before the Assembly - no order of precedence. Introduce only when nothing else pending.

§34 Take matter from table	I move to **take from the table** ...	No	Yes	No	No	Majority
§35 Cancel or change previous action	I move to **rescind/ amend something previously adopted**...	No	Yes	Yes	Yes	2/3 or maj. w/ notice
§37 Reconsider motion	I move to **reconsider** the vote ...	No	Yes	Varies	No	Majority

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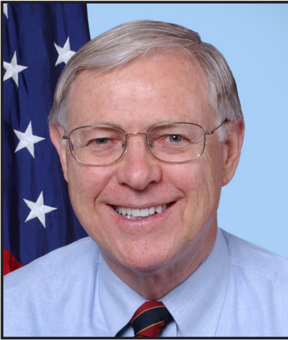
COUNTY OF LOS ANGELES BOARD OF SUPERVISORS

The Board of Supervisors is the governing body of the County of Los Angeles, a charter county. As such, it has the unique function of serving as the executive and legislative head of the largest and most complex county government in the entire United States. A civil service staff which performs the duties for the County departments and agencies serves the needs of the County's population of more than 10 million people.

The Executive Office supports the Board of Supervisors in performing its duties as the governing body of the largest local government in the Nation. In this capacity, the staff of the Executive Office prepares the Board's weekly Agenda and Statement of Proceedings, maintains its official records which date back to the 1850's, and provides technology, accounting, procurement, personnel, payroll, facility management and other administrative services to the Board of Supervisors.

County of Los Angeles Board of Supervisors

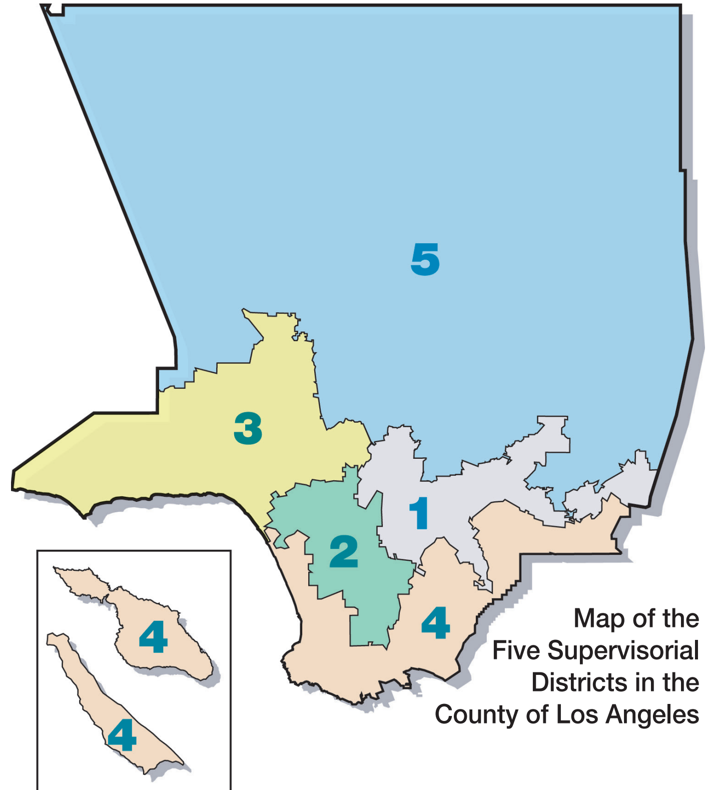
Kenneth Hahn Hall of Administration
500 West Temple Street, Los Angeles CA 90012



Mayor

Michael D. Antonovich

Supervisor, Fifth District
Population: 1,946,135
Square Miles: 2,807
Room 869
213-974-5555
Fax #: 213-974-1010
antonovich.com
E-mail: FifthDistrict@lacbos.org



Map of the Five Supervisorial Districts in the County of Los Angeles

Hilda L. Solis

Supervisor, First District
Population: 1,967,029
Square Miles: 246
Room 856
213-974-4111
Fax #: 213-613-1739
hildalsolis.org
E-mail: FirstDistrict@bos.lacounty.gov

Mark Ridley-Thomas

Supervisor, Second District
Population: 1,977,349
Square Miles: 162
Room 866
213-974-2222
Fax #: 213-680-3283
ridley-thomas.lacounty.gov
E-mail: MarkRidley-Thomas@bos.lacounty.gov

Sheila Kuehl

Supervisor, Third District
Population: 1,956,453
Square Miles: 431
Room 821
213-974-3333
Fax #: 213-625-7360
Website
E-mail: Sheila@bos.lacounty.gov

Don Knabe

Supervisor, Fourth District
Population: 1,971,639
Square Miles: 458
Room 822
213-974-4444
Fax #: 213-626-6941
knabe.com
E-mail: don@bos.lacounty.gov

County of Los Angeles Strategic Plan

The Board of Supervisors approved the County's first Strategic Plan on November 16, 1999. The Plan included a Vision Statement (with Shared Values), four Organizational Goals (Operational Effectiveness, Workforce Excellence, Organizational Effectiveness, and Fiscal Responsibility) and one Programmatic Goal (Children and Family Well-Being). The Board has kept the Plan relevant by periodically assessing progress, reviewing strategic issues impacting the County, and evaluating the need for changes. Since the first Strategic Plan, the following updates have been approved:

- 2002: A County Mission Statement was added, as well as new Strategies for existing Strategic Plan Goals, and three new Programmatic Goals (Community and Municipal Services, Health and Mental Health, and Public Safety).

- 2005: Updates to existing Strategies were included, as well as and several new Strategies.

- 2006: Minor update.

- 2009: This included updates to the County Values and restructuring the Plan from eight to five Goals. The four prior Organizational Goals were combined under a new Goal 1: Operational Effectiveness. The four prior programmatic goals remained with minor revisions as: Goal 2: Children, Family and Adult Well-Being; Goal 3: Community and Municipal Services; Goal 4: Health and Mental Health; and Goal 5: Public Safety. All Goals reflected new Strategies.

- 2010: This update included minor changes to Strategies.

- 2011: This included a significant restructuring of the Strategic Plan, with an expanded Countywide Goal 1 focusing on a limited number of key Initiatives that drive countywide priorities impacting all departments, employees and operations: Human Resource Management, Risk Management, Fiscal Management, and Communications. The Programmatic Goals (Goals 2 through 5) remained part of the County Strategic Plan; however, they were to be developed, tracked, monitored and reported to the Board at the departmental grouping level, coordinated by the CEO, and under the policy guidance of Board offices.

- 2012: This update reflected new updated action plans for Countywide Goal 1 (Operational Effectiveness), and two new Programmatic Goals to replace Goals 2 through 5 (described above). The two new goals focused on: 1) Fiscal Sustainability to ensure a countywide emphasis on fiscal strength and stability, and 2) Integrated Services to emphasize the need for integrated services across all health, human, and public safety service delivery systems. Similar to Goal 1, Goals 2 and 3 focused on a limited number of key programmatic initiatives critical to ensuring the County's mission of providing quality and efficient services. As a result of these changes, increased focus was placed on departmental strategic plans to reflect the unique roles and services each department provides to County residents.

- 2013: This update reflected updated focus areas for areas for Strategic Plan Goal 1 (Operational Effectiveness), Goal 2 (Fiscal Sustainability), and Goal 3 (Integrated Services Delivery). Development, management, and monitoring of work-level action plans were shifted to the appropriate Clusters and/or departments. Regular updates of action plans were to be provided at the appropriate forum, e.g., Strategic Leadership Council meeting, Cluster meetings, budget meetings, etc.

The latest update approved by the Board on June 24, 2014, included the following changes:

- Changed Goal 2 from "Fiscal Sustainability" to "Community Support and Responsiveness" to reflect the County's renewed focus on serving constituents in a proactive and responsive manner;
- Renamed Goal 1 from "Operational Effectiveness" to Operational Effectiveness/Fiscal; Sustainability" to emphasize the County's commitment to both organizational effectiveness and strong fiscal management; and
- Included new and updated strategic initiatives for aforementioned Goals, as well as Goal 3 (Integrated Services Delivery)

Links:

County Strategic Plan Structure
County Strategic Plan Goal 1 – Operational Effectiveness/Fiscal Sustainability
County Strategic Plan Goal 2 – Community Support and Responsiveness
County Strategic Plan Goal 3 – Integrated Services Delivery

County of Los Angeles
Strategic Plan

County Mission

- **To enrich lives through effective and caring service**

County Values

Our **philosophy** of **teamwork** and **collaboration** is anchored in our shared values:

- **Accountability** – We accept responsibility for the decisions we make and the actions we take.
- **Can-Do Attitude** – We approach each challenge believing that, together, a solution can be achieved.
- **Compassion** – We treat those we serve and each other in a kind and caring manner.
- **Customer Orientation** – We place the highest priority on meeting our customers' needs with accessible, responsive quality services, and treating them with respect and dignity.
- **Integrity** – We act consistent with our values and the highest ethical standards.
- **Leadership** – We engage, motivate and inspire others to collaboratively achieve common goals through example, vision and commitment.
- **Professionalism** – We perform to a high standard of excellence. We take pride in our employees and invest in their job satisfaction and development.
- **Respect for Diversity** – We value the uniqueness of every individual and their perspective.
- **Responsiveness** – We take the action needed in a timely manner.

Strategic Plan Goals

1. **Operational Effectiveness/Fiscal Sustainability:** Maximize the effectiveness of processes, structure, operations, and strong fiscal management to support timely delivery of customer-oriented and efficient public services.
2. **Community Support and Responsiveness:** Enrich lives of Los Angeles County residents by providing enhanced services, and effectively planning and responding to economic, social, and environmental challenges.
3. **Integrated Services Delivery:** Maximize opportunities to measurably improve client and community outcomes and leverage resources through the continuous integration of health, community, and public safety services.

Gloria Molina, Supervisor, First District
Mark Ridley-Thomas, Supervisor, Second District
Zev Yaroslavsky, Supervisor, Third District
Don Knabe, Supervisor, Fourth District
Michael D. Antonovich, Supervisor, Fifth District

June 2014

FACTS: Mental Health Commission

State law requires that each county have a Mental Health Board or Commission. Members are appointed by the Board of Supervisors for three-year terms. Those terms may be extended. Commissioners advise the Board of Supervisors and the Director of Mental Health on various aspects of local mental health programs.

- **The role of the commission is established in the Welfare and Institutions Code, under 5604.2.**
- **Review and evaluate the community's mental health needs, services, facilities, and special programs.**
- **Review any county agreements entered into pursuant to Section 5650 W.I.C.**
- **Advise the Board of Supervisors and the local mental health director regarding any aspects of the local mental health programs.**
- **Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.**
- **Submit an annual report to the Board of Supervisors on the needs and performance of the county's mental health system.**
- **Review and make recommendations on applicants for the appointment of the local director of mental health services. The Commission shall be included in the selection process prior to the vote of the governing body.**
- **Review and comment on the county's performance outcome data and communicate its findings to the State Mental Health Planning Council.**
- **Assess the impact of the realignment of services from the state to the county on services delivered to clients and on the local community.**

The Board of Supervisors may transfer additional duties or authority to a mental health board or commission.

Service Area Advisory Committee

Mental Health Commission Public Meeting

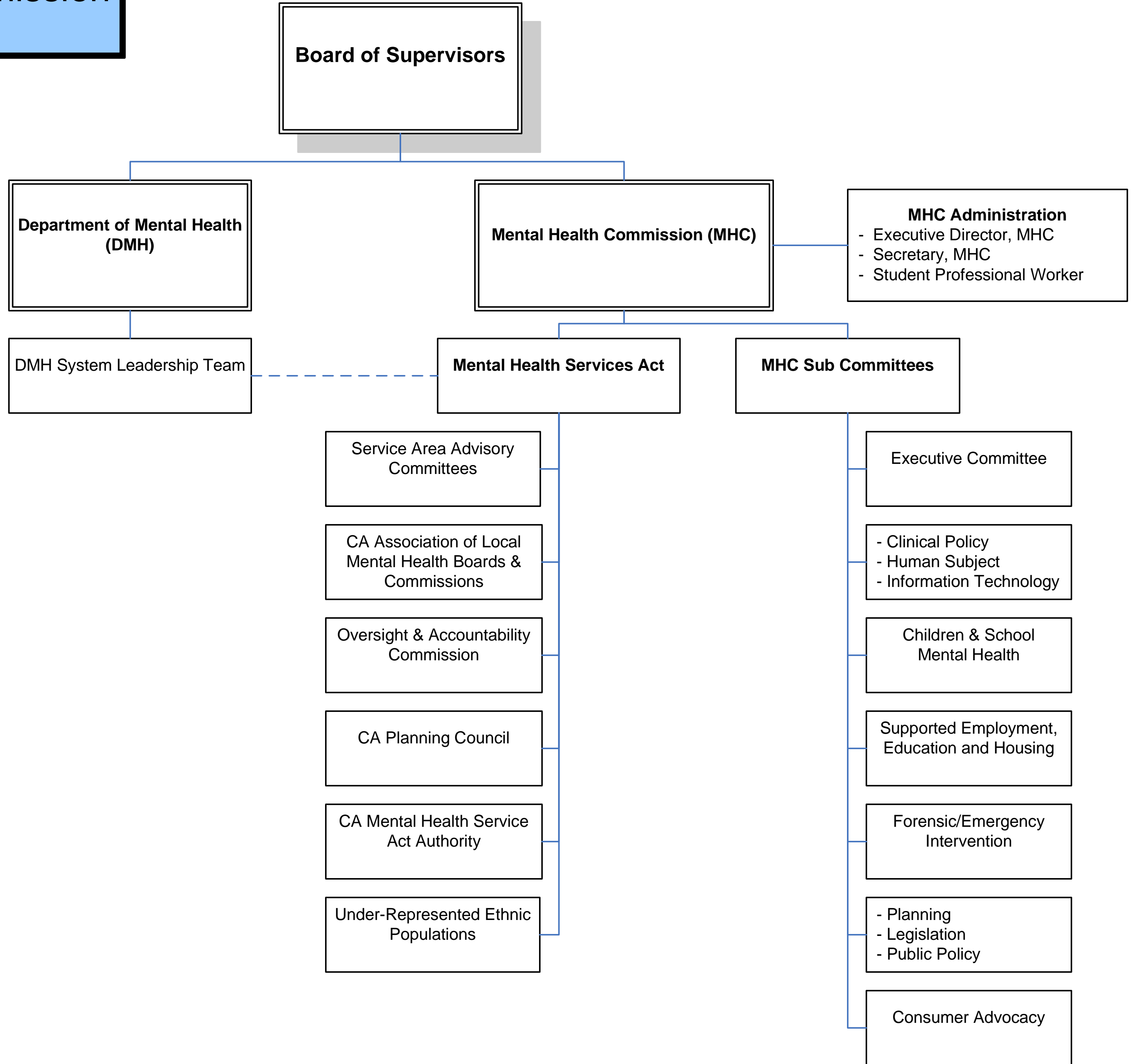
The Los Angeles County Mental Health Commission meets on the fourth Thursday of each month, January through October, and the third Thursday in November and December. Meetings are held from 11:00 A.M. to 1:30 P.M. Most meetings are held in Room 739 of the Kenneth Hahn Hall of Administration, Los Angeles, CA 90012.

The Executive Committee meets the second Thursday of each month, except for the months of November and December the Commission meets on the first Thursday of those two months. The chairperson and the Executive Committee may change the date and time of the Executive Committee. These meetings are held at Department of Mental Health Headquarters, 550 South Vermont, Avenue, Los Angeles, CA 90020

Each December, the Commission meets at a local mental health agency within one of the eight Service Areas. This annual meeting is usually held on the third Thursday of December. The information is updated in the agenda for the public.

For Commission minutes or other information, please call the Commission at (213) 738-4772. Spanish translation services are available.

Los Angeles County
Mental Health Commission



Mental Health Commission Membership

The Los Angeles County Mental Health Commission consists of sixteen members. By law, one member of the Commission must be a member of the Board of Supervisors. Section 5604 W.I.C. sets very specific membership requirements. Fifty percent of the Commission membership shall be consumers or the parents, spouse, sibling, or adult children of consumers, who are receiving or have received mental health services. Consumers constitute at least 20% of the total membership. Families of consumers constitute at least 20% of the membership.

The law also establishes special requirements on ethnic diversity and conflict of interest. Commission membership should reflect the ethnic diversity of the client population in the county and the demographics of the county as a whole, to the extent feasible.

The special requirement in relation to conflict of interest is that “No member of the Commission or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Mental Health, or an employee of, or a paid member of the governing body of a Bronzen - McCorquodale contract agency.”

If you are interested in becoming a member of the Mental Health Commission, contact your Board of Supervisors representative.

First District
Hilda L. Solis (213) 974-4111

Second District
Mark Ridley-Thomas (213) 974-2222

Third District
Sheila Kuehl (213) 974-3333

Fourth District
Don Knabe (213) 974-4444

Fifth District
Michael D. Antonovich (213) 974-5555

Mental Health Commission Sixteen Members

Fiscal Year 2014 -2015
Larry Gasco, PhD, LCSW
Chair

Herman L. DeBose, PhD
Vice-Chair & CALMH/BC Representative

Vacant
Secretary

Barry Perrou, PsyD
Member-at-Large

Victoria A. Sofro
Member-at-Large

Jerry Lubin, FAICP
Past Chair

Districts	Commissioners	Health Deputy
First	Howard L. Askins, MD, JD Lawrence J. Lue Vacant	
Second	Herman L. DeBose, PhD Jo Helen Graham, MA Songhai Miguda-Armstead, JD	
Third	Frank C. Baron Arnold L. Gilberg, MD, PhD Jerry Lubin, FAICP	
Fourth	Larry Gasco, PhD, LCSW Vacant Vacant	
Fifth	Barry Perrou, PsyD Victoria A. Sofro Judy A. Cooperberg, MS, CPRP	Fred Leaf

Service Area Advisory Committee

Los Angeles County – Department of Mental Health

Mental Health Commission Resources

- **National Alliances for the Mentally Ill** – nami.org (1-800-950-NAMI)
- **Los Angeles County Mental Health Commission** - (213) 738-4772
- **Los Angeles County ACCCESS 24 Hour Helpline** (1-800-854-7771)
- **California Mental Health Authority (CalMHSA)** – calmhsa.org (916) 859-4824
- **Mental Health Advocacy Services - mhas-la.org** (213) 389-2077
- **Network of Care** - losangeles.networkofcare.org/mh/
- **California State Legislature** - legislature.ca.gov
- **Suicide Prevention Center Survivor Hotline** (1-877-727-3900)
- **Child Protection Hotline** (1-800-540-4000)
- **Domestic Violence/Safety Plan Hotline** – (1-800-540-4000)
- **Homeless Health Care** – (1-800-564-6600)
- **California Youth Crises Hotline** – (1-800-540-4000)
- **Alzheimer's Association Helpline** – (1-800-272-3900)
- **Elder Abuse Hotline** – (1-800-992-1660)
- **California Association of Local Mental Health Boards/Commissions -** www.calmhb.org
- **Los Angeles Non-Emergency Numbers (Se Habla Espanol)**

  211 – Los Angeles County Info Line

  311 – City of Los Angeles Info Line

  911 – Life threatening emergencies

Service Area Advisory Committee

2015 Commission Meetings Schedule

MHC/SAAC CHAIRS

550 S. Vermont Ave,
Los Angeles, CA 90020
(unless otherwise noted)

January 13
February 10
March 10
April 14
May 12
June 9
July 14
August 11
September 8
October 13
November 10
December 8

2nd Tuesday of each month
from 11:30 am – 1:30 pm

Brown Bag Lunch

EXECUTIVE COMMITTEE

550 S. Vermont Ave
Los Angeles, CA 90020
(unless otherwise noted)

January 8
February 12
March 12
April 9
May 14
June 11
July 9
August 13
September 10
October 8
*November 5
*December 3

2nd Thursday of each month
from 10 am — Noon
*1st Thursday of the month.

FULL COMMISSION

Hall of Administration
500 W. Temple Street, Room 739
Los Angeles, CA 90012

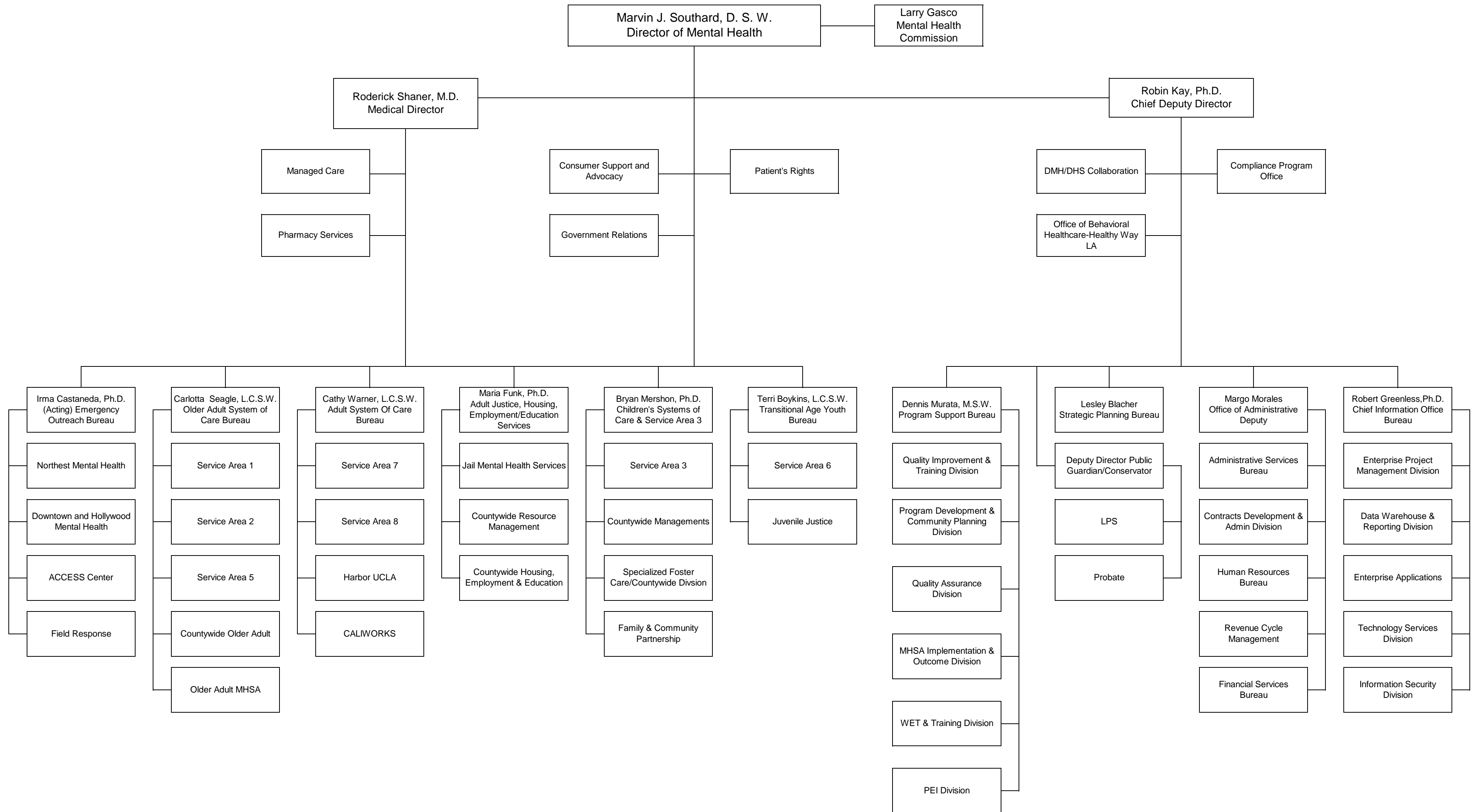
January 22
February 26
March 26
April 23
May 28
June 25
July 23
August (Dark)
September 24
October 22
*November 19
*December 17

4th Thursday of each month
from 11 am — 1:30 pm
*3rd Thursday of the month.

FOR MORE INFORMATION:

Mailing Address: 550 S. Vermont Ave, Suite 1201 A, Los Angeles, CA 90020
Phone: 213 738 4772 ~ Fax: 213 738 2120
Email: mentalhealthcommission@dmh.lacounty.gov

DEPARTMENT OF MENTAL HEALTH
Marvin J. Southard, D.S.W., Director
Fiscal Year 2014-15



1/12/2015

County of Los Angeles
Department of Mental Health

LAC
DMH
LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH

STRATEGIC PLAN

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COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

Strategic Plan FY 2010—2013

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hope wellness recovery

LACDMH Mission

Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

Our Values

Integrity: We conduct ourselves professionally according to the highest ethical standards.

Respect: We recognize the uniqueness of every individual and treat all people in a way that affirms their personal worth and dignity.

Accountability: We take responsibility for our choices and their outcomes.

Collaboration: We work together toward common goals by partnering with the whole community, sharing knowledge, building strong consensus, and sharing decision-making.

Dedication: We will do whatever it takes to improve the lives of our clients and communities.

Transparency: We openly convey our ideas, decisions and outcomes to ensure trust in our organization.

Quality and Excellence: We identify the highest personal, organizational, professional and clinical standards and commit ourselves to achieving those standards by continually improving every aspect of our performance.

Los Angeles County Department of Mental Health is dedicated to partnering with clients, families and communities to create hope, wellness and recovery.

http://dmh.lacounty.gov

Message from the Director

We thank you for your interest in the Los Angeles County Department of Mental Health's 2010-2013 Strategic Plan (LACDMH Plan). In helping to achieve our vision *to partner with consumers, families and communities to create hope, wellness and recovery*, the LACDMH Plan guides the Department's and the Los Angeles County's mission to enrich lives.

The LACDMH Plan is intended to help the Department effectively use the opportunities presented by California's Mental Health Services Act (MHSA) to prepare for the full implementation of the federal Patient Protection and Affordable Care Act (health reform) in 2014. The LACDMH Plan relies on public, private and community partnerships in order to develop and sustain effective integrated services for diverse populations across multiple delivery systems.

We thank all the internal and external stakeholders whose collaboration and input over a nine month period was instrumental in the development and adoption of the LACDMH Plan. Care was taken to align the LACDMH Plan not only with major changes in the field of behavioral health and anticipated changes under health reform, but also with Los Angeles County's overarching strategies. Accountability for achieving the LACDMH Plan's goals has been established through the County's Management Appraisal and Performance Plan process.

The LACDMH Plan focuses on six areas: the quality and capacity of services; health disparities among population groups; social and emotional well-being of communities; diversity and competency of the workforce; fiscal strength of the service delivery system; and the adoption of research and technological advancements. The Department intends to periodically review and update the LACDMH Plan to ensure it reflects changes in governing policies and laws, funding and the Department's progress towards achieving its goals.

We welcome your comments and questions regarding the LACDMH Plan. Together with our partners, we hope to accomplish its goals and build a sustainable, integrated mental health care system that enriches lives in Los Angeles County.

Sincerely,

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

Marvin J. Southard, DSW
Director

About the Department

The Los Angeles County Department of Mental Health (LACDMH) is the largest county mental health department in the country. LACDMH directly operates 75 program sites and more than 100 co-located sites. LACDMH contracts with approximately 1,000 providers, including non-governmental agencies and individual practitioners who provide a spectrum of mental health services to people of all ages to support hope, wellness and recovery.

Our diverse workforce, including nurses, psychiatrists, psychologists, social workers, marriage and family therapists, medical doctors, community workers, trained family members and trained mental health consumers, serve over 250,000 residents of all ages each year.

Mental health services provided include assessments, case management, crisis intervention, medication support, peer support and other rehabilitative services. Services are provided in multiple settings including residential facilities, clinics, schools, hospitals, county jails, juvenile halls and camps, mental health courts, board and care homes, in the field and in people's homes. Special emphasis is placed on addressing co-occurring mental health disorders and other health problems such as addiction. The Department also provides counseling to victims of natural or manmade disasters, their families and emergency first responders. The Director of Mental Health is responsible for protecting patients' rights in all public and private hospitals and programs providing voluntary mental health care and treatment, and all contracted community-based programs. The Director also serves as the public guardian for individuals gravely disabled by mental illness, and is the conservatorship investigation officer for the County.

The Mental Health Services Act (MHSA), created by the passage of Proposition 63 in 2004, has expanded the partnerships and capacity of the mental health system in Los Angeles. LACDMH continues to work with a diverse group of community stakeholders to effect the historic expansion of mental health services funded by MHSA.

LACDMH's services to adults and older adults are focused on those who are functionally disabled by severe and persistent mental illness, including those who are low-income, uninsured, temporarily impaired, or in situational crises. Services to children and youth are focused on those who are seriously emotionally disturbed and diagnosed with a mental disorder. They include wards or dependents of the juvenile court, children in psychiatric inpatient facilities, seriously emotionally disturbed youth in the community, and special education students referred by local schools and educational institutions.

LACDMH Plan Development

The Los Angeles County Department of Mental Health's 2010-2013 Strategic Plan (the LACDMH Plan) was developed through a nine month process that culminated in presenting it to the Board of Supervisors in June 2010.

The factors that shaped the development of the LACDMH Plan were the following:

- The adoption of the Recovery Model for behavioral health care services.
- The impact of nation's and the state's economy on service demand and the budget
- The need to show that programs enrich people's lives (outcomes).
- The opportunities afforded by California's Mental Health Services Act.
- The need to prepare in anticipation of the implementation of federal Patient Protection and Affordable Care Act (health reform) in 2014.

Highlights of the LACDMH Plan's development include:

- Alignment of the LACDMH Plan with major changes in the field of behavioral health. An oversight committee reviewed the Department's last strategic plan, "Comprehensive Community Care" and compared its goals and strategies to those contained in other seminal documents such as the President's New Freedom Commission Report, the Federal Action Agenda, and the Institute of Medicine's "Crossing the Quality Chasm." This review ensured that the LACDMH Plan rested on the foundation of our previous work while we pursue the goals and strategies toward which the mental health field is moving.

- Recognition of major changes that will occur as a result of healthcare reform. The LACDMH Plan includes goals and strategies that highlight the importance of integration of mental health, substance abuse, and primary care. The document also underscores the work that must be done in the area of information technology to prepare for health reform in 2014.

- Involvement of stakeholders in the process. Twenty-three focus groups were held in order to seek input on strategies and objectives. Focus groups were conducted by each of the eight Service Area Advisory Committees. Special groups were held for the Mental Health Commission, NAMI, the Los Angeles Client Coalition, the LACDMH staff advisory committee, other County departments, the coalition of parent advocates, the unions, representatives of primary healthcare and others. Participants provided valuable input which was incorporated into LACDMH Plan.

- Alignment of the LACDMH Plan with the County plan and Management Appraisal and Performance Plan (MAPP) process. The LACDMH Plan is aligned with the overall County plan. MAPP participants have primary responsibility for each of the strategies contained in the LACDMH Plan.

Goal I	**Enhance the quality and capacity, within available resources, of mental health services and supports in partnership with clients, family members, and communities to achieve hope, wellness, recovery and resiliency.**
Strategy 1: Develop a system that provides a balanced and transformed continuum of services to as many clients throughout the County as resources will allow.	
Strategy 2: Provide integrated mental health, physical health and substance abuse services in order to improve the quality of services and well-being of mental health clients.	
Strategy 3: Support clients in establishing their own recovery goals that direct the process of mental health service delivery.	
Strategy 4: Ensure that families are accepted as an important component of the recovery process and provide them with the support to achieve that potential.	
Goal II	**Eliminate disparities in mental health services, especially those due to race, ethnicity and culture.**
Strategy 1: Develop mental health early intervention programs that are accessible to underserved populations.	
Strategy 2: Partner with underserved communities to implement mental health services in ways that reduce barriers to access and overcome impediments to mental health status based upon race, culture, religion, language, age, disability, socioeconomics, and sexual orientation.	
Strategy 3: Develop outreach and education programs that reduce stigma, promote tolerance and compassion and lower the incidence or severity of mental illness.	
Goal III	**Enhance the community's social and emotional well-being through collaborative partnerships.**
Strategy 1: Create partnerships that advance an effective model of integration of mental health, physical health and substance abuse services to achieve parity in the context of health care reform.	
Strategy 2: Create, support, and enhance partnerships with community-based organizations in natural settings such as parks and recreational facilities to support the social and emotional well-being of communities.	
Strategy 3: Increase collaboration among child-serving entities, parents, families and communities to address the mental health needs of children and youth, including those involved in the child welfare system.	
Strategy 4: Further strengthen the partnerships among mental health, the courts, probation, juvenile justice and law enforcement to respond to community mental health needs.	
Strategy 5: Support and enhance efforts to provide services in partnership with educational institutions from pre-school through higher education.	
Strategy 6: Develop partnerships with faith-based organizations to enhance opportunities for clients to utilize their spiritual choices in support of their recovery goals.	

Goal IV	**Create and enhance a culturally diverse, client- and family-driven, mental health workforce capable of meeting the needs of our diverse communities.**
Strategy 1: Train all mental health staff in evidence-based, promising, emerging and community-defined mental health practices.	
Strategy 2: Recruit, train, hire, and support mental health clients and family members at all levels of the mental health workforce.	
Strategy 3: Create and provide a safe and nurturing work environment for all employees that supports and embodies client-centered, family-focused, community-based, culturally and linguistically competent mental health services.	
Strategy 4: Identify and support best practices for recruitment and retention of diverse and well-qualified individuals in the mental health workforce.	
Goal V	**Maximize the fiscal strength of our mental health system.**
Strategy 1: Implement tools, processes, and mechanisms to enhance critical DMH business functions that maximize effectiveness without negatively impacting the fiscal viability of community agencies.	
Strategy 2: While maintaining quality, manage and maximize available revenue by ensuring claiming to appropriate funding sources.	
Strategy 3: Identify and fully utilize new and/or non-traditional mental health funding sources outside of our current federal and State resources.	
Strategy 4: Create partnerships with mental health stakeholders to advocate for enhanced revenues that support fiscal stability.	
Strategy 5: Implement risk management strategies that ensure the safety and health of employees and clients.	
Goal VI	**Use research and technological advancements to improve and transform services and their delivery in order to enhance recovery and resiliency.**
Strategy 1: Continuously utilize outcome data and research findings to improve practice.	
Strategy 2: Support opportunities to implement the latest advancements in research and technology to improve service delivery.	
Strategy 3: Develop secure electronic medical records that will enable appropriate care coordination.	
Strategy 4: Use data and performance-based management methods to improve planning, decision-making and organizational accountability.	

Los Angeles County Board of Supervisors

Gloria Molina, First District
Mark Ridley-Thomas, Second District
Zev Yaroslavsky, Third District
Don Knabe, Fourth District
Michael D. Antonovich, Fifth District

William T Fujioka, Chief Executive Officer Los Angeles County

Los Angeles County Department of Mental Health

Marvin J. Southard, D.S.W., Director
Robin Kay, Ph.D., Chief Deputy Director
Roderick Shaner, M.D., Medical Director

Los Angeles County
Department of Mental Health
550 South Vermont, 12th Floor
Los Angeles, CA 90020

http://dmh.lacounty.gov

DEPARTMENT OF MENTAL HEALTH MANAGEMENT STRUCTURE

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213.738.4613

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213.738.4603
Rshaner@dmh.lacounty.gov
Olivia Cadena, Secretary
213.738.4612

SERVICE AREA DEPUTY/DISTRICT CHIEF/MEDICAL DIRECTOR DISTRIBUTION

Deputy Directors	Dist. Chiefs/ Med. Directors	Programs	Phone	Email Address
Cathy Warner	**Adult System of Care/SAs 7 & 8**			
213.738.2756	Ana Suarez	**SA 7** Southeast	213.738.3499	ASuarez@dmh.lacounty.gov
CWarner@dmh.lacounty.gov	Youngsook Kim-Sasaki	**SA 8** South Bay	562.435.2337	YKimSasaki@dmh.lacounty.gov
Secretary	Wendi Tovey	ASOC Operations	213.738.4142	WTovey@dmh.lacounty.gov
213.738.3940	Dolorese Daniel	CalWORKs, DPSS Co-located	213.738.2819	Ddaniel@dmh.lacounty.gov
	Dr. Stephen Jacobson	Harbor/UCLA MH Programs	310.222.1643	sjacobson@dmh.lacounty.gov
	Dr. Karen Lee	Regional Medical Director, **SA 7, SA 8** & ASOC	213.738.3572	kalee@dmh.lacounty.gov
Irma Castaneda	**Emergency Outreach Bureau/SA 4**			
213.738.4924	Edward Vidaurri	**SA 4** Admin/Navigation Team/Specialized FC	213.738.4924	Evidaurri@dmh.lacounty.gov
ICastaneda@dmh.lacounty.gov	Miriam Brown	PMRT **SA 1-4**/ Law Enforcement/SMART/START/MET	213.738.3412	Mbrown@dmh.lacounty.gov
Maria DeVera	LaTina Jackson	PMRT **SA 5-8**/ HOME	213.738.3433	LTJackson@dmh.lacounty.gov
213.738.2862	Stacy Williams	Downtown MHC, Hollywood MHC & Skid Row Mgmt Team	213.922.8121	SWillliams@dmh.lacounty.gov
	Anthony Alvarado	Northeast MHC, Northeast Wellness Center	323.478.8200	AAlvarado@dmh.lacounty.gov
	Dr. James Jones	Regional Medical Director, **SA 4** & EOB	213.738.4000	Jajones@dmh.lacounty.gov

Updated: 8/04/15

Deputy Directors	Dist. Chiefs/ Med. Directors	Programs	Phone	Email Address
Bryan Mershon	**Children's Systems of Care/SA 3**			
213.738.2147	Alfredo Larios	**SA 3** CSOC	213.739.5455	ALarios@dmh.lacounty.gov
BMershon@dmh.lacounty.gov	Robert Byrd	CSOC Countywide Services	213.739.2334	RByrd@dmh.lacounty.gov
Annette Mendoza	Sam Chan	Family & Community Partnerships - Birth to 5, PEI	213.739.5427	SChan@dmh.lacounty.gov
213.738-2148	(Vacant)	Program Administration/MHSA	213.739.5403	
	Gregory Lecklitner	Child Welfare Division	213.739.5466	Glecklitner@dmh.lacounty.gov
	Dr. William Arroyo	Regional Medical Director, **SA 3 & CSOC**	213.738.6152	warroyo@dmh.lacounty.gov
Carlotta Childs-Seagle	**Older Adults System of Care/SAs 1, 2 & 5**			
213.738.4851	JoEllen Perkins	**SA 1 Palmdale Geographic Admin.**	661.223-3827	jperkins@dmh.lacounty.gov
CChildsSeagle@dmh.lacounty.g	Eva Carrera	**SA 2 Child Administration**	213.739.5538	ecarrera@dmh.lacounty.gov
La Sonne Jackson	Lisa Wong	**SA 2 Adult Administration**	818.610.6707	lwong@dmh.lacounty.gov
213.738.4852	**Jacquelyn Wilcoxen**	**SA 5 West LA Geographic Initiative**	310.482.6601	jwilcoxen@dmh.lacounty.gov
	Kevin Tsang	Older Adult System of Care Bureau / GENESIS	213.739.7347	ktsang@dmh.lacounty.gov
	Martin Jones	Older Adult MHSA Specialty Programs	213.639.6002	mjones@dmh.lacounty.gov
	Dr. Sarah Gelberd	Regional Medical Director, **SA 1**	**213.351.5268**	sgelberd@dmh.lacounty.gov
	Dr. Carol Eisen	Regional Medical Director, **SA 2, SA 5** & OASOC	213.738-3400	ceisen@dmh.lacounty.gov
Dennis Murata	**Program Support Bureau/MHSA Administration**			
213.738.4978	Debbie Innes-Gomberg	MHSA/Implementation	213.251.6817	Digomberg@dmh.lacounty.gov
DMurata@dmh.lacounty.gov	Naga Kasarabada	Quality Improvement/INN/Cultural Competence/ URCP	213.251.6885	Nkasarabada@dmh.lacounty.gov
Camille Mehaffie	Brad Bryant	Quality Assurance	213.738.2289	BBryant@dmh.lacounty.gov
213.738.4925	Lillian Bando	MHSA/PEI	213.251.6710	LBando@dmh.lacounty.gov
	Angelita Diaz-Akahori	MHSA/WET	213.251.6876	Adiaz@dmh.lacounty.gov
Terri Boykins	**Transition-Age Youth System of Care (TAY-SOC)/SA 6**			
213.738.2408	Karen Streich	Juvenile Justice-Camps & Halls	213.738.2895	Kstreich@dmh.lacounty.gov
tboykins@dmh.lacounty.gov	Elena Farias	**SA 6** West Central MH	310.668.3962	efarias@dmh.lacounty.gov
Cherilyn Cody	Elena Farias	**SA 6** Specialized Foster Care Program	310.668.3962	efarias@dmh.lacounty.gov
213.738.2193	Elena Farias	**SA 6** Augustus F. Hawkins & Compton Mental Health	310.668.3962	efarias@dmh.lacounty.gov
	Yolanda Whittington	**SA 6** Administration	213.738.4753	ywhittington@dmh.lacounty.gov
	Christopher Thompson	Juvenile Justice Halls - Medical Director	213.738.2078	cthompson@dmh.lacounty.gov
	Hanumantha Damerla	Juvenile Justice Camps – Medical Director	213.738.2902	hdamerla@dmh.lacounty.gov
	Lori Willis	Juvenile Justice Transition Aftercare Services	213.351.7733	lwillis@dmh.lacounty.gov
	Dr. James Jones	Regional Medical Director, **SA 6**	213.738.4000	jajones@dmh.lacounty.gov

Updated: 8/04/15

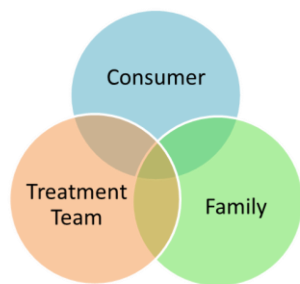
COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

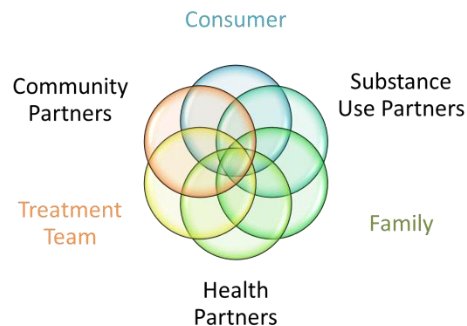
OFFICE OF CONSUMER AND FAMILY AFFAIRS

Consumers, family members, friends, multidisciplinary teams and community partners each have a distinct perspective and expertise on mental health. The recovery journey is the equal responsibility of all partners. Each unique contribution should be respected, heard, supported and valued as essential components to quality integrated behavior health care. Our Consumer and Family Affairs staff are dedicated to quality improvement which support service excellence for all community stakeholders and healthier neighborhoods.

Purpose: To provide communication and collaboration within the mental health culture for improving the treatment of mental illness.

Mission: To support recovery principles, mentorship models, resiliency strategies, community education, relationship building and system problem solving across the mental health field.





Consumer Choice

Consumers are people who live with behavioral health conditions which affect their day to day activities. Many experience stigma from within themselves and also from the larger community. Being accepted as a person with a behavioral health condition is not an easy undertaking and usually requires support and understanding from others.

Service Area Advisory Committee

Family Engagement

Consumers often want support from people in the community and consumers define their support system which includes consumer identified "family". Families need support and encouragement as much as the person who is in recovery because the changes that affect their loved one with mental illness, also impacts the family as a functioning system.

Treatment Team

Each consumer drives his/her recovery and is the focus of the Interdisciplinary Team's efforts. This team includes and requires participation from the consumer, professionals from diverse disciplines, and family members. Effective communication amongst all team members is essential to work towards the common consumer driven recovery goal.

Patients' Rights Office

550 South Vermont Ave, 6th Fl., Rm. 608, Los Angeles, CA 90020 800-700-9996 or 213-738-4888

Why the Office of Patients' Rights?

The Office of Patients' Rights was created in response to state legislation requiring the mental health director of each county to appoint patients' rights advocates to protect and further the Constitutional and Statutory rights of mental health clients.

Whose interests do Patients' Rights Advocates serve?

Patients' Rights Advocates protect the rights of mental health clients as outlined by Federal Law, State Regulation and County Guidelines.

What the Office of Patients' Rights Does

- Investigates and resolves complaints
- Represents involuntarily detained individuals in Probable Cause and Medication Hearings
- Provides training regarding mental health laws and patients' rights
- Collects data regarding denial of rights and involuntary detention
- Monitors mental health facilities for compliance with patients' rights laws, regulations and policies

Specialized Programs and Services

Representation at Certification Review/Probable Cause & Riese Medication Capacity Hearings

Patients' Rights Advocates travel to hospitals throughout Los Angeles County representing patients at administrative hearings. These hearings are held to determine if a patient meets criteria for extended involuntary hospitalization (14-day and 30-day holds) and to determine if a patient has capacity to make an informed decision whether or not to take psychiatric medications.

Beneficiary Services Program

- Investigates and responds to grievances/complaints regarding directly operated clinics, contract agencies and affiliates
- Assists with appeals and State Fair Hearings and provides advocacy and mediation services
  213-738-4949

Residential Advocacy Program

- Enhances the quality of life for mental health clients in all types of residential housing through advocacy and mediation

Specialized Programs and Services Cont.

Jail Advocacy Program

- Provides support and a voice for mental health inmates
- Investigates and responds to inmates' complaints
- Educates Jail Mental Health staff on patients' rights issues
  213-738-4888

Minors' Advocacy Program

- Specializes in issues regarding minors' rights and parents' rights/responsibilities

IMD Program

- Works directly with IMD clients, providers, family and interested parties
- Monitors IMDs for compliance with patients' rights laws, regulations and policies

Project Search

- Assists families and friends in finding missing mental health clients without violating clients' privacy or HIPAA regulations

Training & Consultation

- Provides training and educational presentations to clients, providers and interested parties

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

EMERGENCY OUTREACH BUREAU

FIELD RESPONSE OPERATIONS

Through the Department of Mental Health (DMH) Emergency Outreach Bureau (EOB), there are Emergency Response Teams (ERT) comprised of DMH staff specialized in providing field response to critical incidents such as school violence, earthquakes, or acts of terror. ERT provides on-scene consultation and crisis intervention services to survivors and their families, victims, first responders, and the community at large. In a major event, ERT collaborates with the Los Angeles County Office of Emergency Management and the Los Angeles City Office of Emergency Management.

Psychiatric Mobile Response Teams (PMRT)

Psychiatric Mobile Response Teams (PMRT) consist of DMH licensed clinical staff assigned to a specific Service Area in Los Angeles County. Teams have legal authority per Welfare and Institutions Code (WIC) 5150 and 5585 to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder.

Law Enforcement Teams (LET)

This co-response model pairs a DMH clinician with a law enforcement officer to provide field response to situations involving mentally ill, violent or high risk individuals. Primary mission is to provide 911 response to community requests or patrol officer requests for service. Teams also assist PMRT as resources permit. Current programs:

- Santa Monica Police Department Homeless Liaison Program (HLP)
- Burbank Police Department Mental Health Evaluation Team (BMET)
- Los Angeles County Sheriff's Department Mental Evaluation Team (MET)
- Long Beach Police Department Mental Evaluation Team (Long Beach MET)
- Los Angeles County Metropolitan Transit Authority Crisis Response Unit (CRU)
- Pasadena Police Department Homeless Outreach Psychiatric Evaluations (HOPE)

- Los Angeles Police Department Case Assessment and Management Program (CAMP)

- Los Angeles Police Department Systemwide Mental Assessment Response Team (SMART)

School Threat Assessment and Response Team (START)

START provides threat prevention and management services to educational institutions in collaboration with school districts, colleges, universities and technical school, and local, county, and Federal law enforcement agencies. The program provides services designed to prevent targeted school violence.

Homeless Outreach Mobile Engagement (HOME)

HOME provides countywide field-based outreach and engagement services to unserved homeless persons who are mentally ill, living in homeless persons who are mentally ill, living in homeless encampments, and other locations where outreach is not provided in a concentrated manner.

Mental Health Alert Team (MHAT)

MHAT collaborates with federal and local law enforcement agencies to provide mental health response to SWAT call-outs. Clinical staff collaborate with law enforcement in facilitating a negotiated solution to barricade and hostage situations.

Special Prevention Unit (SPU)

SPU provides collaboration with federal and local law enforcement agencies to mitigate threats, decrease use of the 911 system and provide linkage and case management to the mental health system. SPU addresses persons of concern including 911 high utilizers, chronic callers to public figures, suicide-by-cop issues.

Emergency Response Teams (ERT)

Emergency Response Teams (ERT) are comprised of DMH staff that provide field response to critical incidents such as school violence, earthquakes, or acts of terror. ERT provides on-scene consultation and crisis intervention to survivors, their families,

first responders, and the community. ERT collaborates with the LA County Office of Emergency Management and the LA City Office of Emergency Management.

Homeless Outreach Teams (HOT)

Homeless Outreach Teams (HOT) are comprised of PMRT staff who provide outreach, engagement, and field response to mentally ill homeless persons. HOT serves to increase the likelihood of effective outcomes for this population in situations when they are at risk of involuntary hospitalization.

Psychiatric Emergency Teams (PET)

Psychiatric Emergency Teams (PET) are mobile teams operated by psychiatric hospitals approved by the Department of Mental Health to provide 5150 and 5585 evaluations. Team members are licensed mental health clinicians. PET operates similar to PMRT and provides additional resources in specific geographical regions.

Links:

Disasterservices@dmh.lacounty.gov

http://dmh.lacounty.gov

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

OLDER ADULTS SYSTEM OF CARE

County of Los Angeles Department of Mental Health provides a range of programs and services designed for older adults (60+) who reside in Los Angeles County. Mental Health services are available through directly operated and contract agencies throughout the County. Services in these agencies typically involve screening and assessment, case management services, individual and family treatment and crisis intervention services.

As a result of the Mental Health Services Act, often referred to as "Prop 63", new programs and services have been added; these include: Field Capable Clinical Services (FCCS) and Full Service Partnership (FSP).

Links

Field Capable Clinical Services (FCCS)

Full Service Partnerships (FSP)

Older Adult Complete FSP Guidelines

Older Adult FSP Referral-Authorization From

Older Adults FSP Brochure (English)

Older Adult FSP Brochure (Spanish)

Older Adult FSP Brochure (Arabic)

Older Adult FSP Brochure (Armenian)

Older Adult FSP Brochure (Chinese)

Older Adult FSP Brochure (Farsi)

Older Adult FSP Brochure (Korean)

Older Adult FSP Brochure (Russian)

Older Adult FSP Brochure (Samoan)

Older Adult FSP Brochure (Tagalog)

Older Adult FSP Brochure (Vietnamese)

Older Adults FSP Summary of Referrals Authorized by Countywide

New short-term treatment models are now available; these evidence-based practices include the following:

- Crisis Oriented Recovery Services
- Group Cognitive Behavioral Therapy
- Interpersonal Therapy
- Problem Solving Therapy
- Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)
- Seeking Safety

Community presentations for seniors and senior caregivers are available through the Older Adult Specialty Programs. These psycho-educational are designed to address basic mental wellness and suicide prevention. Attached are two training menus that describe the options that are available.

LAC DMH Partners in Suicide Prevention (PSP) Training Menu

Training/Presentation	Length of Time	Audience	Description
Suicide Prevention Training for Service Providers	2 hours	Providers (Directly or contracted mental health agencies, hospitals, educational facilities, etc.)	All age group information included, general risk factors, risk assessment, prevention (strength based focused) and intervention. Video included. * 2 CEUs
Question, Persuade and Refer (QPR) (Specifically for non-mental health professionals)	2.0 hours	Community Based Organizations (schools, clergy, parents, etc)	Suicide First Aid for gatekeepers. Audience will learn how to question, persuade and refer someone to get help.
Promoting Emotional Well-Being in Senior Living Communities	45 – 60 minutes	Seniors in senior living communities, senior centers and adult day health care centers.	Late life depression, warning signs, resources and activities to improve emotional well-being. Available in English, Spanish. Farsi and Korean language
Applied Suicide Intervention Skills Training (ASIST)	2 days	ANYONE over the age of 15	Suicide First Aid. Helps all kinds of caregivers learn suicide first aid intervention. *13 CEUs for BBS, BRN, 13 CE for Psychologist
Mental Health First Aid (MHFA)	8 hours over the course of 2 days	Community Based Organizations including key professionals such as police officers, primary care workers, faith communities, college representatives, etc. *Must be over 18 years of age to participate	Overview of mental illness and substance use disorders in the U.S. and risk factors & warning signs of mental health problems. Teaches participants a 5 step action plan to help someone with a mental health problem or experiencing a mental health crisis.
Recognizing and Responding to Suicide Risk (RRSR)	2 days	Health and Mental Health Professionals	Advanced interactive training for clinicians. Teaches effective assessment and management for suicide risk * 12 CEUs for BBS, BRN, 12 CE for Psychologists

"Every Californian is Part of the Solution"

If you would like to learn more about any of the above trainings or to make a training request, please contact us at:
Suicideprevention@dmh.lacounty.gov

10/30/14

THE MENTAL WELLNESS SERIES

Health, Wellness, and Wholeness

Discover how staying emotionally and physically fit can keep you healthy and give you a positive attitude. Learn how establishing social networks and support can benefit you, your friends, your family and the community in which you live.

Depression and Anxiety

Learn to recognize the symptoms of depression and anxiety in seniors. Find out what contributes to these problems and what needs to be done when you or someone you love suffers from depression or anxiety.

Preserving your Memory

As we age we have moments of forgetfulness. Useful tips and brain exercises to sharpen your thinking and keep moments of forgetfulness to a minimum.

Good Sleep for Emotional Well-Being for older adults

Getting a good night's sleep is key for emotional well-being. Learn about the importance of sleep and get helpful tips on healthy sleep habits.

Hoarding

Learn to identify the differences between collecting, cluttering, and hoarding, and the need for treatment for those who might have a significant problem.

Promoting Emotional Well-being

Learn about symptoms of depression, warning signs of suicide and recommendations for emotional well-being.

Managing your Medication

Learn the importance of sticking to your medication regimen and other useful information on the proper use of medications. Get tips on what to ask your doctor and pharmacist when you get a new prescription.

Resiliency

We all have challenging events that occur in our lives, but how can we better cope with the stress of these life events? Resilience is an ability that can be developed in anyone. Learn tips on cultivating this valuable skill.

Substance Use

Learn about the different forms of substance use and how the use of substances can affect seniors physically and emotionally. Find out how substance use can impact the effect of your prescribed medications.

Bullying

Bullying can occur at any time throughout our lives. Learn how to recognize it and tips on what to do if you feel it's happening to you.

Holiday Blues

Holidays can be a challenging time for seniors who have suffered losses or who are feeling alone and without family or social support. This seasonal presentation discusses strategies to combat feelings of sadness or "the blues" during the winter holidays.

If you are interested in scheduling any of these classes, please feel free to contact our team from the Older Adult System of Care Bureau listed below:

Lisa Nunn (213) 738-2315 lnunn@dmh.lacounty.gov

10/29/14

County of Los Angeles Department of Mental Health
Older Adult (OA) Partners in Suicide Prevention Training Menu

Training/Presentation	Length of Time	Description
Training/Presentation for Non-professionals (community-based organizations, faith-based organizations, volunteers or senior citizens)		
Suicide Prevention	90min – 2 hours	Suicide prevention education including all age group information
Suicide Prevention for Older Adults	1 hour	OA related suicide facts and prevention.
	2 hours	Exercises and vignettes added
Promoting Emotional Well-being in the Senior Living Community (Suicide Prevention Workshop for Seniors)	45minutes	Using of SAMHSA Suicide Prevention Toolkit for Senior Living Communities (English/Spanish/Farsi/Korean available)
Training/Presentation for Gatekeepers and Human Service Providers		
Suicide Prevention for Older Adults	60-90min	OA related suicide facts and prevention.
	2 hours	Exercises and vignettes added. *2CEUs available for BBS, BRN, CAADAC and Psychologists*
QPR (Question, Persuade and Refer) Training	1-2hours	Designed for gatekeepers/1st responders Require min 10 to max 30 participants. Role plays included in 2-hour training.
Training for Mental Health Professionals/Students		
Suicide Prevention for Older Adults	1 hour	OA related suicide facts and prevention.
	2 hours	Risk assessment, exercises and vignettes added. *2CEUs available for BBS, BRN, CAADAC and Psychologists*
	2-3 hours	College/University students
Training for Anyone in the Community		
ASIST (Applied Suicide Intervention Skills Training)	2 days (8:30am to 4:30pm)	Suicide First Aid *13 CEUs available for BBS, BRN, CAADAC* Visit our DMH website for registration: http://lacdmh.lacounty.gov/training&workforce.html

If you would like to learn more about any of the above trainings or to make a training request, please contact us.

Jae Won Kim, LCSW (213) 738-2304 email: jkim@dmh.lacounty.gov
Aileen Montoya, MCW (213) 738-2303 email: amontoya@dmh.lacounty.gov

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

ADULT SYSTEM OF CARE

Los Angeles County Department of Mental Health Adult System of Care provides an array of mental health and supportive services for clients, between the ages of 26 and 59, who live with serious mental illness and co-occurring substance use disorders. Mental health services are available through directly operated and contract agencies throughout the County.

Services typically provided in these agencies are assessment, therapy, medication, case management/brokerage, crisis intervention, and other supportive services related to housing, prevocational and employment. These services are intended to reduce psychiatric symptoms, increase independent functioning and self-reliance so that individuals can achieve the fullest and most productive life.

The Recovery Model is the framework for all adult services and is based on the belief that adults diagnosed with a mental illness can lead productive lives by seeking and maintaining meaningful relationships through employment, education, or volunteer work, and participating fully in their community.

As a result of Mental Health Services Act (MHSA), additional services are available to create a full continuum of care for clients with a different level of mental health needs and recovery goals. Current Adult MHSA programs range from the most intensive services, which include Full Service Partnerships (FSP) and Field Capable Clinical Services (FCCS), to Wellness Centers and Client Run Services that are designed to support clients who are in later stages of recovery. Through MHSA, ASOC also provides specialty services to our Veterans through the VALOR project. Finally, ASOC provides specialty mental health services to families and individuals returning to work through the Cal Works and GROW programs.

Adult Full Service Partnership Program

Adult Full Service Partnership (FSP) programs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive service program. The foundation of Full Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness. Full Service Partnerships embrace client driven services and supports with each client choosing

services based on individual needs. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability, field capability, and a team approach that is a partnership between mental health staff and consumers.

Adult FSP programs assist with housing, employment and education in addition to providing mental health services and integrated treatment for individuals who have a co-occurring mental health and substance abuse disorder. Services can be provided to individuals in their homes, the community and other locations. Peer and caregiver support groups are available. Embedded in Full Service Partnerships is a commitment to deliver services in ways that are culturally and linguistically competent and appropriate.

Adult Field Capable Clinical Services

FCCS programs provide specialized mental health services delivered by a team of professional and Para-professional staff. The focus of FCCS is working with community partners to provide a wide range of services that meet individual needs. FCCS team members work outside the clinic in community settings with their partners to addresses mental health and other life needs, with a primary focus on overall health and building supportive community relationships. Community partnerships may be established at local health clinics, domestic violence shelters, refugee or cultural centers, community centers, and homeless shelters. The FCCS program is designed to provide services to individuals who are isolated, unwilling or unable to access traditional mental health outpatient services due to location/distance barriers, physical disabilities, or because of the stigma associated with receiving clinic-based services.

Adult Wellness and Client Run Centers

Wellness Centers provide recovery focused outpatient services for Adults. Services are collaboratively delivered by a team of professionals and Peer Specialists to assist individual clients in realizing their own recovery goals. Services include medication, community service linkage, clinical treatment groups, self-help groups, and assistance with life needs such as housing, employment, education, spirituality, and connection with the community. Adult Wellness programs are designed to provide services to individuals who are able to access services on site, and follow up with care needs.

Client Run Centers are 100% Peer-Run service centers that provide individual and

group services to consumers and community members seeking support. Client Run Centers offer linkages to community resources and a safe and supportive environment to promote healing and recovery.

Veterans Services

Approximately 30% of returning Operation Iraq Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) Veterans will meet full criteria for Post-Traumatic Stress (PTSD), Substance Use and Abuse, Depression, and/or will struggle with Anxiety-related challenges. This does not include our Veterans from wars and military actions long forgotten. Almost 40% of the homeless in the Los Angeles County are Veterans, which is the largest population of veterans in the United States. In order to reduce veteran homelessness in Los Angeles County, and prevent other consequences from untreated mental and physical challenges from our nation's existing and returning heroes, the VALOR (Veterans and Loved Ones Recovery) program has been established to aid our nation's current and forgotten heroes. The services provided by the VALOR program include the following: Benefit Establishment, Employment and Education Assistance, Peer Support, Collaboration with other Veteran Service Organizations, Referral for Children and Family Support, and Housing for the Homeless.

Prevention and Early Intervention Services

Adult PEI services focus on evidence-based, promising or community defined evidence practices, education, support, and outreach to help inform and identify those who may be affected by some level of mental health issue. Specifically, early intervention services are directed towards individuals and families for whom a short-term (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health situation early in its manifestation. Early intervention services may avoid the need for more extensive mental health treatment, or prevent the mental health problem from becoming worse.

CalWORKS

Department of Public Social Services' CalWORKs Program provides temporary financial assistance and employment services to eligible families with minor children. Eligible families may receive cash aid, Medi-Cal benefits and food stamps. Most parents receiving CalWORKs aid are required to participate in a comprehensive welfare-to-work

program entitled "Greater Avenues For Independence", commonly referred to as GAIN.

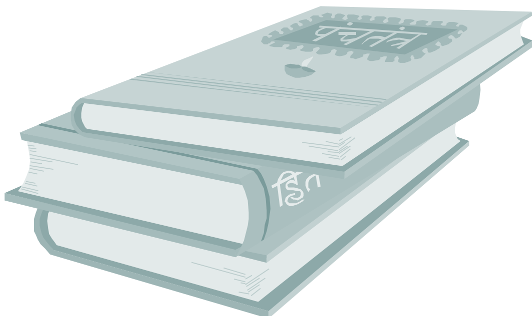
When needed, CalWORKs participants may receive specialized supportive services which include mental health, substance abuse and/or domestic violence treatment services. Twenty-two Department of Mental Health directly-operated clinics and thirty contracted mental health agencies are authorized to provide CalWORKs mental health supportive services to eligible CalWORKs participants. CalWORKs mental health supportive services differ from traditional outpatient treatment as the focus of treatment is specifically designed to remove mental health barriers to employment. The long-term goal of treatment is employment and self-sufficiency, and the emphasis in the therapeutic process is on managing the symptoms and functional impairments identified as preventing the client from working.

DMH CalWORKs Program Administration is responsible for monitoring the fidelity of the CalWORKs mental health program in the clinics and agencies county-wide.

EMPLOYMENT AND EDUCATION

CHEERD provides oversight of the employment and education services in DMH clinics and the State Department of Rehabilitation/Department of Mental Health Cooperative Agreement. CHEERD develops resources and provides training and technical assistance to those providing employment and education services throughout the mental health system including the Mental Health Services Act funded Full Service Partnership and Wellness Center Programs. Employment services include vocational assessments and assistance with job development, placement and retention. CHEERD has facilitated the development of partnerships with programs throughout the County including Los Angeles Unified School District, WorkSource Centers, community colleges, adult education and apprenticeship programs.

CHEERD manages a website resource that is updated daily with job and educational opportunities: www.wcrc.pbwiki.com. Look for the employment and education link on the right side of the web page.



12/0414

Los Angeles County Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

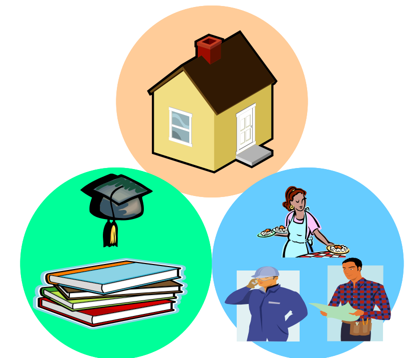
Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

County of Los Angeles — Department of Mental Health
Countywide Housing, Employment
and Education Resource Development
695 South Vermont Avenue, 10th Floor, Los Angeles, CA 90005
213-251-6582
CHEERD@dmh.lacounty.gov

COUNTYWIDE HOUSING, EMPLOYMENT & EDUCATION RESOURCE DEVELOPMENT



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Marvin J. Southard, D.S.W.
Director

CHEERD
Maria Funk, Ph.D., District Chief
695 South Vermont Avenue, 10th Floor
Los Angeles, CA 90005
213-251-6582
CHEERD@dmh.lacounty.gov

COUNTYWIDE HOUSING, EMPLOYMENT AND EDUCATION RESOURCE DEVELOPMENT

Los Angeles County Department of Mental Health (DMH), Countywide Housing, Employment and Education Resource Development (CHEERD) provides administrative oversight, management, and technical support to those who assist consumers of DMH services with the following:

- Temporary Shelter Program
- Federal Housing Subsidies Program
- Affordable Housing
- Countywide Housing Assistance Program
- Employment and Education Services

Consumers can access these resources through their service providers.

CHEERD also provides training and advocacy and develops new housing, employment and education resources for the mental health system, and the community. The Division's services are considered essential to supporting the wellness and recovery of consumers as they reclaim their hopes, dreams, and aspirations.

For more information go to:

dmh.lacounty.gov

Look for Housing or Employment and Education under Our Services

TEMPORARY SHELTER PROGRAM

The Temporary Shelter Program provides short-term basic living support services to consumers and their families who are homeless or at risk of becoming homeless. Basic living support services include a safe and clean shelter bed and general staff oversight on a 24-hour basis, three meals a day and appropriate toiletries. The program is limited to consumers who lack sufficient financial resources to pay for housing, and who need a temporary place to stay while a plan for permanent housing is implemented.

Referrals for the Temporary Shelter Program are made by the consumer's Service Coordinator to the Service Area Gatekeepers.

FEDERAL HOUSING SUBSIDIES

DMH has Shelter Plus Care grants and Homeless Section 8 Housing Choice Vouchers from the City and County Housing Authorities. These programs provide Federal housing subsidies to make units affordable for consumers who pay a limited percentage of their income as rent, with the balance of the rent paid to the owner by the Housing Authority. Consumers need to meet the definition of homelessness and income threshold criteria set by Housing and Urban Development (HUD). For the Shelter Plus Care Program, supportive services equal in cost to the dollar amount of the rent paid by the Housing Authorities are required to be provided to participating consumers.

Referrals are submitted on behalf of the consumer by the Housing Liaison.

AFFORDABLE HOUSING

CHEERD's Housing Policy and Development Unit oversees the MHSA Housing Program and the MHSA Housing Trust Fund which provide funding for Permanent Supportive Housing.

- The MHSA Housing Program provides capital development and operating subsidies for Permanent Supportive Housing for individuals who are homeless and mentally ill.
- The MHSA Housing Trust Fund Program provides funding for supportive services in Permanent Supportive Housing.

Applications are submitted to the Housing Policy and Development Unit on behalf of the consumer by their Service Coordinator or Housing Specialist.

HOUSING ASSISTANCE PROGRAM

The Housing Assistance Program assists DMH consumers with funds for security deposits, household goods and eviction prevention. Consumers accessing these resources must be homeless or at risk of homelessness and have limited or no income.

Applications are submitted to the Housing Policy and Development Unit on behalf of the consumer by their Case Manager or Housing Specialist.

Partnering with Clients, Families and Communities to Create Hope, Wellness and Recovery

Ending Homelessness: The Work of the Los Angeles County Department of Mental Health

Background

Since the early 1990s, Los Angeles County Department of Mental Health (LACDMH) has recognized and embraced its responsibility to ending homelessness for individuals with mental illness. A variety of strategies have been developed and implemented in order to effect positive change in our community. These strategies include:

- Developing specialized community-based programs that are equipped to serve the complex needs of homeless individuals with mental illness.
- Increasing housing resources (such as Permanent Supportive Housing) that will expand the available and desirable housing options for our clients.

Developing Specialized Community-Based Programs that Target the Homeless Population

Homeless Outreach Teams

These teams provide outreach and engagement services to the homeless population with the goal of linking them to on-going mental health, physical health and other community services.

CalWORKS Homeless Families Project

This project assists homeless families receiving CalWORKS assistance with transitioning into permanent housing.

Full Service Partnership Programs

These programs serve clients of all ages with intensive needs, including those who are homeless, and provide services that support recovery.

Housing Trust Fund

This funding is used to provide supportive services to LACDMH clients living in Permanent Supportive Housing (PSH).

Project 50/60, Street-to-Home and Other Similar Projects

These projects target the most vulnerable individuals who are homeless and mentally ill, and use a housing first model to assist them with obtaining and maintaining affordable permanent housing.

Innovation Integrated Mobile Health Team

These field-based teams provide integrated health, mental health and substance abuse services to the most vulnerable individuals and families that are homeless, using a housing first model to assist them with obtaining and maintaining affordable permanent housing.

Increasing the Housing Resources Available to Clients

Permanent Supportive Housing

Mental Health Services Act (MHSA) Housing Program

This program provides capital and operating funds for the development of PSH dedicated to LACDMH clients.

Facilitating Partnerships Between PSH Developers and Mental Health Service Providers

These efforts assist PSH developers in meeting the requirement of making services available to tenants that are homeless and mentally ill who live in their units, which increases the number of PSH units available to this population.

Federal Housing Subsidy

This program secures grants from the City and County Housing Authorities that provide Shelter Plus Care certificates and Homeless Section 8 vouchers for PSH for LACDMH clients that meet the Housing and Urban Development (HUD) definition of homelessness.

Rental Assistance

This program provides funding for security deposits, household goods and eviction prevention for LACDMH clients who are homeless or at risk of homelessness and have limited or no income.

Temporary Shelter

This program provides short-term basic living support services to consumers and their families who are homeless or at risk of becoming homeless.

MHSA Housing Program Five Year Anniversary at The Villas at Gower Grand Opening Ceremony, November 2012
(Marvin J. Southard, D.S.W., Darrell Steinberg, California State Senate President pro Tem, Robin Kay, Ph.D.)

Housing Resources Fact Sheet

(As of June 30, 2013)

Federal Housing Subsidies

- LACDMH applies for new grants annually.
- LACDMH has 11 grants with the City and County of Los Angeles Housing Authorities for Shelter Plus Care, Tenant Based Supportive Housing, and Homeless Section 8:
  - 928 Shelter Plus Care certificates
  - 226 Homeless Section 8 vouchers
  - 100 Tenant Based Supportive Housing vouchers
  - 91% retention rate for Shelter Plus Care
  - In FY 2011-12, LACDMH assisted 269 clients with submitting applications to the Housing Authorities resulting in a lease-up rate of 86%.
    - 78% Chronically Homeless
    - 81% Individuals
    - 19% Families
  - In FY 2012-13, LACDMH assisted 271 clients with submitting applications to the Housing Authorities resulting in a lease-up rate of 74%.
    - 88% Chronically Homeless
    - 91% Individuals
    - 10% Families

Rental Assistance

- In FY 2011-12, 1,200 were served.
- In FY 2012-13, 1,224 were served.

MHSA Housing Program

- LACDMH invested $115 million in 2007 and added $2 million in 2012.
- $111.6 million is currently obligated.
- Leveraged over $400 million of local, state and federal funding.
- Partnering with 21 housing developers.
- Projects in each Service Area and Supervisorial District.
- 37 projects are in various stages of development.
- 1,714 total units, including 849 MHSA units.
- 19 projects are completed with 556 MHSA units occupied.

MHSA HOUSING PROGRAM PROJECTS

Age Group	Number of Projects	Number of Units
Transitional Age Youth (TAY)	8	91
Adults (Including Older Adult Units)	15	442
Older Adults	6	141
Families (Including Single Adults & TAY)	5	116
Families	3	59
Total	**37**	**849**

Temporary Shelter Program

- LACDMH contracts with 19 providers.
- 30 different shelter sites throughout the county.
- In FY 2011-12, 443 unique clients were served.
- In FY 2012-13, 447 unique clients were served.

COURTHOUSES SERVED BY THE COURT LIAISON PROGRAM

CLARA SHORTRIDGE FOLTZ (CCB)
Nancy Corona, RN
(213) 974-2963

COMPTON
Amanda Garrick, LCSW
(310) 603-8077

EAST L.A./WEST COVINA
Sylvia Luna, LPT
(626) 403-4381
(323) 780-2075 East LA

SAN FERNANDO/NEWHALL
Ruben Vargas, LCSW
(818) 898-2490 – San Fernando

PASADENA
Tonya Jewell, LCSW
(626) 356-5374

EL MONTE/ DOWNEY
Sandra Lepe, LCSW
(626) 403-4370

AIRPORT COURT
Cynthia Reston-Parham, PhD
(626) 403-4370

LONG BEACH
Cinthya Alcaraz, LCSW
(562) 247-2529

VAN NUYS
Jennifer Miele, LCSW
(818) 374-2349

BURBANK/GLENDALE
Sandra Bautista-Lechner, LCSW
(626) 403-4370

POMONA
Arlene Veliz, MSW
(213) 258-6829 - BB

NORWALK/BELLFLOWER
Theresa Arredondo, LCSW
(562) 804-8219

TORRANCE/INGLEWOOD
Kendall Saddler, LCSW
(310) 222-4067 - Torrance

ANTELOPE VALLEY
Monica Jacobs, RN
(661)974-7408

10/29/14

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT

MENTAL HEALTH COURT LINKAGE PROGRAM

COURT LIAISON PROGRAM
(626) 403-4370

A problem solving collaboration between the Los Angeles County Superior Court and the Los Angeles County Department of Mental Health

Marvin J. Southard, D.S.W.
Director

Program Overview

The Court Liaison Program serves adults with mental illness who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice system and mental health systems, improve access to mental health services and supports, reduce incarceration time and enhance continuity of care.

SERVICES:

- Onsite courthouse outreach to defendants
- Individual service needs assessment
- Develop post release plans which take into account court outcomes and stipulations
- Inform consumers and the court of appropriate treatment options
- Link consumers to treatment programs and expedite mental health referrals
- Present treatment alternatives on behalf of consumers during court proceedings
- Provide support and assistance to defendants and families in navigating the court system

Referral Process

Referrals can be initiated with the individual court liaison listed on the back. Please make contact with the liaison as soon as a defense attorney has been appointed.

DEFENDANT ELIGIBILITY FACTORS

- Established Mental Illness or Co-Occurring Substance Disorder
- Over 18 years of age
- Readiness to engage in treatment

LEGAL ELIGIBILITY FACTORS

- Pre-sentenced criminal case status
- Alternative sentencing is at the discretion of the court
- Defense attorney and client approval required for services
- Treatment cannot be court ordered
- Exclusions: Convictions requiring registration

Frequently Asked Questions

Is the CLP the same as the Mental Health Court (Court 95)

No, Court 95 is a civil court where conservatorships and competency hearings are held. The CLP serves individuals with mental illness at Superior Courts throughout L.A. County.

Can a defendant be "court ordered" into mental health treatment?

Mental health treatment is offered on a voluntary basis with the exception of defendants declared "incompetent to stand trial."

How do I seek psychiatric services for someone in jail?

The Los Angeles County Sheriffs website has specific directions on how to make a referral www.lasd.org

Additional information

Access-24 hr. MH Hotline
800 854-7771

Public Defender
213 974-2811

Dept. of Mental Health
Office of Family Engagement
213-738-3948

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MENTAL HEALTH COURT LINKAGE PROGRAM

COURT LIAISON PROGRAM

The Court Liaison Program is a problem-solving collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of 14 mental health clinicians who are co-located at 22 courts countywide. This recovery based program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The Court Liaison Program further aims to provide ongoing support to families and to educate the court and the community at large regarding the specific needs of these individuals. Participation is voluntary and available to those 18 and above. Funding is provided by the Mental Health Services Act (MHSA/Prop 63).

Services include:

- On-site courthouse outreach to defendants
- Individual service needs assessment
- Inform consumers and the Court of appropriate treatment options
- Develop alternative and post-release plans that take into account best fit treatment alternatives and Court stipulations
- Link consumers to treatment programs and expedite mental health referrals
- Advocate for the mental health needs of consumers throughout the criminal proceedings
- Provide support and assistance to defendants and families in navigating the court system

1370.01 PC PROGRAM

In collaboration with the Jail Mental Health Program, the 1370.01 PC Program seeks to expedite stabilization of misdemeanor defendants found incompetent to stand trial under Penal Code 1370.01. The program provides 1370.01 PC defendants direct linkage from the Los Angeles County Mental Health Court/Department 95 to treatment and restoration of competency at either the Misdemeanors Incompetent to Stand Trial (MIST) Program in Jail, or in the community.

COMMUNITY REINTEGRATION PROGRAM

The Community Reintegration Program offers mentally ill defendants community-based treatment as an alternative to incarceration. Prior to the disposition of their criminal court case, defendants who desire mental health treatment may be referred by the Court to participate in one of two specialized treatment programs. These specialized programs focus on providing rehabilitation skills and reintegration into the community. A total of 67 beds are available for defendants who reside at these programs from six months to one year. For these community reintegration residential services, DMH contracts with Olive Vista -- a locked licensed skilled nursing facility, and Gateways Residential Program -- an unlocked IMD step-down facility.

CO-OCCURRING DISORDERS COURT PROGRAM

The Co-Occurring Disorders Court (CODC) is a specially-designated court program created to rehabilitate criminal defendants experiencing both mental illness and substance disorders. Many of the defendants also experience chronic homelessness. The CODC Program is offered to non-violent criminal defendants with co-occurring mental health and substance addiction disorders who voluntarily agree to participate in an 12-to-18 month comprehensive, court-supervised COD treatment program. Residential and outpatient treatment services are provided by a DMH-contract Full Service Partnership (FSP) provider. The CODC represents a unique partnership between the criminal justice system, the drug treatment community, and the mental health community. The CODC began operating as a pilot program in April 2007, and is funded by the County of Los Angeles, Homeless Prevention Initiative, and Mental Health Services Act.

AB109 REVOCATION COURT PROGRAM

The Mental Health Court Linkage Program, under the oversight of DMH Countywide Resource Management, staffs a team of 7 clinicians at the Bauchet Court. This team is tasked with conducting real-time on-site screenings and level of care recommendations for the Court on behalf of Post-Release Supervised Persons who have mental illness or co-occurring disorders. These efforts are accomplished in conjunction with both the Jail Mental Health Services discharge planners and the Countywide Resource Management administrative staff.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH COURT LINKAGE PROGRAM

COURT LIAISON PROGRAM

Service Area 1 / Antelope Valley

ANTELOPE VALLEY
MONICA JACOBS (661) 974-7408

Service Area 2 / San Fernando Valley

BURBANK / GLENDALE
SANDRA BAUTISTA-LECHNER (626) 403-4370

SAN FERNANDO / SANTA CLARITA
RUBEN VARGAS (818) 898-2490

VAN NUYS
JENNIFER MIELE (818) 374-2349

Service Area 3 / San Gabriel Valley

EL MONTE
SANDRA LEPE (626) 403-4370

PASADENA
TONYA JEWELL (626) 356-5374

POMONA
ARLENE VELIZ (213) 258-6829

WEST COVINA / EAST LOS ANGELES
SYLVIA LUNA (323) 780-2075 (ELA)

Service Area 4 / Metropolitan Los Angeles

FOLTZ CRIMINAL JUSTICE CENTER (CCB)
NANCY CORONA (213) 974-2963

Service Area 5 / West Los Angeles

SANTA MONICA / LAX / BEVERLY HILLS
CYNTHIA RESTON-PARHAM (626) 403-4370

Service Area 6 / South Los Angeles

COMPTON
AMANDA GARRICK (310) 603-8077

INGLEWOOD
KENDALL SADDLER (310) 222-4067

Service Area 7 / Southeast Los Angeles

NORWALK / BELLFLOWER
THERESA ARREDONDO (562) 804-8219

DOWNEY
SANDRA LEPE (626) 403-4370

Service Area 8 / South Bay

LONG BEACH
CINTHYA ALCARAZ (562) 247-2529

TORRANCE
KENDALL SADDLER (310) 222-4067

COMMUNITY REINTEGRATION PROGRAM

(626) 403-4370

CO-OCCURRING DISORDERS COURT PROGRAM

NICOLE RILLO (213) 842-4610
ADRIENNE GEE (626) 403-4370

PC 1370.01 PROGRAM

SABRINA DIBIAGIO (323) 226-8061

AB109 – REVOCATION COURT

(626) 403-4370

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CHILDREN'S SYSTEM OF CARE

In Los Angeles County, Children's System of Care is dedicated to enriching the lives of children and their families who are 0 to 15 years old experiencing mental health challenges by providing a wide range of client-centered family-focused services. Our goals are to:

- Provide quality, strength based mental health services to children;
- Help children achieve success at school and in the community;
- Strengthen and empower family relationships by fostering hope, wellness and resiliency.

Children and families may access mental health services through a network of County-operated and contracted agencies providing services in the Antelope Valley, San Gabriel Valley, Metro Los Angeles, West Los Angeles, Central Los Angeles, Southeast Los Angeles and Long Beach/South Bay areas.

Children's Programs Include

Child Welfare Division Services

Children's Full Services Partnership

Children's Field Capable Clinical Services

Family and Community Partnerships

Therapeutic Behavioral Services

Child Welfare Division

The Child Welfare Division of the Los Angeles County Department of Mental Health was created as part of the Enhanced Specialized Foster Care Mental Health Services Plan. The division represents a centralized DMH administrative structure, supported by Service Area administrative linkages, to provide overall oversight and coordination of countywide activities related to the provision of mental health services for children and youth in the county's child welfare system. This unit works bring the county system into

compliance with the requirements of the 2003 settlement agreement related to the Katie A. lawsuit.

Treatment Foster Care (TFC)

Created by the Department of Children and Family Services (DCFS) as an alternative to congregate care, the program places foster children in homes with specially trained foster parents who are matched to the specific needs of the youth. The program uses a team approach to provide services and the foster parents are considered to be active participants in the treatment planning process. The program has two different models, Intensive Treatment Foster Care (ITFC) and Multidimensional Treatment Foster Care (MTFC) with the latter being an evidenced-based practice developed by TFC, Inc. in Oregon.

For more information, please contact the program's supervisor, G. Kaliah Salas, PsyD at (213) 739-5473 or by e-mail at gsalas@dmh.lacounty.gov.

Multidisciplinary Assessment Team (MAT)

The Multidisciplinary Assessment Team (MAT) is an exciting collaborative effort between the Department of Children and Family Services (DCFS), the Department of Mental Health (DMH), and other Community Mental Health Providers. When a child is newly detained by the court, and removed from his/her family of origin, he/she is eligible for a MAT assessment. The MAT assessment is designed to make sure that all child and family needs are assessed as a child/youth enters foster care.

Intensive Field Capable Clinical Services (IFCCS)

Developed to meet the needs of DCFS-involved youth who have significant symptoms and behaviors that may lead to frequent placement disruptions, IFCCS was created as the county's first phase of implementation of Intensive Care Coordination and Intensive Home Based Services. IFCCS initiates a rapid response to children and youth who are discharging from psychiatric hospitals, have come through the DCFS Children's Welcome Center or Youth Welcome Center, have had a response from the Psychiatric Mobile Response Team (PMRT), or have had contact with the Exodus Urgent Care Centers. The primary function of IFCCS is to form a Child and Family Team, identify and assess underlying needs, and help bring in resources to help meet those needs.

For more information, please contact the program supervisor, G. Kaliah Salas, PsyD at (213) 739-5473 or by e-mail at gsalas@dmh.lacounty.gov.

Family Preservation

Created by the Department of Children and Family Services (DCFS), Family Preservation is an integrated, comprehensive approach to strengthening and preserving families who are at risk or are already experiencing problems in family functioning with the goal of assuring the physical, emotional, social, educational, cultural and spiritual development of children in a safe and nurturing environment. Children and families receiving Family Preservation services can also be referred to mental health services from a designated Family Preservation Mental Health Provider.

For more information about the mental health services provided through Family Preservation, please contact the program's supervisor, G. Kaliah Salas, PsyD at (213) 739-5473 or by e-mail at gsalas@dmh.lacounty.gov.

Wraparound Program - Mental Health Services

Wraparound provides access to an array of comprehensive mental health services. Service delivery objectives are to assist youth in returning home and successfully remaining home; preventing future disruption or placements, symptom reduction as well as overall improvement of family functioning and preventing psychiatric hospitalization. Each child, adolescent, and family enrolled in Wraparound will participate as a driving force in the development of their treatment plan, and as an ongoing partner in the implementation and review of their plan.

For more information on Wraparound, please contact Shirley Robertson, LCSW, Supervisor at (213) 739-5462 or by email srobertson@dmh.lacounty.gov.

Children's Full Service Partnership

The Children's Full Service Partnership (FSP) program is a unique intensive in-home mental health service program for children ages 0 – 15 and their families. Child FSP providers are dedicated to working with children and their families to assist them plan

and accomplish goals that are important to the health, well-being, safety and stability of the family.

If you have questions regarding the referral process or how the FSP program works, please contact the Impact Unit in your area.

Antelope Valley	(661) 223-3800
San Fernando Valley	(818) 610-6737
San Gabriel Valley	(626) 455-4599
Metro Los Angeles	(213) 922-8123
West Los Angeles	(310) 482-6610
South Central Los Angeles	(213) 351-7268
Southeast Los Angeles	(213) 738-2900
Long Beach/South Bay	(562) 435-2078

Children's Field Capable Clinical Services

Children's Field Capable Clinical Services (C-FCCS) are specialty mental health services for children ages 0-15 and their families who may want services outside of traditional mental health settings. Services are delivered in a variety of settings including schools, health centers and community centers. The program focuses on children who may have:

Experienced trauma, school failures, a suicide risk, foster care or juvenile justice involvements, a history of psychiatric hospitalizations or are at risk for psychiatric hospitalization, a diagnosed co-occurring substance abuse, developmental or medical disorder.

For questions please contact Kanchana Tate, LCSW at (213)739-5481 or by email ktate@dmh.lacounty.gov.

Family and Community Partnerships

The Family and Community Partnerships (FCP) administrative unit strengthens system and community capacity to address the mental health needs of children and their families, contributes to related workforce, program and policy development, and promotes strategic investments in perinatal, infant, early childhood, and school-based mental health. This unit does not provide direct mental health services but supports the following programs and partnerships:

- Prenatal to Five;
- PEI Evidenced-Based Practices for Children;
- School-based Mental Health;
- Partners in Suicide Prevention;
- Stigma and Discrimination Reduction.

For assistance or any information regarding FCP's programs, please call 213-739-5428.

Therapeutic Behavioral Services

TBS is an intensive, individualized, one-to-one behavioral mental health service available to children/youth with serious emotional challenges and their families, who are under 21 years old and have full-scope Medi-Cal.

The following lists the eligibility criteria for TBS services:

- Child/Youth is placed in a group home facility of RCL 12 or above or in a locked treatment facility for the treatment of mental health needs; or
- Child/Youth is being considered by the county for placement in a facility described above; or
- Child/Youth has undergone at least one emergency psychiatric hospitalization related to his/her current presenting mental health diagnosis within the preceding 24 months; or

•Child/Youth has previously received TBS while a member of the certified class; or

•Child/youth is at risk of psychiatric hospitalization.

For more information, contact Zoe Trachtenberg LCSW, ztrachtenberg@dmh.lacounty.gov or at (213) 739-2394.

Hospital Discharge Planning – Children's Inpatient Clinical Case Management CICCM

The primary responsibility of the CICCM Unit is to participate in discharge planning conferences for DCFS and Probation minors who are being discharged from directly operated and county-contracted psychiatric hospitals.

The conferences include one of the CICCM case managers, DCFS host, a representative from the hospital, the minor's CSW, SCSW, and frequently, the minor's mental health provider or group home staff. Often, a representative of the minor's attorney participates as well.

The goal of these conferences is to develop an appropriate discharge plan for the hospitalized youth. The DMH case manager collaborates with DCFS and mental health staff to determine what mental health services the minor needs to best reduce the chance of re-hospitalization and to provide the youth with stability in the community.

Recommendations include referrals to intensive mental health programs such as Intensive Field Clinical Capable Services, Full Service Partnership, or Wraparound. Other recommendations include referring a minor for Therapeutic Behavioral Service (TBS), recommending presentation of the youth to the RCL level 14 screening committee, or referrals for assessment for Regional Center or services. The CICCM case manager provides the necessary follow up to ensure linkage to mental health services. This includes completing referrals or following up with CSW's, group home providers to verify linkage to appropriate services or verifying mental health services with previous provider.

For more information, contact Renee Thompson, Mental Health Clinical Supervisor, RThompson@dmh.lacounty.gov, (213) 739-2337

SB785 Out of County

Senate Bill (SB) 785 is intended to facilitate the receipt of medically necessary specialty mental health services needed for a foster child who is placed outside of their county of origin.

DMH, in consultation with stakeholders, established a standardized contract and documents to be used by all mental health plans and providers when requesting and authorizing specialty mental health services.

DMH staff facilitate the receipt of medically necessary specialty mental health services needed for a foster child up to age 21, who is placed outside of their county of origin and has full scope Medi-Cal.

For more information, contact Christy Maeder, Mental Health Clinical Program Head, CMaeder@dmh.lacounty.gov, (213) 739-2345

Interagency Screening Committee

Meeting that consolidate and coordinate of the public agency decision making structures for children and adolescents with chronic and persistent mental, emotional, and behavioral disorders for whom placement in an RCL-14 Group Home or Community Treatment Facility (CTF) is indicated. The goal of ISC is to ensure placement and transition of the most difficult to serve children and adolescents of Los Angeles County in the most appropriate and least restrictive environment.

For more information, contact Bart Callender, Mental Health Clinical Supervisor, BCallender@dmh.lacounty.gov, (213) 739-2399.

Infant and Early Childhood Mental Health services draw from the strengths of a variety of disciplines.

All service providers must have specialty training and use a relationship-based approach.

10/29/14

Developed by the
Infancy, Childhood and Relationship Enrichment (ICARE) Steering Committee

For further information, contact:
Los Angeles County Department of Mental Health Family and Community Partnerships / Child PEI Unit
(213) 739-5428

082514

Infant and Early Childhood Mental Health

All parents want what is best for their children. Sometimes, family experiences or behaviors in very young children require specialized help. Infant and early childhood mental health treatment programs may provide the help you need.

What is Infant and Early Childhood Mental Health?

Infant and Early Childhood Mental Health is a comprehensive approach to the social and emotional well-being of very young children. Positive relationships between young children and adults lay the foundation for healthy social and emotional development. This foundation allows children to:

- experience a range of emotions, cope with frustrations, and regulate their behaviors
- safely explore and learn from their environments
- feel protected in the context of their families, neighborhoods, and cultures

Types of Infant and Early Childhood Mental Health Services

- Therapy for the child and the parent and primary caregiver together (dyadic therapy)
- Family therapy
- Dyadic education with videotaped feedback
- Assessment services
- Parent support groups
- Therapeutic preschool programs
- Relationship-based therapeutic interventions
- Home visiting
- Coordination with schools, other service agencies, and professionals
- Training and consultation for parents and professionals

When should an infant or young child be referred to a treatment program?

Here are some examples of emotional and behavioral signs that may show a need for evaluation for infant and early childhood mental health services.

Consider an evaluation if a child:

- has long-term sleeping or feeding problems
- is overly fussy or irritable
- is crying all the time, unable to be consoled
- is extremely upset when left with another adult
- doesn't pay attention to caregivers or is willing to go home with anyone
- is unable to adapt to new situations
- is easily startled or alarmed by routine events
- is unable to establish relationships with other children or adults
- hits, bites or pushes other children or is very withdrawn
- doesn't respond to consequences or tries to please too much
- has any other behaviors that concern the caregivers

Parents give the following reasons for seeking specialized infant and early childhood mental health treatment services

- "Learning that my son has behavior problems."
- "The way my child handles animals, very rough."
- "To know if my child had physical and mental problems like me."
- "To learn parenting skills."
- "Behavior problems, fight among siblings."
- "Playing hard, hitting, talking back."
- "Wanting to learn how to care for my child better and know how she is developing."

Here are some conditions that may increase the risk of problems which could benefit from early childhood mental health services:

- Premature birth
- Very low birthweight
- Prenatal exposure to alcohol or drugs
- Failure to Thrive (FTT)
- Abuse or neglect
- Developmental delays or disabilities
- Speech and language problems
- Physical disabilities
- Multiple foster placements
- Domestic violence
- Alcohol or drug use in the home

Community Partners

We provide consultation to diverse partners, organizations, and communities and participate in multiple countywide and local networks that include:

- DMH Birth to Five Service Area Collaboratives
- Transdisciplinary Leadership Consortium
- First 5 LA
  - Prenatal to Five Workforce Development Project
  - Best Start LA
- LA Partnership for Early Childhood Investment
- Perinatal Mental Health Task Force Systems Change Workgroup
- Policy Roundtable for Child Care and Development
- LA County Strengthening Families Learning Community
- Magnolia Community Initiative
- School-based Mental Health Service Area Collaboratives
- Mental Health Provider EBP Networks
- DMH System Leadership Team Standing Committee on Innovative Projects

This program does not provide direct mental health services.

For further information, contact:

Los Angeles County
Department of Mental Health
Children's System of Care
Family and Community Partnerships Program

(213) 739-5428

10/29/14

082514

Los Angeles County
Department of Mental Health

Family & Community Partnerships and Child PEI

What We Do

- Strengthen system and community capacity to address the mental health needs of children and their families
- Contribute to related workforce, program and policy development
- Promote strategic investments in infant and early childhood, and school-based mental health

We do this through the following programs:

- **Prenatal to Five**
- **PEI Evidenced-Based Practices (EBPs) for Children**
- **School-based Mental Health**
- **Partners in Suicide Prevention**
- **Stigma and Discrimination Reduction**

Prenatal to Five

The **Prenatal to Five** program strives to strengthen the socio-emotional well-being of young children and their families through mental health promotion, prevention, and early intervention.

Main Activities: Countywide and Service Area capacity-building for perinatal, infant, and early childhood mental health and family support:

- Networking
- Resource-sharing
- Collaborative learning opportunities
- Workforce development
- Clinical practice
- Service delivery
- Funding opportunities
- Local, statewide and national policy issues

This includes: hosting **I**nfancy, **C**hildhood **A**nd **R**elationship **E**nrichment (**ICARE**) sessions and the ICARE Steering Committee; and supporting the Service Area Birth to Five Coordinators.

Our staff also links DMH with selected community initiatives, networks and systems related to maternal and child health, child development, early care and education, health care, and the Regional Centers for the developmentally disabled.

Evidence-Based Practices (EBPs) for Children

California's Mental Health Services Act (MHSA) funds Prevention and Early Intervention (PEI) services and programs that include Evidence-Based Practices (EBPs) designed for priority populations.

Our unit's "Practice Leads" provide support for mental health providers who are implementing parent/caregiver and child-focused EBPs. This support includes:

- Coordination of Training
- Consultation
- Technical assistance
- Program Evaluation

Among the EBPs that staff manage are: Child-Parent Psychotherapy (CPP), Incredible Years (IY), Nurse-Family Partnership (NFP), Parent-Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Positive Parenting Program (Triple P). Other practices for children and youth include Crisis Oriented Recovery Services (CORS) for children and Managing and Adapting Practice (MAP).

This unit also administers the First 5 LA grant-supported PCIT Project.

School-based Mental Health

Through its directly operated programs and contract providers, DMH offers mental health services to public schools in Los Angeles County.

We provide technical assistance and guidance to DMH Service Area leadership and school partners to promote best practices in the delivery of school-based mental health services.

Our School Mental Health staff:

- Support DMH Service Area School-based Mental Health Coordinators by convening regular meetings and providing individual consultation
- Develop administrative policies and protocols to guide the delivery of school-based mental health services and maintain data bases that include a county-wide list of the schools where mental health services are provided
- Represent DMH in the School Health Center Policy Roundtable and the School Attendance Task Force
- Provide countywide coordination and technical assistance for the Integrated School Health Center (ISHC) project and participate in related meetings and workgroups

Partners in Suicide Prevention (PSP) Team for Children

The **PSP Team** is dedicated to increasing public awareness of suicide and reducing stigma associated with seeking mental health and substance abuse services. The team offers:

- Education and Trainings
- Appropriate suicide prevention resources
- Linkage and referrals to age- appropriate services

The **PSP Team** also supports the:

- Youth Suicide Prevention Project – consists of a website for school personnel in LA County and targeted outreach activities to selected school districts
- Los Angeles County Suicide Prevention Network – includes advocates, providers, researchers, survivors, and representatives from multiple agencies and whose vision is to "promote public and professional awareness, education, training, and engagement regarding suicide and suicide prevention, intervention, and postvention in Los Angeles County.

A Reason to Care and Connect (ARCC)

Through "social inclusion" this initiative aims to reduce the stigma and discrimination that children with serious mental health needs and their families experience. Staff provide community and school-based trainings for parents and youth using an empathy-based approach.

Available Trainings include:

- Stigma Reduction: A Reason to Care and Connect
- Understanding and Connecting with our Children
- Caring for our Children's Mental Health
- Having that Conversation with your Child's Doctor
- Educate, Equip & Support (EES)
- Feeling in Control
- Bullying: Stigma and Prevention
- Health Relationships: Friendships & Dating
- Youth Mental Health First Aid (Y-MHFA)

Get The Help You Need Now...

Los Angeles County Department of Mental Health provides a range of programs and services designed for Children aged 0-15 who reside in Los Angeles County. Mental Health services are available through directly operated and contract agencies throughout the County.

Full Service Partnerships For Children

The Los Angeles County Department of Mental Health offers a Full Service Partnership Program (FSP) for Children age 0-15 and their families, who would benefit from and are interested in participating in a program designed to address the total needs of a family whose child (and possibly other family members) experience significant emotional, psychological or behavioral problems that are interfering with their well-being. FSP Programs for Children are capable of providing an array of services beyond the scope of traditional mental health outpatient services. Those participating in an FSP Program have services available to them 24 hours a day, 7 days a week.

If you are in crisis and need help right away

Call Toll-Free, 24/7 Access Helpline:

1-800-854-7771

William T Fujioka, *Chief Executive Officer*
Los Angeles County

Los Angeles County Board of Supervisors

Gloria Molina, *First District*
Mark Ridley-Thomas, *Second District*
Zev Yaroslavsky, *Third District*
Don Knabe, *Fourth District*
Michael D. Antonovich, *Fifth District*

Marvin J. Southard, D.S.W., *Director*
Los Angeles County
Department of Mental Health
550 South Vermont, 12th floor
Los Angeles, CA 90020

Phone: 213-738-4601
Fax: 213-386-1297

http://dmh.lacounty.gov

hope wellness recovery

Full Service Partnership For Children

FSPs Provide Comprehensive, Intensive Mental Health Services For Children And Their Families In Their Homes And Communities

FSP programs have several defining characteristics, including providing a wide array of services and supports, guided by a commitment by providers to do "whatever it takes" within the resources available to help individuals within defined populations make progress on their particular paths to recovery and wellness.

Children and their families will find the following are potential examples of mental health support and services clients may receive if participating in FSP:

- Counseling for your child and family members
- Peer and parent support from people who have had experiences similar to yours.
- Assistance in obtaining transportation relating to the mental health treatment goal.
- Help with access to physical health care for your child and family members.
- Assistance in finding a safe and affordable place to live, or assistance remaining in a present home.
- Assistance getting the eligible financial and health benefits for your child and family.
- Substance abuse and domestic violence counseling and assistance.
- A team dedicated to working with your child and family as you plan and accomplish goals that are important to your health, well-being, safety and stability
- 24/7 Assessment & Crisis Services

10/29/14

Key Components of FSPs

- FSP teams provide 24/7 crisis services and develop plans with families to do whatever it takes (within the resources available and the recovery plan agreed between the client and the FSP provider team) to help clients meet individualized recovery, resiliency, and development and/or recovery goals or treatment plan
- FSPs are responsive and appropriate to the cultural and linguistic needs of the child and their family
- FSPs are provided by multi-disciplinary teams of professional, paraprofessional and volunteer providers who have received specialized training, preparing them to work effectively with children and their families

Who Is Eligible To Receive FSP Services For Children?

A child aged 0-15 with a Serious Emotional Disturbance (SED) who:

- Has been or is at risk of being removed from the home by child protective services.
- Has a parent/caregiver with a mental illness and/or substance abuse problem (applies to children age 0-5 only).
- Has extreme behavior problems at school.
- Has been in out-of-home placement and is moving back into a home/community setting.
- Has been involved with Probation, is on psycho-tropic medications and transitioning back to a less structured home/community setting.

Interested in FSP Services?

To be considered for a Children's FSP program, a referral must be submitted to a Department of Mental Health Impact Unit. The referral will be screened for eligibility by a group of representatives from the Department of Mental Health, FSP programs and other human services professionals, as appropriate. It is the job of the Impact Unit team to ensure that eligible children and families receive FSP services.

If you have questions regarding the referral process or how the FSP program works, please contact the Impact Unit in your area.

IMPACT UNITS

Antelope Valley	(661) 223-3816
San Fernando Valley	(818) 610-6737
San Gabriel Valley	(626) 455-4599
Metro Los Angeles	(213) 922-8123
West Los Angeles	(310) 482-6610
South Central Los Angeles	(213) 351-7268
Southeast Los Angeles	(213) 738-2900
Long Beach/South Bay	(562) 435-2078

hope recovery wellness

Program Goals

- Timely and comprehensive strength-based assessment of children and families
- Earlier diagnosis of critical medical and mental health conditions
- Increased cooperation between families, caregivers, providers of services and DCFS
- More appropriate placement decisions for children
- More consideration given to sibling, relative, and community placements
- Earlier access to medical, educational and mental health services for children and families

DEPARTMENT OF MENTAL HEALTH

Anabel Rodriguez, L.C.S.W. ~ Program Manager
Office: (213) 739-5474
Email: ANrodriguez@dmh.lacounty.gov

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

Laura Andrade, Ph.D. ~ Program Manager
Phone: (213) 351-5732
Email: Andral@dcfs.lacounty.gov

Los Angeles County

Department of Children and Family Services
and
Department of Mental Health

Multidisciplinary Assessment Team (MAT)

What is MAT?

Multidisciplinary Assessment Team (MAT) is an exciting collaborative effort between the Department of Children and Family Services (DCFS), the Department of Mental Health (DMH), and other community providers. It is designed to ensure the immediate and comprehensive assessment of children and youth entering out-of-home placement. The MAT Program has been operational countywide as of October 2009.

Program Description

When a child is newly detained, he/she is eligible to receive a Multidisciplinary Assessment Team (MAT) assessment through DCFS. The MAT assessment was designed to make sure that all child/family needs are assessed when a child/youth enters foster care.

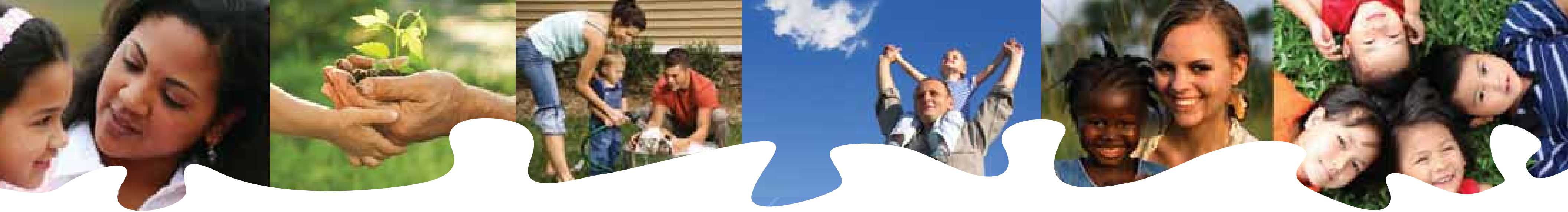
This assessment is meant to help a family meet some special needs a child(ren) may have that place this family in danger of a lengthy separation. The information gathered by this assessment will be used to determine what services are most needed by the child(ren) with the intention of using this information for the most appropriate placement of the child while ensuring that his/her needs will be met.

MAT Assessments address the following areas:

- Child and family strengths and needs
- Caregiver strengths and needs
- Education
- Mental Health
- Medical
- Dental
- Developmental
- Hearing/Language
- Vocational

MAT Provider Agencies

- Alafia Mental Health Institute
- Amanecer Community Counseling
- Almansor
- Alma Family Services
- Aviva Family and Children's Services
- Bienvenidos
- CHCADA
- Child and Family Center
- Child and Family Guidance Center
- ChildNet
- Children's Bureau
- Children's Institute, Inc.
- Children's Hospital Los Angeles
- Compton Mental Health Services (SFC)
- Counseling 4 Kids
- DiDi Hirsch
- Drew Child Development Corporation
- Dubnoff Center for Child Development
- El Centro de Amistad
- ENKI
- Five Acres
- Foothill
- For the Child
- Hathaway/Sycamores
- Hillsides
- Kedren Community Mental Health Center
- Los Angeles Child Guidance Clinic
- Masada
- Mc Kinley
- PACS
- Pacific Clinics
- Penny Lane
- Personal Involvement Center
- Prototypes
- Providence
- SFVCMHC, Inc.
- South Central Health and Rehab Program
- SHIELDS for Families
- St. John's Child and Family Dev Ctr
- Star View Community Services
- Stirling Behavioral Health Institute
- Tarzana Treatment Center
- Tessie Cleveland Community Services
- The Guidance Center
- The Help Group
- The Village Family Services
- The Whole Child
- TIES for Families
- VIP
- Vista del Mar



Interested?

If you are interested in becoming one of the most important people in a foster youth's life, please contact TFC to become a part of our family of professional foster parents.

Unlike other foster parents, TFC parents benefit from:

- **24/7 TFC Team Support**
- **Increased Reimbursement**
- **Creative Support**
- **Respite Services**

A program brought to you by the County of Los Angeles Board of Supervisors, Department of Children and Family Services, and the Department of Mental Health.

10/29/14

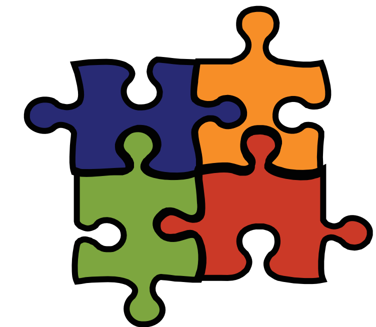
Treatment Foster Care

(888) 811-1121

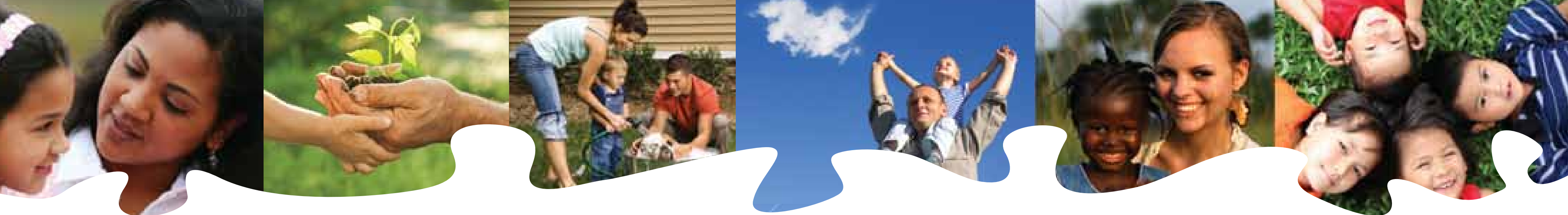
E-mail: LACountyTFC@gmail.com

BE A TREATMENT FOSTER CARE PARENT

Los Angeles County



Healing Youth... One Home at a Time



There are thousands of children in Los Angeles County being served by the Department of Children and Family Services (DCFS) who cannot safely live with their own families due to abuse, neglect or abandonment.

These children need to be with a safe, stable, and loving family who can provide temporary care.

They are often of African-American or Latino decent and due to past trauma have emotional and behavioral needs. They are wonderful children who could thrive in a loving home.

You can become a Treatment Foster Care Parent and help one of these deserving children.

What is Treatment Foster Care?

Treatment Foster Care (TFC) is a unique type of foster parenting that prevents children with behavioral challenges from moving from foster home to foster home. Foster parents that are part of the TFC team work hand in hand with staff to prevent the child from being moved and help the child succeed. We accomplish this by having:

- Loving and caring foster parents who are professionally trained
- Timely accessibility to good mental heath services
- Foster Family Agencies (FFAs) that work with TFC families are supportive and responsive
- Only one or two children placed with each family

What Does it Mean to be Part of a TFC Team?

It means you will:

- Share your valuable experience and ideas with other professionals
- Participate in creating a plan to help a child reach their potential
- Learn more about how past trauma can affect a child's current behavior
- Explore new ways to mentor and parent a child who needs direction
- Receive more support and services than regular foster parents

Why Would I Want to be a TFC Foster Parent

Besides making a true difference in the life of a child that might otherwise grow up in a group home rather than with a family, TFC offers:

- 24-hour support from your TFC team
- Easy access to proven successful mental health and educational services
- A matching process that matches the child's needs with your strengths as a caregiver
- Higher foster parent financial reimbursement than other foster care rates
- Respite care services

Who Can Become a Treatment Foster Care Parent?

You can be single, married, divorced, or living with a partner. Further, you can live in an apartment or house and either rent or own.

There is no minimum income, as long as you can support yourself and provide stability for the child you are caring for.

You can still work. For working parents, appropriate childcare arrangements need to be made.

You can be of any race, ethnicity, religion, sexual orientation, or culture – all of which can be the same or different as the child you want to parent.

This is a Big Responsibility! What Type of Help is There for Me?

Personal Support

Your TFC team will prepare, train, and support you through this process and provide you with all the resources that you might need. If you choose to adopt a child, post adoptive services are available to all adoptive families.

Financial and Medical Assistance

The child you care for will receive medical and dental coverage. Further, you can receive monthly financial support until the child is 21.

This Sounds Great! How Can I Learn More?

You are invited to come to an orientation provided by the foster family agency you will be working with to get an overview and have all your questions answered.

To register to attend an orientation, please call:

(888) 811-1121

CHILDREN'S FCCS PROVIDER CONTACT LIST

SA	PROV #	FCCS PROVIDER	FACILITY MAIN #	FCCS CONTACT	CONTACT #	Ext.	FAX #
1	7225	CHILD & FAM. GUID. - VALLEY CHILD GUIDANCE	(661) 265-8627	Lisa Thompson	(661) 265-8627	2866	(661) 265-7936
1	7473	CHILD BUREAU - LANCASTER	(661) 949-0131	Debra Devine	(661) 949-0131		(661) 729-8912
1	7741	HATHAWAY SYCAMORES	(661) 942-5749	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
1	7541	OPTIMIST BOYS' HOME AND RANCH, INC.	(661) 272-4733	Nancy Ramos	(661) 575-8395	214	(661) 272-2784
1	7455	PENNY LANE - JENKINS	(818) 755-4950	Janie Strasner	(818) 755-4950		(818) 752-0783
2	1975	CHILD & FAMILY GUIDANCE CENTER	(818) 993-9311	Evy Lowe	(818) 739-5229		(818) 739-5291
2	7390	CHILD & FAMILY GUIDANCE CENTER (LENNOX)	(818) 739-5400	Ruth Azrael	(818) 739-5416		(818) 442-0290
2	7413	CHILD AND FAMILY CENTER - NEWHALL	(661) 259-9439	Michelle Brown	(661) 259-9439		(661) 286-2567
2	7479	CHILD AND FAMILY CENTER - SANTA CLARITA	(661) 259-9439	Michelle Brown	(661) 259-9439		(661) 286-2567
2	7812	DIDI HIRSCH GLENDALE CENTER	(310) 751-5352	Lyn Morris	(310) 895-2305		(310) 751-5204
2	7102	DUBNOFF CENTER - NIDORF CTR	(818) 364-2152	Carol Shauger	(818) 364-6876		(818) 362-3446
2	7571	DUBNOFF CENTER - SCHOOL BASED	(818) 752-0783				
2	7371	EL CENTRO/AMISTAD - SCHOOL BASED	(818) 898-0223	Tania Fallert	(818) 347-8565		(818) 347-0506
2	7050	EL CTRO DE AMISTAD	(818) 347-8565	Katherine Fleisher	(818) 347-8565		(818) 347-0506
2	7247	FAMILY STRESS CTR-AB1733	(818) 830-0200	Evy Lowe	(818) 739-5229		(818) 739-5291
2	7600	HATHAWAY-SYCAMORES	(818) 897-3346	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
2	7502	PACIFIC CLINICS	(818) 547-9544	Gina Mardian	(818) 547-9544	1001	(818) 549-9041
2	6863	PENNY LANE	(818) 892-3423	John Wu	(626) 287-2988	219	(626) 287-0168
2	7855	PENNY LANE CENTERS	(818) 755-4950	Janie Strasner	(818) 755-4950		(818) 752-0783
2	7445	SAN FERNANDO VALLEY COMMUNITY MHC, INC	(818) 908-4999	Shain Roman	(818) 908-4999	210	(818) 997-3138
2	7355	SFV CMHC, INC. - YOUTH CONTACT PRGM	(818) 908-4990	Anita Sandler	(818) 901-4879	232	(818) 997-1370
2	7362	SSG - ASIAN PACIFIC/SFV	(818) 909-0698	Tiger Doan	(818) 267-1114		(818) 267-1199
2	7624	THE HELP GROUP CHILD & FAMILY CENTER - VAN NUYS	(818) 267-2600	Paulina Morales	(818) 267-2753		(818) 267-2693
3	7708	ALMANSOR CLINICAL SERVICES OP	(323) 344-5536	Nancy Miller	(323) 344-5547		(323) 344-5550
3	7439	CHARTWRAP WRAPAROUND	(626) 967-1667	Lisa Goodwin	(626) 967-1667	145	(626) 967-6027
3	7302	CHILD BUREAU - SG VALY-AB1733	(626) 337-8811	Steve Stoltz	(626) 337-8811		(626) 856-5653
3	7566	DAVID AND MARGARET HOME	(909) 596-5921	Michael Miller	(909) 596-5921	3500	(909) 506-3954
3	7173	ENKI - LA PUENTE	(626) 961-8971	Brooke Bender	(626) 961-8971	112	(626) 974-0774
3	7452	ENKI YTH FAM SRVS - EL MONTE	(626) 227-7001	Amy Rea	(626) 227-7001	103	(626) 227-7002
3	7755	FOOTHILL FAMILY SERVICES DUARTE	(626) 301-9700	Katy Rader	(626) 795-6907	130	(626) 795-7080
3	7463	FOOTHILL FAMILY SVC - EL MONTE SITE	(626) 442-8391	Katy Rader	(626) 795-6907	130	(626) 795-7080
3	7407	FOOTHILL FAMILY SVC - HUDSON SITE	(626) 795-6907	Katy Rader	(626) 795-6907	130	(626) 795-7080
3	7330	FOOTHILL FAMILY SVC - PASADENA SITE	(626) 993-3000	Katy Rader	(626) 795-6907	130	(626) 795-7080
3	7331	FOOTHILL FAMILY SVC - WEST COVINA SITE	(626) 338-9200	Katy Rader	(626) 795-6907	130	(626) 795-7080
3	7669	HATHAWAY SYCAMORES COVINA OP	(626) 388-9050	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
3	7601	HATHAWAY-SYCAMORES EN PACE	(626) 798-0853	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
3	7599	HATHAWAY-SYCAMORES FAIR OAKS PACE	(626) 395-7100	Tonya Nowakowski	(661) 942-5749		(661) 940-3795
3	7231	HILLSIDES FAMILY CENTER	(323) 254-2274	Stacey Roth	(323) 254-2274	466	(323) 254-9087
3	7401	PACIFIC CLINICS	(626) 287-2988	John Wu	(626) 287-2988	219	(626) 287-0168
3	1974	PACIFIC CLINICS	(626) 441-4221	Joana Garcia	(626) 441-4221	309	(626) 441-6479
3	7561	PACIFIC CLINICS - BONITA FAMILY SRVC CTR	(909) 626-7207	Jan Hong	(909) 625-7207	3435	(626) 844-0481
3	7441	PACIFIC CLINICS - EL MONTE	(626) 652-0755	Stacey Morhar	(626) 652-0755		(626) 433-1318
3	1979	PACIFIC CLINICS - FOOTHILL	(626) 357-3258	Daniel Jinesta	(626) 357-3258	231	(626) 301-0868
3	7418	PACIFIC CLINICS - FOOTHILL	(626) 744-5230	Lisa Lansing	(626) 744-5230	211	(626) 744-5242
3	7227	PACIFIC CLINICS - MONROVIA	(626) 303-1541	Scott Fairhurst	(626) 303-1541		(626) 599-9928
3	7858	PC CENTRO FAMILIAR EL MONTE OP	(626) 744-5230	Tatiana Nazaryn	(626) 744-5230	217	
3	7101	PC-API - ASIAN PACIFIC FAMILY CENTER	(626) 287-2988	John Wu	(626) 287-2988	219	(626) 287-0168
3	7380	SIERRA FAMILY CENTER	(626) 335-5980	Judy Grover	(626) 335-5980	159	(626) 335-5989
4	7186	ASIAN PACIFIC	(213) 252-2100	Karen Lim	(213) 252-2112		(213) 252-2199
4	7519	CA HISPC COMMSION A&D ABUSE	(323) 222-4591	Dexter Jefferson	(562) 942-9625		(562) 942-9695
4	7843	CHILDRENS HOSPITAL LOS ANGELES	(323) 361-3814	Brad Hudson	(323) 361-3814		(323) 361-8305
4	7614	CHILDREN'S HOSPITAL OF LOS ANGELES	(323) 361-6102	Karlyn Beck	(323) 361-6102		(323) 361-8196
4	1989	CHILDREN'S HOSPITAL OF LOS ANGELES	(323) 361-2350	Brad Hudson	(323) 361-3814		(323) 361-8305
4	7328	CHILDREN'S INSTITUTE, INC.	(213) 385-5100	Nicole Ward	(213) 385-5100	7825	
4	7780	CHILDREN'S INSTITUTE, INC. (6-15 Age Grp)	(310) 783-4677	Paula Villegas	(213) 252-5723	7023	
4	7817	CII OTIS BOOTH CAMPUS OP (0-5 Age Grp)	(213) 260-7600				
4	7472	ENKI YTH FAM SRVS - BOYLE HTS	(323) 261-4900	Emma Shaw	(323) 261-4900		(323) 261-4343
4	7749	FAMILIES FIRST	(323) 463-2119	Judi Stadler	(323) 769-7101		(323) 463-0619
4	7278	HATHAWAY FAMILY RESOURCE CENTER	(323) 257-9600	Andi Gonzalez	(323) 257-9600	7111	(323) 257-8118
4	7645	HILLSIDES COMMUNITY CENTER	(213) 201-5380	Stacey Roth	(323) 254-2274	466	(323) 254-9087
4	7103	KOREATOWN YTH AND COMM CTR	(213) 365-7400	Nayon Kang	(213) 365-7400	5530	(213) 383-1280
4	7265	LA CHILD GUIDANCE - FAMILIES IN TOUCH	(323) 766-2345	Andrew Kurtz	(323) 766-2360	2315	(323) 766-3636
4	6870	LA CHILD GUIDANCE CLINIC	(323) 766-2345	Andrew Kurtz	(323) 766-2360	2315	(323) 766-3636

CHILDREN'S FCCS PROVIDER CONTACT LIST

SA	PROV #	FCCS PROVIDER	FACILITY MAIN #	FCCS CONTACT	CONTACT #	Ext.	FAX #
4	7187	SSG - APCTC METRO CTR	(213) 558-1850	Lan Nguyen-Chawkinf	(213) 553-1850		(213) 553-1867
4	7538	ST. ANNE'S	(213) 381-2931	Sarah Tayebi	(213) 381-2931	239	(213) 381-7804
4	7503	STAR VIEW COMMUNITY SERVICES	(323) 999-2404	Roni Maybin	(323) 999-2404		(323) 999-2414
5	6792	ST JOHNS CH&FAM DEV CTR	(310) 829-8921	David Narang	(310) 829-8702		(310) 829-8455
5	6773	ST JOHNS CHILD & FAM	(310) 829-8921	David Narang	(310) 829-8702		(310) 829-8455
5	7394	THE HELP GROUP CHILD & FAMILY CENTER - CULVER CITY	(310) 751-1171	Melissa Chisholm	(310) 751-1172		(310) 313-7652
5	7196	VISTA DEL MAR C&F	(310) 836-1223	Shuli Lotan	(310) 451-9747		(310) 451-6106
6	6864	AUGUSTUS F. HAWKINS MHC	(310) 668-4271	Jeremy Winn	(310) 668-5059		(310) 223-0712
6	7846	CHILDRENS INSTITUTE INC OP	(213) 385-5100	Cecilia Larin	(213) 252-5723	1121	(213) 807-1650
6	7736	CHILDREN'S INSTITUTE, INC.	(310) 783-4677	Cindy Rivera	(213) 252-5723	8154	
6	7861	EGGLESTON YOUTH CENTERS, INC.	(323) 299-9554	Audri Vermilian	(626) 695-5495		
6	7744	HATHAWAY-SYCAMORES	(626) 395-7100	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
6	7750	HOLLYGROVE (EMQ)	(323) 769-7178	Ann Kupferman	(323) 769-7156		(310) 886-5326
6	7577	KEDREN COMMUNITY HEALTH CENTER	(323) 733-3886	Karen Adams	(323) 733-3886	415	(323) 432-5186
6	7276	LA CHILD GUID ANCE - CRENSHAW	(323) 766-2345	Andrew Kurtz	(323) 766-2360	2315	(323) 766-3636
6	7211	LAUSD 97TH ST SCHOOL MHC	(323) 754-2856	Kelly Jones	(323) 754-2856		(323) 754-1843
6	7681	SSG WEBER COMMUNITY CENTER	(323) 234-4445	Irma Pagan	(323) 234-4477		(323) 234-4477
6	7493	STAR VIEW COMMUNITY SERVICES	(310) 868-5379	Yvonne Lazano	(310) 868-5379	143	(310) 868-5398
6	7279	THE GUIDANCE CENTER (COMPTON SOC)	(310) 669-9510	Janet Fleishman	(310) 669-9510	222	(310) 669-9501
7	7019	ALMA FAMILY SERVICES	(562) 801-4626	Ian Lobell	(562) 801-4626	12	(562) 801-4630
7	7562	CENTRO ESTRELLA	(323) 881-3799	Cyndi Baker	(323) 526-4016	208	(323) 526-4096
7	7246	COMMUNITY FAMILY GUID. CTR (FAMILY & YOUTH STARS)	(562) 924-5526	Tracy Schmidt	(562) 865-6444		(562) 865-5864
7	7360	ENKI - MARGARITA MENDEZ SITE	(323) 832-9795	Christina Barber	(323) 832-9795		(323) 832-9796
7	7670	HATHAWAY-SYCAMORES	(323) 837-0838	Cynthia Boada-Doutt	(818) 388-9050	8717	(818) 897-1766
7	7495	PACIFIC CLINICS - LATINA	(562) 942-8256	Maria Martin	(562) 942-8256		(562) 942-9789
7	7511	PENNYLANE	(323) 887-1917	Marcel Mendoza	(323) 887-1917	3261	(323) 780-3211
7	7572	PROVIDENCE COMM SRVS	(562) 865-3644	Denise Oja	(562) 865-3644	127	(562) 246-5702
7	7579	SSG - APCTC CERRITOS	(562) 860-8838	Hsiang Ling-Hsu	(562) 860-8838	111	(562) 860-0248
7	7667	THE ALMANSOR CENTER	(323) 622-0715	Nancy Miller	(323) 344-5547		(323) 344-5550
7	1972	THE WHOLE CHILD	(562) 692-0383	Arthea Larson	(562) 692-0383	256	(562) 692-0380
8	7625	CHILDRENS INSTITUTE INC OP	(213) 385-5100	Jesus Parra	(310) 783-4677	4203	(213) 252-5803
8	7275	CHILDREN'S INSTITUTE, INC.	(310) 783-4677	Veronica Salazar	(213) 385-5100		(213) 252-5803
8	7779	CHILDREN'S INSTITUTE, INC.	(213) 385-5100	Jesus Parra	(310) 783-4677	4203	(213) 252-5803
8	7064	COASTAL ASIAN PACIFIC	(310) 217-7312	Min Rhee	(310) 217-7312		(310) 352-3111
8	7207	LONG BEACH ASIAN PACIFIC	(562) 599-9401	Gail Holtan	(562) 218-4010		(562) 591-7536
8	7342	MASADA HOMES	(310) 715-2020	Alexandra Crooks	(310) 715-2020	239	(310) 715-2705
8	7432	MASADA HOMES - LOS PADRINOS	(562) 940-8767	Alexandra Crooks	(310) 715-2020	239	(310) 715-2705
8	7329	SPECIAL SERVICE FOR GROUPS (SSG)	(310) 323-6887	Alicia Yabana	(310) 323-6887	236	(310) 323-1570
8	7367	STAR VIEW COMMUNITY SERVICES	(562) 427-6818	Reginold Alfon	(562) 427-6818		(562) 427-3367
8	7335	STAR VIEW COMMUNITY SERVICES	(310) 787-1500	Ana Gustafson	(310) 787-1500	102	(310) 787-9713
8	7270	SUNBRIDGE HARBOR VIEW COMM SVCS	(562) 981-9392	Sophia Sheehan	(562) 981-9392	205	(562) 981-2622
8	7793	TESSIE CLEVELAND COMMUNITY SRVCS OP	(323) 586-7333	Oscar Gonzalez	(323) 586-7333	7479	(323) 588-5622
8	7433	THE GUIDANCE CENTER	(562) 595-1159	Kristen Martin	(562) 485-2270		(562) 490-9759

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

TRANSITION AGE YOUTH

The Transition Age youth (TAY) System of Care (SOC) seeks to provide an array of mental health and supportive services for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) youth ages 16-25. The TAY SOC has identified a number of priority TAY populations to receive these services; along with a specific emphasis on outreaching and engaging TAY who are currently unserved and underserved. These priority populations include the following:

- TAY struggling with substance abuse disorders;
- TAY who are homeless or at-risk of homelessness;
- TAY aging out of the children's mental health, child welfare, or juvenile justice systems;
- TAY leaving long-term institutional care; or
- TAY experiencing their first episode of major mental illness.

TAY Programs

MHSA Community Services and Supports (CSS)

- Full Service Partnership (FSP);
- Field Capable Clinical Services (FCCS);
- Probation Camp Services;
- Drop-in Centers;
- Enhanced Emergency Shelters for TAY (EESP);
- Project Based Operating Subsidies for Permanent Housing; or
- TAY Navigation Team.

Full Service Partnership (FSP)

FSP programs have several defining characteristics, including providing a wide array of services and supports, guided by a commitment by providers to do "whatever it takes "within the resources available to help individuals within defined populations make progress on their particular paths to recovery and wellness.

Field Capable Clinical Services (FCCS)

Field Capable Clinical Services, delivered under the Mental Health Services Act, are intended to address the needs of individuals who are SED/SPMI but do not have the

intensive service needs of individuals who qualify for Full Service Partnerships. FCCS utilizes evidence-based strategies whenever they can be identified. FCCS provides a way of transitioning former FSP clients to less intensive programs as they meet their recovery goals.

Probation Camp Services

Probation Camp Services provides services to youth ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED/SPMI, those with co-occurring substance abuse disorders and/or those who have suffered trauma. Services in the Probation Camps are critical in assisting this population to reach their maximum potential and eventually transition back to the community rather than continue their involvement in the criminal justice system as adults. Multidisciplinary teams, including parent advocates, clinicians, Probation staff, and health staff provide an array of on-site treatment and support services that include the following: assessments, substance-abuse treatment, gender-specific treatment, medication support, transition aftercare planning, linkage services (including FSP and other intensive community-based mental health services).

A key component of the planned services is outreach and engagement to the incarcerated youth's family providing transportation to the camps to ensure opportunities to participate in the youth's treatment during camp placement and through the transition back into the community.

Drop-In Centers

Drop-In Centers provide temporary safety and basic supports for SED/SPMI TAY who are living on the streets or in unstable living situations. Drop-In Centers provide "low-demand, high tolerance" environments in which TAY can make new friends, participate in social activities, access computers, books, music, and games. As the youth is ready, staff persons can connect them to the services and supports they need in order to work toward stability and recovery. Drop-In Center services include the following: showers, meals, clothing, peer support groups, linkage to mental health and case management services, linkage to substance abuse treatment information, educational services, and employment assistance.

Enhanced Emergency Shelter Program

The Enhanced Emergency Shelter Program contained in the Mental Health Services Act (MHSA) Plan will serve the immediate and urgent housing needs of the SED/SPMI TAY population. The primary objective of this program is to provide temporary shelter

for TAY clients in a supportive housing environment for up to 36 nights (including extensions) while pursuing the long-term goals of secure, permanent housing. The Enhanced Emergency Shelter Program offers a warm, clean and safe place to sleep, hygiene facilities, hot meals (breakfast, lunch, and dinner), and case management services. Since placement in the Enhanced Emergency Shelter Program is very short-term, a plan for transitioning the TAY client into stable housing is made at the time of placement into the program.

Project Based Operating Subsidy

This program provides subsidies for Unit-based Permanent Supportive Housing programs to address the long-term housing needs of SED/SPMI TAY and TAY who are homeless or at risk of homelessness. This program targets TAY who are eligible for Full Service Partnerships (FSP), Field Capable Clinical Services (FCCS), other mental health services, and TAY who are coming directly from transitional housing programs. The Project-Based Operating Subsidy targets youth who, with sufficient support, could live independently in community settings. Supportive mental health and other services will be made available for youth.

TAY Navigation Team

The TAY Navigation Team's primary role is to assist SED/SPMI youth with navigating through the various human services systems to achieve effective linkages to needed mental health, housing, and other essential services. The Navigation Team consists of Navigators (clinicians who provide linkage services), Housing Specialists, and Substance Abuse Counselors. Navigation Teams develop comprehensive housing resource lists, assist SED/SPMI TAY with completing applications for rental subsidies, and prepare consumers for the interview with prospective property owners or housing managers. Navigation Teams case management services include benefits establishment, educational resources, employment resources, linkage to mental health services, and linkage to substance abuse programs.

Additional TAY Navigators are assigned to the Los Angeles County Probation camps where they provide effective linkage to continuing Mental Health Services and community supports for SED/SPMI TAY leaving the camp settings.

For additional information please see our website:
http://dmh.lacounty.gov/wps/portal/dmh/our_services/tay

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PROGRAM SUPPORT BUREAU

The Program Support Bureau is dedicated to the enhancement of the delivery of quality mental health services through the provision of excellent training, customer service, and support services to Department of Mental Health bureaus and programs.

The following divisions/units are part of the Program Support Bureau:

- MHSA Prevention and Early Intervention (PEI)
- MHSA Workforce Education and Training Division (WET)
- MHSA Implementation and Outcome Division
- Quality Assurance Division
  - Medi-Cal Certification/Program Review
  - Medi-Cal Audit/Technical Assistance
  - Health Information Management
- Quality Improvement Division
  - Data/Geographical Information System
  - Under Represented Cultural Populations (URCP)
  - Cultural Competency

Service Area Advisory Committee

8/04/15

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

QUALITY IMPROVEMENT

The Quality Improvement Division (QID) is under the administration and direction of the Program Support Bureau (PSB), Deputy Director. Within the structure of the Program Support Bureau, the QID is concerned with improving the accessibility and quality of system wide mental health services provided to eligible consumers and families. The Countywide Quality Improvement (QI) Program is guided by strategic Quality Improvement Work Plan goals and corresponding performance management activities. The QID monitors the Department's QI Program activities for effectiveness using national strategies and standards to organize, implement, and evaluate applied contributions that lead to improved quality of care and reduced disparities.

The structure and processes of the QI Program are defined in the Department's Policy and Procedure 105.1, Quality Improvement Program Policy, to ensure that the quality and accessibility of mental health services meets and exceeds local, State, and Federal requirements. The QI Program is organized and implemented in support of uniform QI functions, responsibilities and oversight for both the directly operated and contracted providers of the County's public mental health services system. The QI Program focuses on an organizational culture of continuous quality improvement that fosters wellness and recovery; reduces disparities; promotes consumer and family involvement; improves cultural competency; and integrates mental health and substance use treatment services.

The QID includes the Cultural Competency (CC) Unit, the Data Unit, and Under-Represented Cultural Populations (URCP)/Innovation Unit.

Contact Person

Naga Kasarabada, Ph.D.
District Chief
(213) 251-6732
nkasarabada@dmh.lacounty.gov

Service Area Advisory Committee

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

CULTURAL COMPETENCY

The Cultural Competency Unit functions as an internal Departmental mechanism that is integral to the planning, assessment, and evaluation of mental health services that are culturally and linguistically responsive to the unique needs of the County of Los Angeles diverse communities. The primary objective of Cultural Competency Unit is to increase service accessibility for the ethnically, linguistically and other culturally diverse communities.

The Cultural Competency Unit is committed to providing the technical assistance, the education, and the training necessary to integrate cultural competency in all the Department's operations.

Cultural Competency Committee

The Cultural Competency Committee (CCC) is a Committee of the Departmental Quality Improvement Council (QIC). The CCC promotes cultural awareness and sensitivity in The Department's response to the needs of diverse and underserved populations. It is comprised by LACDMH staff, contracted providers and consumers who are interested in promoting progress in the provision of culturally and linguistically competent services within the Department.

The CCC provides support and program-specific data for the implementation of the Cultural Competency Plan Requirements (CCPR). It also functions as a vehicle for the achievement of the Cultural Competency Unit goals. The CCC also collaborates with the Departmental Quality Improvement Council and with Service Area Quality Improvement Committees.

Contact Person

Sandra Chang-Ptasinski, Ph.D.
(213) 251-6815
SChang@dmh.lacounty.gov

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

UNDER REPRESENTED CULTURAL POPULATIONS (URCP)

One of the cornerstones of the Mental Health Services Act is to empower under represented cultural populations (URCP). It aims to expand services to include culturally and linguistically competent approaches to ethnic communities that have been historically marginalized by the mental health system and to give them a voice in the stakeholder process.

During the planning phase of MHSA, a URCP Work Group, consisting of 56 culturally diverse mental health professionals and community and client advocates, was created to make implementation recommendations to the Department of Mental Health. This Work Group established the URCP Guiding Principles and five subcommittees' representative of the major ethnic groups within Los Angeles County.

URCP groups meet regularly to provide service and funding recommendations that are culturally and linguistically competent to each of their respective communities. They also play an integral role in the planning and implementation of MHSA plans such as Prevention and Early Intervention (PEI) and Workforce Education and Training (WET). The five groups are:

African American	American Indian	Latino
Asian/Pacific Islander	Middle Eastern/Eastern European	

The County of Los Angeles Department of Mental Health is committed to working alongside ethnic and cultural communities that have been historically on the periphery of the mental health system. It seeks to draw on the collective wisdom of un-served and underserved communities and establish a process that can help to address service inequities.

Contact Person

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Service Area Advisory Committee

8/04/15

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PUBLIC GUARDIAN

The Public Guardian provides a vital service to persons unable to properly care for themselves or who are unable to manage their finances. The service is provided through a legal process known as conservatorship. Persons in need of conservatorship are physically or mentally disabled to the point where they cannot utilize community services and resources and there are no know viable alternatives to conservatorship.

Conservatorship is a serious matter. It requires a court hearing with all interested parties present. If the conservatorship is established the conservatee loses many civil rights most of us take for granted, including the right to decide where to live and what medical or mental health treatment to accept or refuse. They may also lose the right to control their assets or manage their income. The conservator, by assuming these responsibilities, becomes legally accountable to Superior Court.

The Los Angeles County office the Public Guardian was established in 1945 – the first in the state. Initially, the primary responsibility was for the finances of persons civilly committed to psychiatric facilities. As society evolved and the laws changed to meet new social challenges, the role of the Public Guardian broadened to include more responsibility for the care of the individual. The landmark LPS Act of 1969 and subsequent changes to the Probate Code meant that the Public Guardian became the substitute decision maker for vulnerable populations of the county, such as the frail elderly, victims of elder abuse and persons with serious mental illness.

The Los Angeles County Office of the Public Guardian is organizationally located within the Department of Mental Health. Dr. Marvin Southard, Director of the Department of Mental Health has been appointed by the Board of Supervisors as the Public Guardian and County Conservatorship Investigator. Office of the Public Guardian operations is managed by Deputy Director Connie D. Draxler.

Los Angeles County – Department of Mental Health
Adult System of Care

Introduction and Overview of Integrated Services for Veterans

Carl P. McKnight, Psy.D.
Mental Health Clinical Program Head

Veteran Facts

1 According to the RAND Corporation, it is anticipated that 30% of returning Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) veterans will meet full criteria for:

1) PTSD
2) Substance Abuse
3) Depression
4) Anxiety Disorders

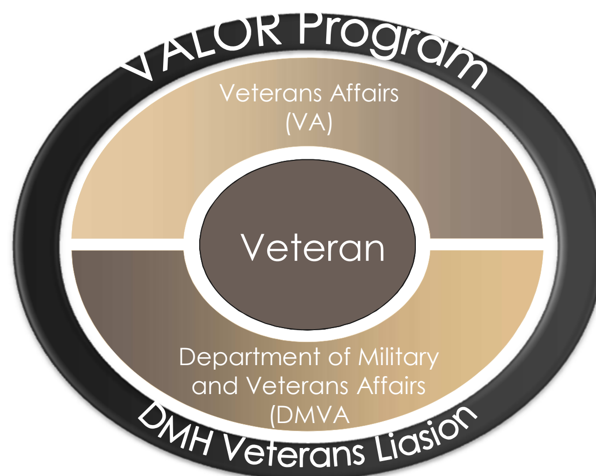
2 According to the California Department of Veterans Affairs, the Southern California region encompassing Los Angeles and San Diego has the most returning OIF/OEF/OND veterans in the nation.

3 Los Angeles County has the most homeless veterans in the United States. Approximately 40% of the homeless in Los Angeles County are veterans (including single mothers with children).

Increasing Veteran's Services

- DMH policy was changed on October 6, 2008 allowing veterans, regardless of military discharge status, to be seen at all directly-operated clinics.
- No eligible veteran shall be denied mental health services, to the extent resources are available, based on his or her status as a veteran.

Integrated Services



Prevention and Early Intervention (PEI) Programs

- Patriotic Hall/VALOR Program
- FOCUS
- Prolonged Exposure
- Veterans Systems Navigators
- Vet to Vet

Patriotic Hall/VALOR

- **Three Areas of Focus**
  1) Increase efficiency of homeless outreach for veterans.
  2) Strategic programs for military and Veterans families.
  3) ***Serve as resource center for other Veterans programs housed at Patriotic Hall.***

Resource Center at Patriotic Hall

- VALOR staff to provide mental health assessment, linkage, and consultation services for service providers at Patriotic Hall.
- Serving veterans via "no wrong door" access.
- Screening for mental health issues and substance abuse, time limited therapy and evidence based services.

Resource Center at Patriotic Hall (cont.)

- VALOR staff will be mobile and will address "high needs" areas and populations throughout the County.
  - Deployed at four locations across DMH.
    - ***Downtown, Edelman, Long Beach, and San Fernando Valley Mental Health Centers***
  - Augment the provision of co-located services.
    - ***Long Beach VA Medical Center***
    - ***West Los Angeles VA Medical Center***

FOCUS on Military and Veteran's Families

- Expansion of Evidence Based Practices (EBPs) i.e. Families OverComing Under Stress (FOCUS).
- VALOR staff trained to provide FOCUS services.
- FOCUS family resiliency sessions addresses family's multiple stressors resulting from military deployments.

Prolonged Exposure

- Expansion of EBPs also includes Prolonged Exposure (PE).
- PE is a treatment for chronic post traumatic stress disorder (PTSD).
- It is specifically designed to help clients psychologically process traumatic events and reduce trauma-induced psychological disturbances.
- VALOR Supervisor already trained.
- DMH staff at 15 clinics already trained.

Veterans Systems Navigators: Department of Military Veteran Affairs

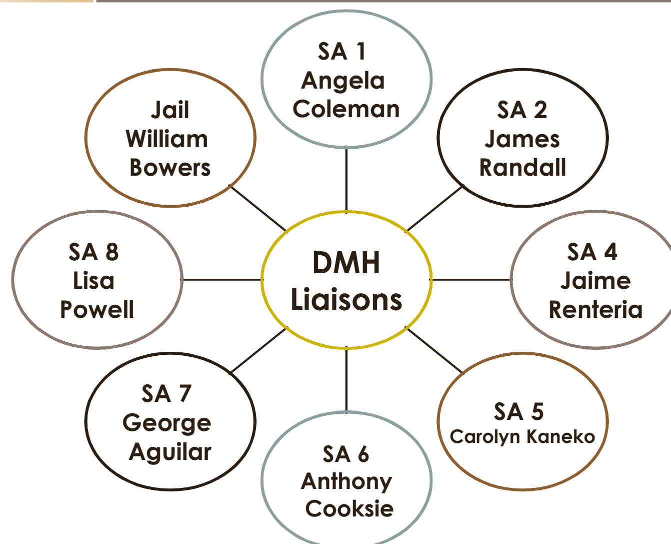
- Veteran System Navigator will provide targeted assistance to veterans experiencing difficulties accessing mental health treatment by referring the Veteran to DMH if they identify mental health needs.

Employment
Education

Benefits Assessments
Housing

Case Management
Substance Abuse

DMH Liaison



Vet to Vet

- Vet-to-Vet is an innovative, peer support, training and consultation program for veterans and communities.
- ***Veterans in recovery***, who have been consumers of Veteran's Administration mental health services, have been ***trained to provide peer counseling services*** for veterans in the community dealing with mental health concerns and substance abuse.
- ***Roy Brown, National Director***

Service Area 1: Antelope Valley

Communities	ZIP Codes						
Lancaster	93243	93534	93539	93550	93553	93586	93591
Palmdale	93510	93535	93543	93551	93563	93590	93599
North County E.	93532	93536	93544	93552	93584		

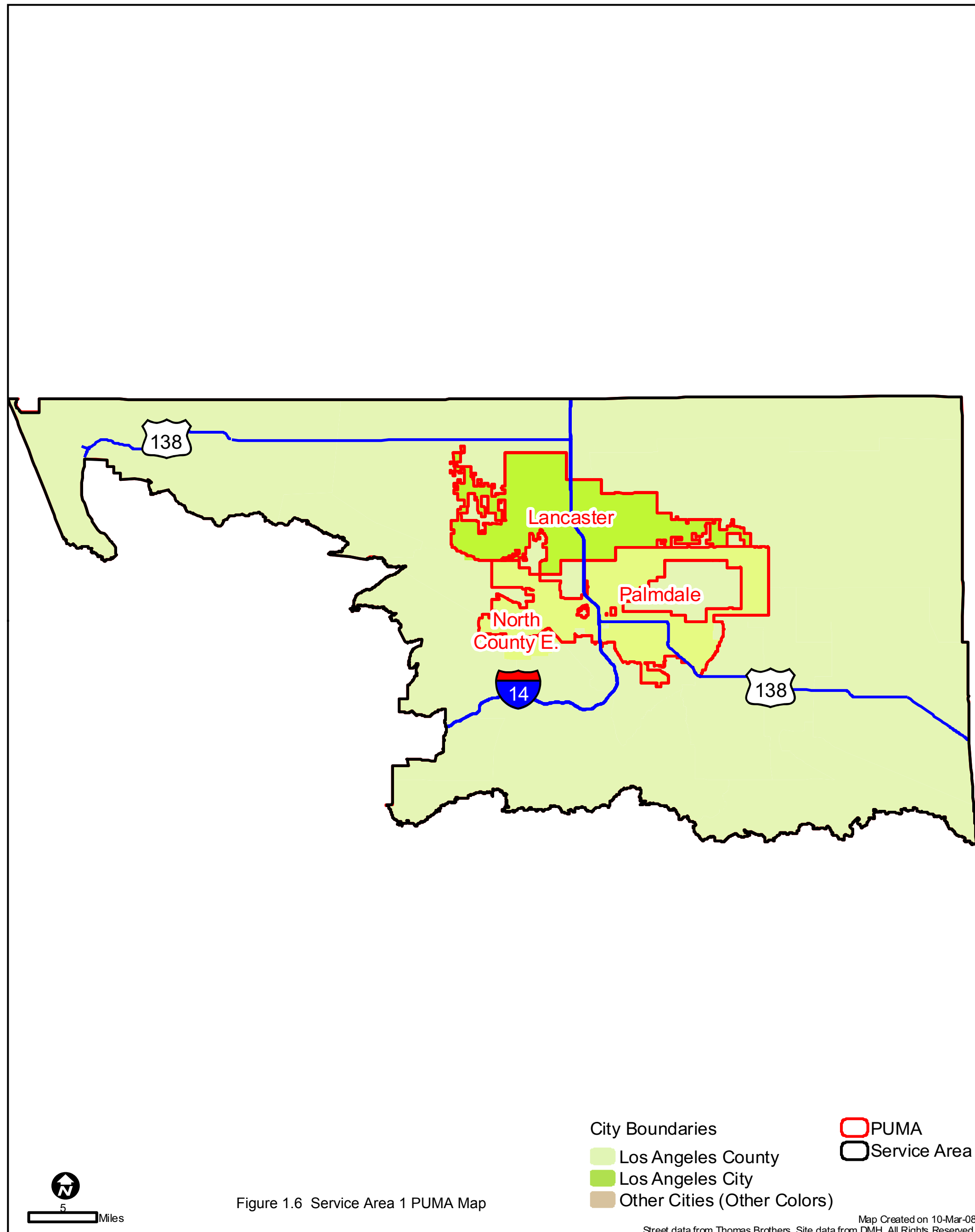


Figure 1.6 Service Area 1 PUMA Map

Service Area 2: San Fernando

Communities

- Santa Clarita
- Burbank
- Glendale
- Northridge
- Granada Hills
- Pacoima-Arleta
- La Tuna Cyn.
- Panorama City
- North Hollywood
- Sherman Oaks
- Encino
- Woodland Hills
- Brentwood N.
- North County W.
- La Canada -Flintridge
- San Fernando -Calabasas-Agoura

ZIP Codes

90290	91203	91302	91324	91343	91364	91394	91412	91504
91011	91204	91303	91325	91344	91365	91395	91413	91505
91012	91205	91304	91326	91345	91367	91396	91416	91506
91020	91206	91305	91327	91346	91371	91399	91423	91507
91021	91207	91306	91328	91350	91372	91401	91426	91508
91023	91208	91307	91329	91351	91376	91402	91436	91510
91040	91209	91308	91330	91352	91380	91403	91470	91521
91041	91210	91309	91331	91353	91381	91404	91482	91522
91042	91214	91310	91333	91354	91383	91405	91495	91523
91043	91221	91311	91334	91355	91384	91406	91496	91526
91046	91222	91312	91335	91356	91385	91407	91497	91601
91050	91224	91313	91337	91357	91386	91408	91499	91602
91051	91225	91316	91340	91361	91388	91409	91501	91603
91201	91226	91321	91341	91362	91392	91410	91502	91604
91202	91301	91322	91342	91363	91393	91411	91503	91605

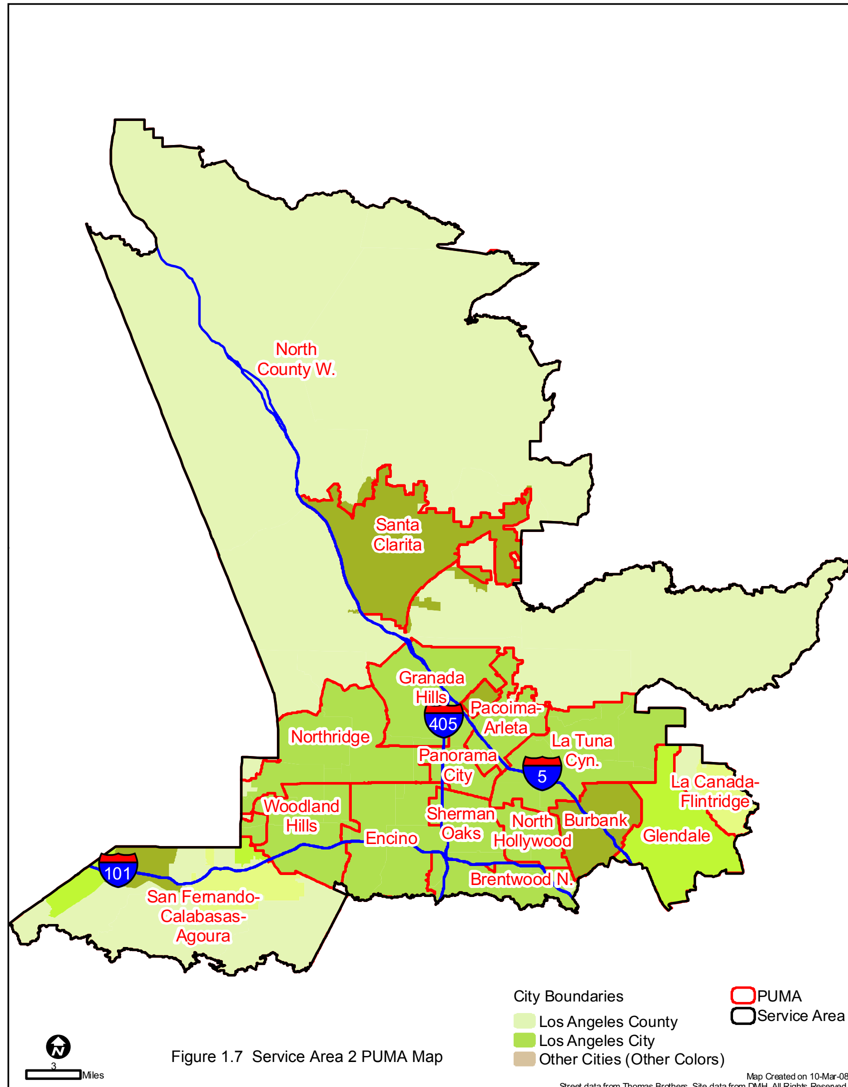


Figure 1.7 Service Area 2 PUMA Map

Service Area 3: San Gabriel

Communities

Pasadena
El Monte
Pomona
West Covina
Altadena-Monrovia-Sierra Madre
Alhambra-S. Pasadena
Arcadia-San Gabriel-Temple City-San Marino
Baldwin Park-Azusa-Duarte
Glendora-Claremont-San Dimas-La Verne
Covina-Walnut
Diamond Bar
La Puente-S. El Monte
Hacienda Heights
Monterey Park-Rosemead

ZIP Codes

91715	91732	91744	91750	91767	91773	91789	91797
91716	91733	91745	91754	91768	91775	91790	91801
91722	91734	91746	91755	91769	91776	91791	91802
91723	91735	91747	91756	91770	91778	91792	91803
91724	91740	91748	91765	91771	91780	91793	91804
91731	91741	91749	91766	91772	91788	91795	91841
							91896

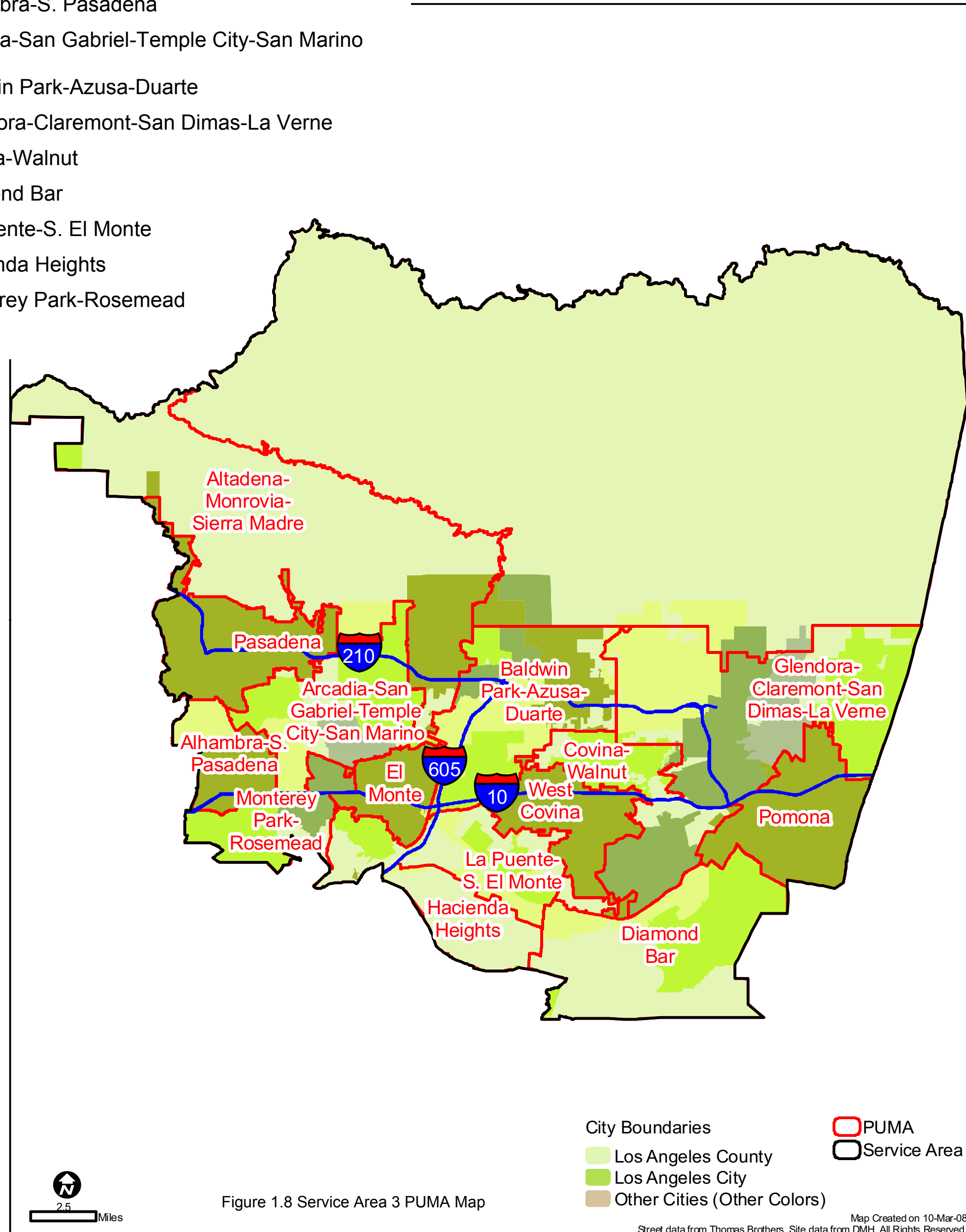


Figure 1.8 Service Area 3 PUMA Map

Service Area 4: Metro

Communities

- Wilshire La Brea E.
- Hollywood
- Pico Heights
- Echo Park
- Highland Park
- Downtown
- USC N.
- West Adams
- West Hollywood

ZIP Codes

90004	90014	90023	90031	90041	90053	90068	90075	90086
90005	90015	90026	90032	90042	90054	90069	90076	90087
90006	90017	90027	90033	90046	90055	90070	90078	90088
90010	90019	90028	90036	90048	90057	90071	90079	90093
90012	90020	90029	90038	90050	90060	90072	90081	90096
90013	90021	90030	90039	90051	90065	90074	90084	90102

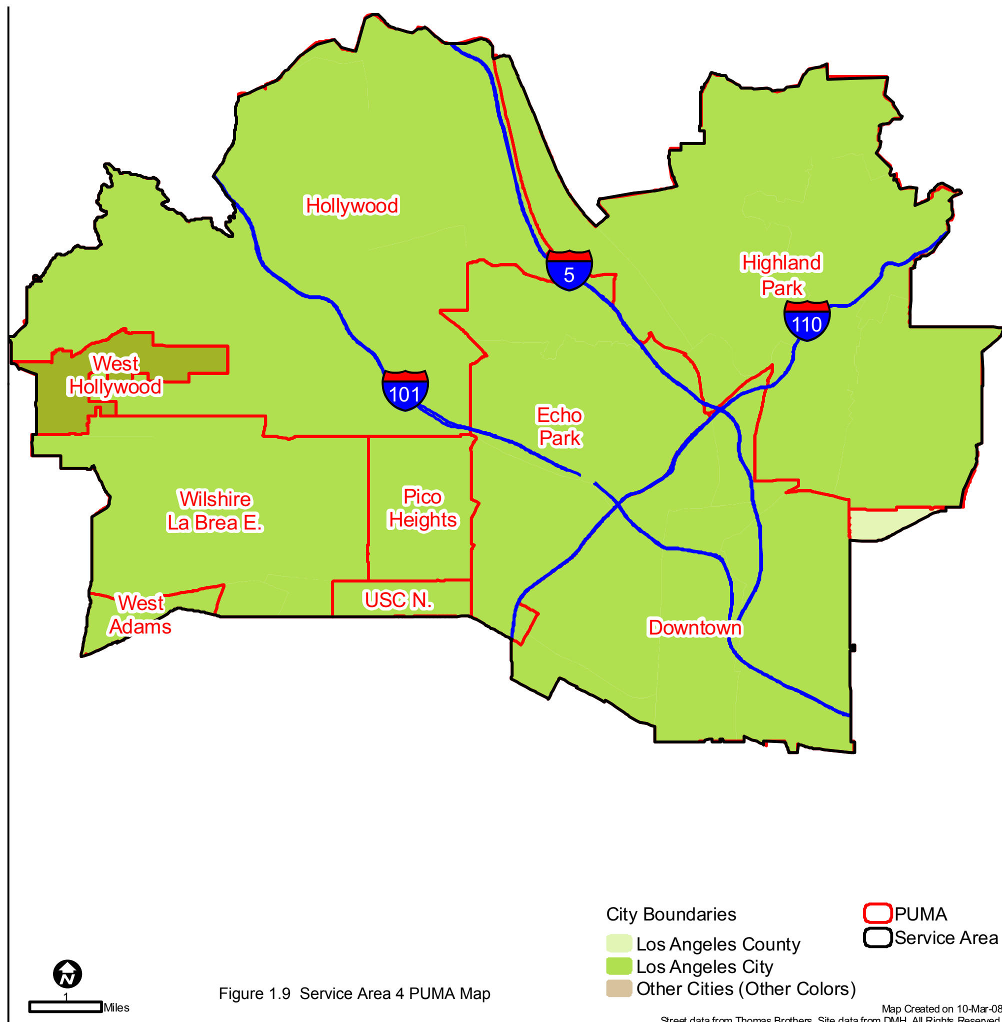


Figure 1.9 Service Area 4 PUMA Map

Service Area 5: West

Communities

Brentwood S.
West LA
Wilshire La Brea W.
Baldwin Hills W.
Playa Vista
Santa Monica-Culver City-Beverly Hills
Malibu

ZIP Codes

90009	90049	90077	90209	90231	90272	90311	90405
90024	90056	90080	90210	90232	90291	90312	90406
90025	90064	90083	90211	90233	90292	90397	90407
90034	90066	90094	90212	90263	90293	90401	90408
90035	90067	90095	90213	90264	90294	90402	90409
90045	90073	90099	90230	90265	90295	90403	90410
					90296	90404	90411

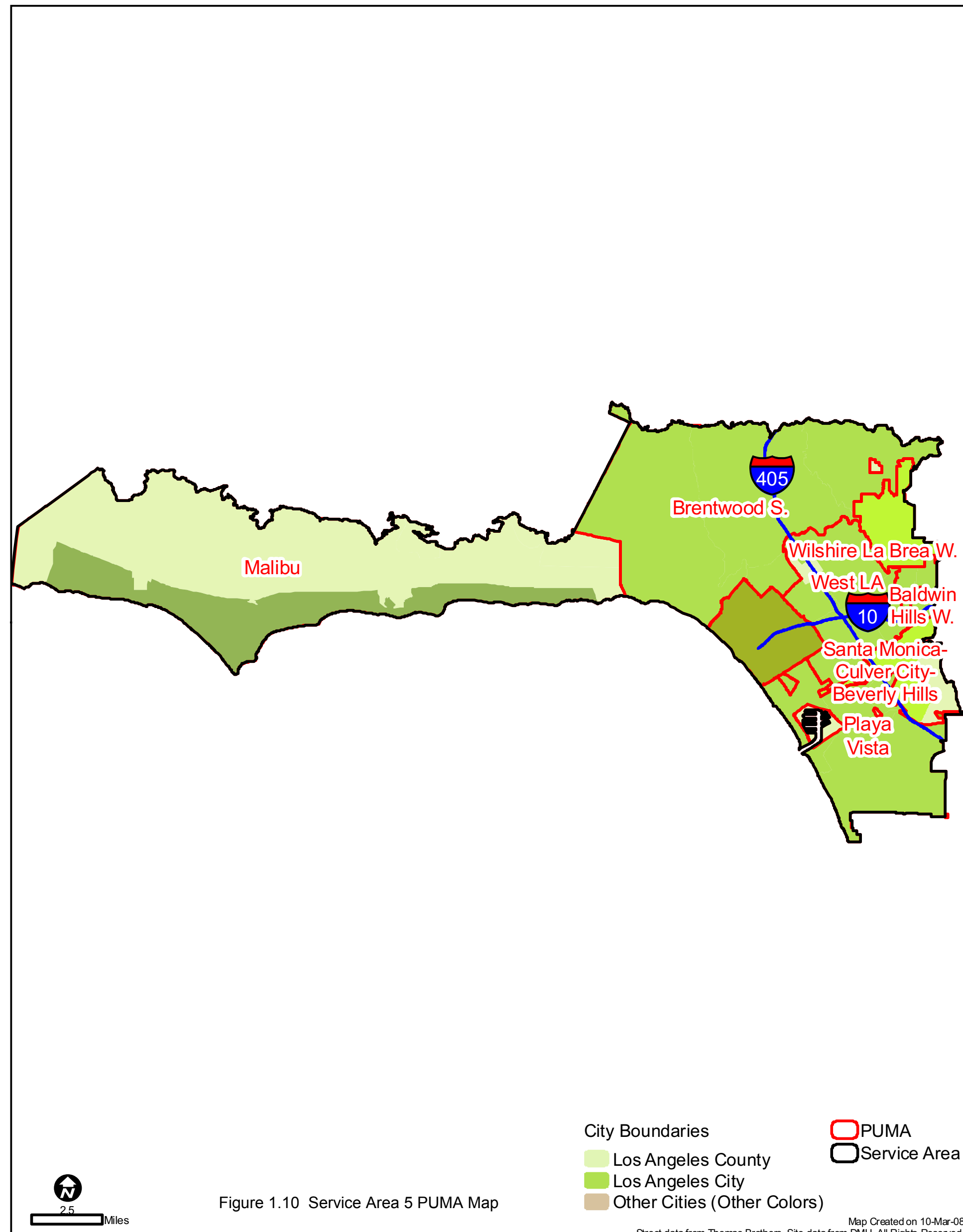


Figure 1.10 Service Area 5 PUMA Map

Service Area 6: South

Communities

USC S.
Baldwin Hills S.
Hancock N.
USC E.
Watts
Florence-Firestone
Lynwood
Paramount
Compton

ZIP Codes

90001	90007	90016	90043	90052	90062	90174	90221	90224
90002	90008	90018	90044	90059	90082	90185	90222	90262
90003	90011	90037	90047	90061	90089	90220	90223	90723

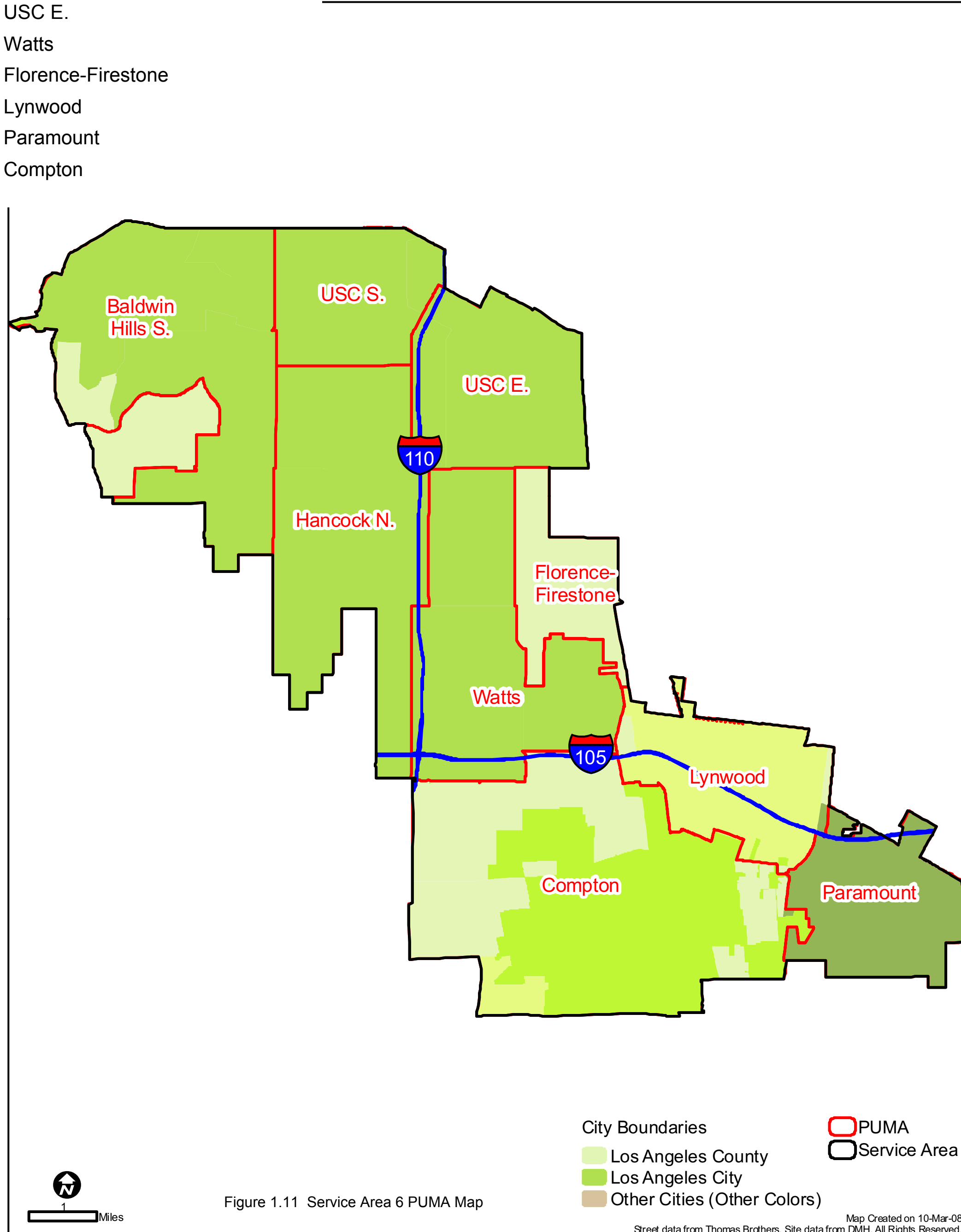


Figure 1.11 Service Area 6 PUMA Map

Service Area 7: East

Communities

East LA
Downey
Norwalk
Whittier
Montebello
Bell Gardens-Bell-Maywood-Cudahy-Commerce
Huntington Park
South Gate
Bellflower
La Mirada-Santa Fe Springs
Lakewood-Cerritos-Artesia-Hawaiian Gardens
Signal Hill

ZIP Codes

90255	90603	90608	90637	90651	90662	90703	90713
90270	90604	90609	90638	90652	90665	90706	90714
90280	90605	90610	90639	90659	90670	90707	90715
90601	90606	90631	90640	90660	90701	90711	90716
90602	90607	90633	90650	90661	90702	90712	90809
							90888

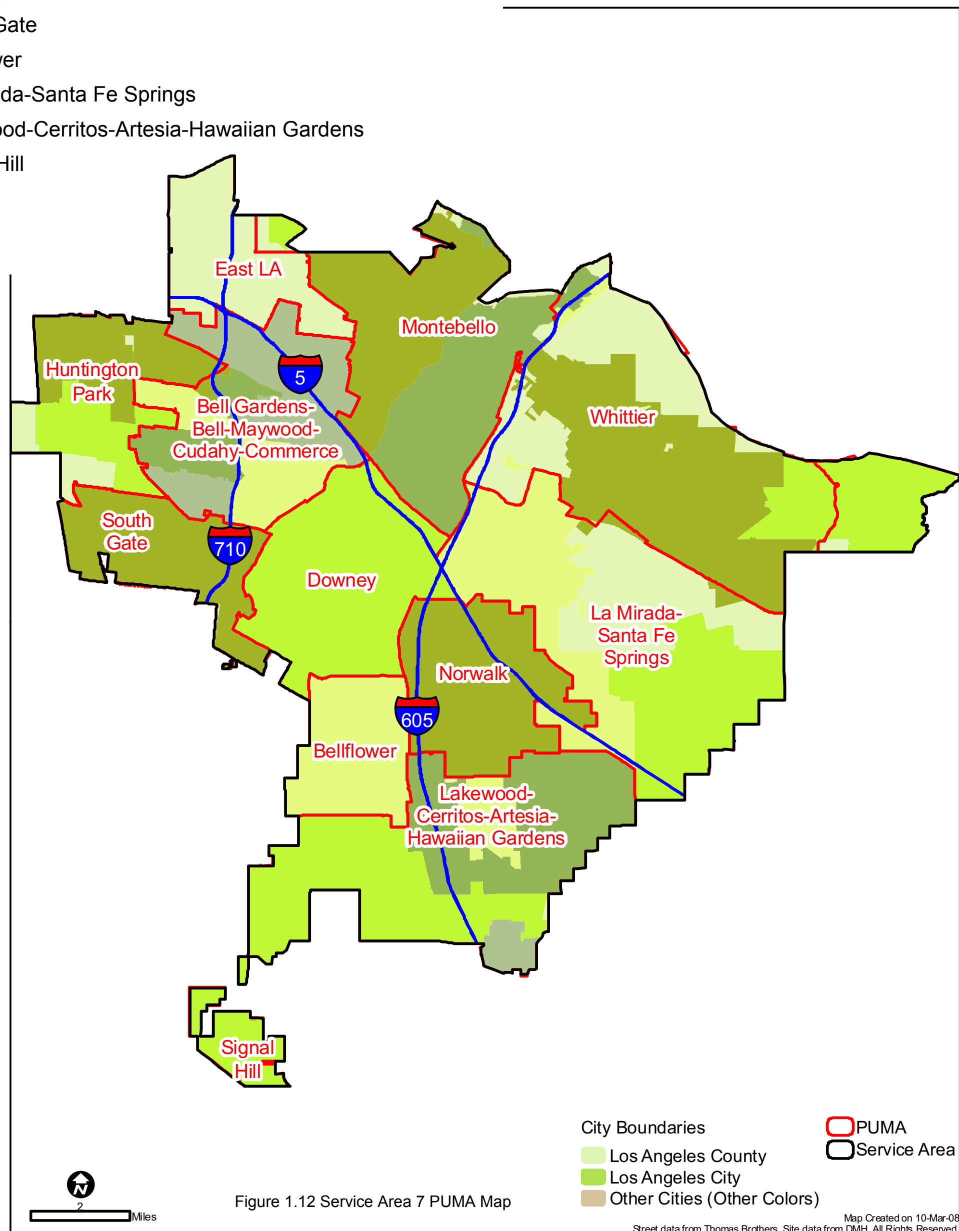


Figure 1.12 Service Area 7 PUMA Map

Service Area 8: South Bay

Communities

- Hancock S.
- Wilmington
- Inglewood
- Torrance
- Long Beach N.
- Long Beach S.
- Long Beach E.
- Carson
- Palos Verdes-Lomita
- Redondo-Manhattan-Hermosa-El Segundo
- Gardena-Lawndale
- Hawthorne

ZIP Codes

90310	90504	90510	90733	90748	90806	90822	90842
90313	90505	90704	90734	90749	90807	90831	90844
90398	90506	90710	90744	90801	90808	90832	90845
90501	90507	90717	90745	90802	90810	90833	90846
90502	90508	90731	90746	90803	90813	90834	90847
90503	90509	90732	90747	90804	90814	90835	90848
				90805	90815	90840	90853

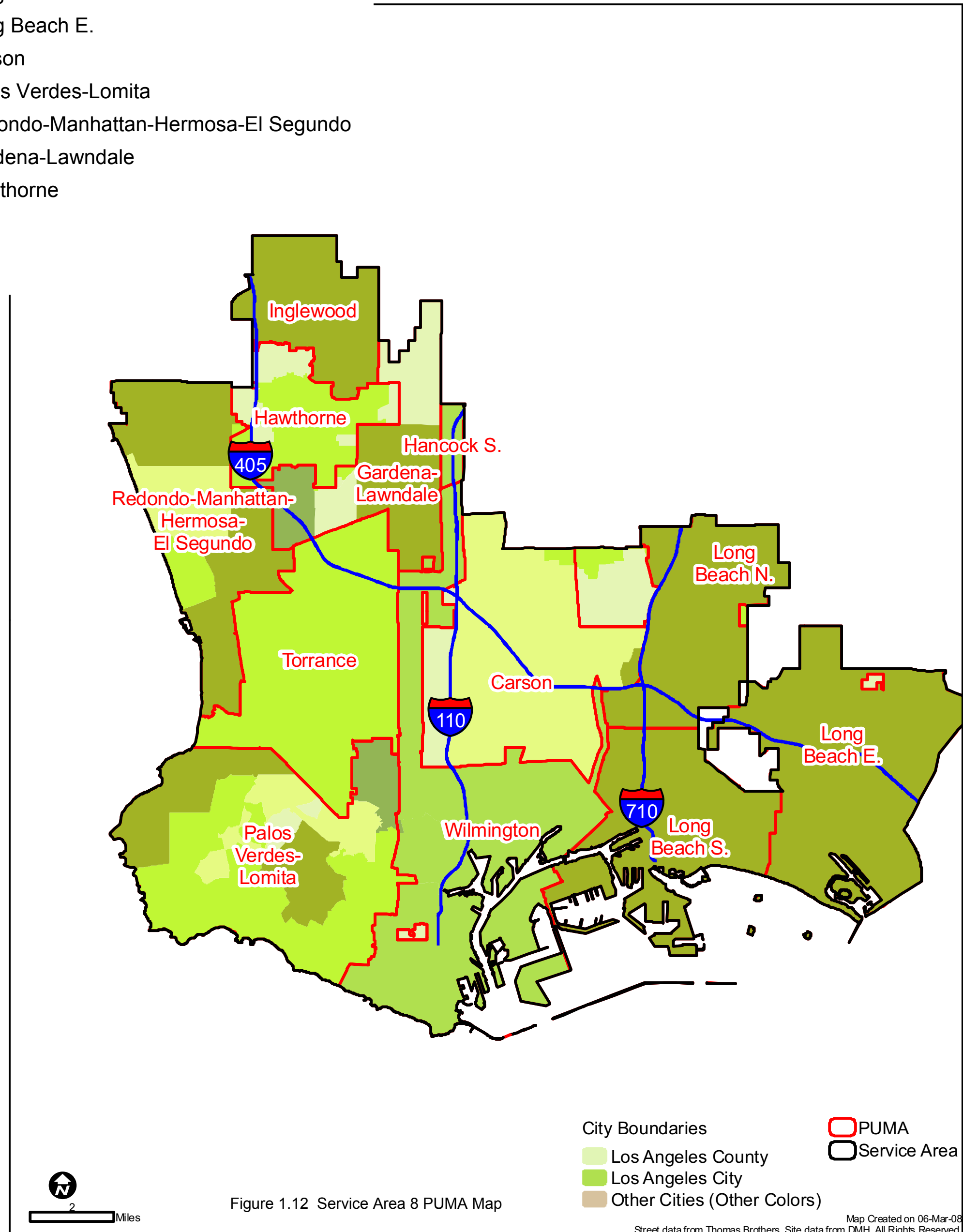


Figure 1.12 Service Area 8 PUMA Map

California Department of Mental Health (DMH)
Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act
February 16, 2005

Introduction

The Mental Health Services Act (MHSA) includes a clear set of challenging goals for all stakeholders to hold in common as the MHSA becomes reality.[1] Within the context of those common goals, the California Department of Mental Health (DMH) developed, in partnership with stakeholders, a ***Vision Statement*** and ***Guiding Principles*** to use as it implements the Community Services and Supports component of the MHSA.[2]

Most of the language and concepts included in the Vision Statement and Guiding Principles document were originally presented to MHSA stakeholders on the DMH website and at a public meeting in Sacramento in December 2004. At that time it was entitled “DMH Vision Statement”. Since then, in response to stakeholder comments and DMH policy clarification, this document has become a Vision Statement and Guiding Principles for DMH to hold for itself and stakeholders as it implements the Community Services and Supports component of the MHSA.

VISION STATEMENT

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

As a designated partner in this critical and historic undertaking, the California Department of Mental Health (DMH) will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families. In its implementation responsibilities under the MHSA DMH pledges to look beyond “business as usual” to help build a system where access will be easier, services are more effective, out-of-home and institutional care are reduced and stigma toward those with severe mental illness or serious emotional disturbance no longer exists.

[1] Mental Health Services Act, “Section 3. Purpose and Intent.”
[2] “Community Services and Supports “ means the same as “System of Care” in the MHSA, Welfare and Institutions Code Sections 5878.1-.3 and 5813.5

GUIDING PRINCIPLES

TO GUIDE DMH IN THE IMPLEMENTATION OF COMMUNITY SERVICES AND SUPPORTS

Beyond the goals in statute for the MHSA as a whole, DMH has developed, with stakeholder input, a set of Guiding Principles. These Guiding Principles will be the benchmark for DMH in its implementation of the MHSA Community Services and Supports component. DMH will work toward significant changes in the existing public mental health system in the following areas:

Consumer and Family Participation and Involvement

1. Significant increases in the level of participation and involvement of clients and families in all aspects of the public mental health system including but not limited to: planning, policy development, service delivery, and evaluation.

2. Increases in consumer-operated services such as drop-in centers, peer support programs, warm lines, crisis services, case management programs, self-help groups, family partnerships, parent/family education, and consumer provided training and advocacy services.

3. Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns and motivations.

Programs and Services

4. Changes in access and increased geographic proximity of services so that clients will be able to receive individualized, personalized responses to their needs within a reasonable period of time and to the extent needed to enable them to live successfully in the community.

5. Elimination of service policies and practices that are not effective in helping clients achieve their goals. Ineffective treatment methods will be replaced by the development and expansion of new values-driven, evidence-based and promising practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures and produce more favorable outcomes.

6. Increases in the array and types of available services so children, transition age youth, adult and older adults clients and their families will be able to choose, in consultation with mental health professionals, the kinds of services and the intensity of services that will assist them in attaining the goals in their individualized plans.

7. Integrated treatment for persons with dual diagnoses, particularly serious mental illness and serious substance use disorders, through a single individualized plan, and integrated screening and assessment at all points of entry into the service system.

Age–Specific Needs

8. For children, youth and their families, implementation of specific strategies to achieve more meaningful collaboration with child welfare, juvenile justice, education and primary healthcare, in order to provide comprehensive services designed to enable youth to be safe, to live at home, to attend and succeed in school, abide by the law, be healthy and have meaningful relationships with their peers.

9. For transition-age youth[3], programming to address the unique issues of this population who must manage their mental health issues while moving toward independence. This should include a person as a point of contact who would follow youth as they transition from the youth systems into the adult system or move out of the mental health system. To meet the needs of these youth, programming needs to include specific strategies for collaboration between the youth and adult systems of care, education, employment and training agencies, alternative living situations and housing and redevelopment departments.

10. For adults, implementation of specific strategies to achieve more meaningful collaboration with local resources such as physical health, housing, employment, education, law enforcement and criminal justice systems in order to promote creative and innovative ways to provide integrated services with the goals of adequate health care, independent living and self-sufficiency.

11. For older adults, implementation of specific strategies to increase access to services such as transportation, mobile and home-based services, comprehensive psychiatric assessments which include a physical and psychosocial evaluation, service coordination with medical and social service providers and integration of mental health with primary care. The ability to reside in their community of choice is a fundamental objective.

[3] The MHSA defines transition age as youth ages 16 to 25 in Welfare and Institutions Code (WIC) 5847.

12. For all ages, reductions in the negative effects of untreated mental illness including reductions in institutionalization, homelessness, incarceration, suicide, and unemployment.

Community Partnerships

13. Significant increases in the numbers of agencies, employers, community based organizations and schools that recognize and participate in the creation of opportunities for education, jobs, housing, social relationships and meaningful contributions to community life for all, including persons with mental illness. Care must be collaborative and integrated, not fragmented.

Cultural Competence

14. Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of mental health services.

15. Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.

Outcomes and Accountability

16. Expanded commitment to outcome monitoring including developing/refining strategies for evaluation of consumer outcomes, and system and community indicators, using standardized measurement approaches whenever possible. Data needs to be readily accessible and viewed as an essential part of program planning.

17. Development and implementation of policy and procedures to ensure that changes in service array in the future are based on intended outcomes. This may necessitate increased training and support for the mental health workforce.

18. Achievement of the MHSA accountability goals necessitates statewide adoption of consistent, effective service delivery approaches as well as standard performance indicators, data measurement and reporting strategies.

Taking a Comprehensive Viewpoint

19. Beyond the MHSA goals, and the DMH Vision Statement and Guiding Principles for implementation of Community Services and Supports, DMH will rely on the principles, goals, strategies, data and other information from the following nationally recognized documents and sources:

    - Principles articulated in the *President's New Freedom Commission Report* on Mental Health report.
    - Accountability based on the spirit of the Institute of Medicine's *Crossing the Quality Chasm* report.
    - Accountability based on the findings of Mental Health: Culture, Race and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001.
    - The vision, mission and values of the public mental health system as articulated in the California Mental Health Planning Council's *Master Plan.*
    - DMH will also consider previous reviews of the public mental health system such as the Little Hoover Commission reports and the reports of the Select Committee of the California Legislature.

Summary of Stakeholder Input

DMH and all stakeholders owe a debt of gratitude to those individuals who attended the December 17, 2004 initial MHSA stakeholders meeting in Sacramento. The comments and input provided on that occasion have proven to be invaluable guidance for DMH in the implementation of Community Services and Supports.

Pacific Health Consulting Groups noted the following as key stakeholder concerns about the original Vision Statement in the summary of the December 17, 2004 meeting:

"Participants provided both written and verbal comments about the vision statement. About 260 people provided about 380 written comments, many making more than one comment. The major themes were, in order of the numbers of comments per theme:

- Populations/Consumers and Family
- Children
- Alternative Treatments/Support Services
- Integration with Primary Care
- Workforce and Training
- Cultural Competence
- Outcomes/Quality of Life
- Prevention and Early Intervention
- Best Practices/Seamlessness/Transformation
- Stakeholders/Collaboration/Criminal Justice
- Substance Abuse/Co-occurring Disorders

DMH concurred with stakeholder comment that the Vision Statement as initially written was too long and yet didn't address all the various components of the MHSA. It was also clear that the goals written in the MHSA itself provide the best over-all picture of what the MHSA should achieve.

DMH adapted the language of the Vision Statement so that it became both a Vision Statement and Guiding Principles. These are intended to refer *only* to DMH's implementation of the MHSA Community Services and Support Component within the context of the goals of the MHSA. DMH realizes it may be necessary to develop similar implementation visions and principles as it proceeds with implementation of other components. In addition, many stakeholder concerns expressed about the initial draft have been clarified and moved to DMH Letter 05-01 which was issued in January, 2005. Remaining concerns are included in the "Draft Community Services and Supports Plan Requirements" that is presently under review by stakeholders.

Mental Health Services Act (MHSA) - Overview

California's voters passed Proposition 63 (Mental Health Services Act-MHSA) in the November 2004, General Election. Proposition 63 promised to greatly improve the delivery of mental health services and treatment across the State of California.

The MHSA represents a comprehensive approach to the provision of community-based mental health services and supports for the residents of California.

The MHSA funds a broad continuum of mental health services ranging from prevention and early intervention to a mental health services and supports to clients and families at various levels of need and recovery. In addition, MHSA provides funds for County infrastructure to support these services, including workforce, education and training, information technology and capital facilities.

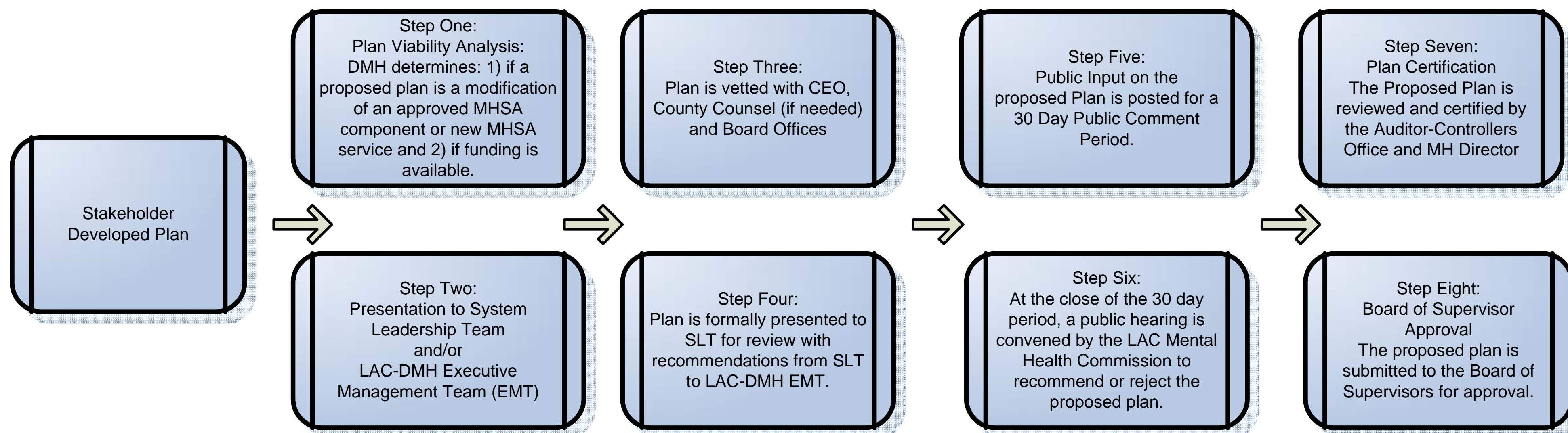
Fundamental to MHSA is the importance of meaningful stakeholder engagement and robust local planning processes. AB 1467 passed in June, 2012 adds to this by stating that counties demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning and implementation, monitoring, quality improvement, evaluation and budget allocations.

The MHSA establishes a Mental Health Services Oversight and Accountability Commission with duties that were amended with the passage of AB 1467 to include providing technical assistance to counties, to work in conjunction with the Department of Healthcare Services (DHCS) and the Mental Health Planning Council and in consultation with the California Mental Health Directors' Association to develop a plan to coordinate the evaluation of client outcomes.

The MHSA requires that each county mental health program prepare and submit an initial three-year plan which shall be updated at least annually. AB 1467 stipulates that County Annual Updates and Three Year Integrated Plans be adopted by County Board of Supervisors after a public hearing and 30 public comment periods. Counties then submit adopted plans to the Mental Health Services Act Oversight and Accountability Commission.

County of Los Angeles Department of Mental Health
MHSA Process for Plan, Update and Expenditure Approval

AB1467: Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations.



<u>Stakeholders</u>: "Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests."

(Note: The Department's System Leadership Team (SLT) has representatives from each of these stakeholder groups and serves as the Department's advisory group.)

August 27, 2012

<u>Public Input</u>: Counties are still required to include stakeholder representatives and conduct a stakeholder process in MHSA community program planning as initially enacted which includes a 30 day public comment period and public hearing convened by the County Mental Health Commissions.

(Note: The public hearing requirements applies only to Three-Year Plans and Annual Updates. Mid-year updates are adopted after the 30 day public comment period if there are no substantive changes. Public hearings are open to stakeholders and the general public)

<u>Plan Certification</u>: County MHSA plans, updates and expenditures must now be certified by the county mental health director and the county auditor controller as complying with the MHSA (programs meet all MHSA requirements including nonsupplantation and stakeholder participation).

<u>Board of Supervisors Approval</u>: County MHSA plans, updates and expenditures must now be approved locally by County Board of Supervisors (BOS)

10/29/14

Community Services and Supports

Community Services and Supports (CSS) refer to" System of Care Services" as required by the MHSA in WIC Sections 5813.5 and 5878.1-3. The change in terminology will differentiate MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local events.

The MHSA requires that "each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the State of California Department of Mental (SDMH) after review and comment by the Oversight and Accountability Commission" The MHSA further requires that "the department (SDMH) shall establish requirements for the content of the plans. Annual updates of this plan will be required pursuant to MHSA requirements.

On February 14, 2006, the California State Department of Mental Health (SDMH) approved the Mental Health Services (MHSA) - Community Services and Supports Plan for the Los Angeles County Department of Mental Health (LACDMH).

Community Services & Supports Plan

Children (0-15)

- Full Service Partnership (FSP)

Transition Age Youth (TAY) (16-25)

- Full Service Partnership (FSP)
- Drop-In Centers
- Enhanced Emergency Shelter Program
- Probation Camps
- Project-Based Operating Subsidies for Permanent Housing
- Field Capable Clinical Services (FCCS) NEW

Adults (26-59)

- Full Service Partnerships (FSP)
- Wellness Centers

Older Adults (60 and older)

- Field Capable Clinical Services (FCCS)
- Full Service Partnerships (FSP)

Mental Health Services Act
WORKFORCE EDUCATION AND TRAINING PLAN
Fact Sheet

What is the Workforce Education and Training Plan (WET)?

The Workforce Education and Training Plan (WET) is one of five components of the Mental Health Services Act (MHSA) being implemented. It is part of the MHSA transformation and supports the continuum of Community Services and Supports (CSS) Plan and Prevention, Early Intervention (PEI) Plan, Innovation Plan and Capital Facilities/Technology Plan. This component targets the workforce education and training needs of the public mental health system. In accordance with MHSA, the County of Los Angeles submitted a Workforce Education and Training Plan on October 15, 2008 and was approved on April 8, 2009. The Plan was developed in collaboration with the WET Ad Hoc Committee (which included representation from the MHSA stakeholders), community based organizations providing public mental health services, educational institutions, consumers and parent/family advocacy organizations) and Los Angeles County DMH programs and administration. Twenty-two action plans outline the manner MHSA workforce education and training program elements are to be implemented system wide. $60.2 million was allocated to Los Angeles County to address the transformation of the mental health workforce; all funds have to be spent by FY 2016-2017.

What are the goals and objectives of WET?

- To address and assess identified shortages in occupations, skill sets and consumer/family involvement in terms of unique cultural and linguistic competencies.
- To identify education and training needs for those who provide services and assistance in the public mental health services sector.
- To identify strengths and opportunities (i.e., gaps, deficiencies) for system transformation or growth.

Such goals and objectives adhere to the MHSA fundamental concepts:

- Wellness, recovery and resilience
- Cultural competence

- Client/Family driven mental health system
- Integrated service experience
- Community collaboration

How does MHSA-WET funding target the workforce transformation needs and what are the education and training program elements?

There are five funding categories intended to remediate the workforce needs. They are as follows:

1. **Workforce Staff & Support** - This category includes specific funds to plan for, administer, support or evaluate the workforce programs and trainings fielded in the remaining four categories.

- Workforce Education and Training Coordination
- County of Los Angeles Workforce Education and Training Advisory Committee

2. **Training & Technical Assistance** – This is defined as events and activities to support the personnel in the public mental health system and deliver services consistent with the fundamental principles originally intended by MHSA. These programs are at different stages of development and implementation. They include the following:

- Transformation Academy Without Walls
  - Public Mental Health Workforce Immersion to MHSA
  - Licensure Preparation Workshops
  - Health Navigators Program
- Recovery Oriented Supervision Trainings
- Interpreter Training Program
- Training for Community Partners
  - Community College Collaborations
  - Faith Based Programs (These are Service Areas identified and incorporate faith based members and mental health staff in roundtable discussions that address the service needs of congregates/consumers they mutually serve.)

3. **Career Pathways Programs** – Mental health career pathway programs consist of educational and training programs designed to recruit, train and re-train individuals in

the public mental health system. Currently the programs in development and implementation are as follows:

- Intensive Mental Health Recovery Specialist Training Program
- Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System
  - Peer Advocate Training
  - Peer Training Institute
- Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
- Expanded Employment and Professional Advancement Opportunities for Family Members Advocates in the Public Mental Health System
- Mental Health Career Advisors
- High School through University Mental Health Pathways
- Market Research and Advertising Strategies for Recruitment and Professionals in the Public Mental Health System
- Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System
  - Faculty/College Immersion

4. **Residency & Internship Programs** – This is MHSA designated funding for psychiatric residency programs, internship programs leading to licensure and physician assistant programs with a mental health specialty. These programs are designed to address workforce shortages and supplement existing programs to increase the share of licensed professionals practicing in community public mental health. The program identified in this funding category targets the preparation of students (the future workforce and their practicum/internship personnel) for entry into a transformed mental health system.

- Recovery Oriented Internship Development

5. **Financial Incentive Programs** – These are stipends, scholarships, and loan forgiveness programs that are financial incentives to recruit and retain both prospective and current public mental health employees who meet the following workforce needs: 1) diversity and language proficiency, 2) provide certain skill sets essential to the workforce and 3) promote employment and career opportunities for individuals with consumer and family member experience in public mental health positions.

- Tuition Reimbursement/Loan Forgiveness Programs
- Stipend Program for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians
- UCLA Affiliation Agreement – Post Docs

For additional information, please contact us:

Workforce Education and Training Division
adiaz@dmh.lacounty.gov
Phone#: (213) 251-6879
Fax#: (213) 252-8775

WELLNESS • RECOVERY • RESILIENCE

Prevention and Early Intervention

The Los Angeles County Prevention and Early Intervention (PEI) Plan focuses on prevention and early intervention services, education, support, and outreach to help inform and identify individuals and their families who may be affected by some level of mental health issue. Providing mental health education, outreach and early identification (prior to diagnosis) can mitigate costly negative long-term outcomes for mental health consumers and their families.

On March 26, 2009, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved L.A. County's PEI Early Start Projects Plan in order to jump start the creation of PEI Services. On August 27, 2009, the Mental Health Services Oversight and Accountability Commission approved the PEI Plan for Los Angeles County.

What is Prevention?
Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills, and increasing support. Prevention promotes cognitive, social and emotional development and encourages a state of well-being.

What is Early Intervention?
Early intervention is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.

Prevention & Early Intervention
mhsapei@dmh.lacounty.gov
Phone: (213) 251-6712
Fax: (213) 252-8749

Capital Facilities

Los Angeles County's Department of Mental Health's (LAC-DMH) Capital Facilities Component Proposal funds will be utilized to increase and improve the existing capital facilities infrastructure to accommodate the implementation of the MHSA plans. The proposal addresses the current and anticipated needs that will arise during the implementation of the various MHSA plans. LAC-DMH Capital Facilities Component Proposal will produce long-term impacts with lasting benefits that will move its mental health system toward the goals of wellness, recovery and resiliency.

The $39 million allocation will fund acquisition of land(s) and building(s); construction of mental health service facilities and administrative space; and renovation and expansion of existing County owned facilities which require modernization and transformation to provide an environment for the clients and families of empowerment, reduce disparities, and increase access and appropriateness of care.

The MHSA Capital Facilities component Proposal was approved by the State on May 27, 2010. Preliminary research for acquisition, construction, and/or renovation of various sites has started.

The MHSA Capital Facilities Plan is now available in draft form for a 30-day public review and comment period. Please check on the following link to view the announcement and access the public comment form:
http//dmh.lacounty.gov/wps/portal/dmh/press_center/announcements

Please click on the link to go directly to the Draft Capital Facilities Plan:
http//file.lacounty.gov/dmh/cms1_159597.pdf

Being There: Making a Commitment to Mental Health (2000) Young Hearts & Mind: Making a Commitment to Children's Mental Health (2001)

Prevention & Early Intervention
mhsapei@dmh.lacounty.gov
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Fax: (213) 351-2026

Workforce Education & Training
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Technology Plan Component – Information System (IS)

Technology

The Chief Information Office Bureau (CIOB) of the Los Angeles County Department of Mental Health (LACDMH) is responsible for meeting the technological needs of the mental health system in Los Angeles County. To assist LACDMH in achieving the goals of the Mental Health Services Act (MHSA), CIOB is responsible for developing a long-term information systems infrastructure program and expenditure plan for mental health to facilitate the highest quality, cost-effective services and supports for consumer and family wellness, recovery, and resiliency.

MISSION
Chief Information Office Bureau

To facilitate the accomplishment of the DMH Mission through carefully selected, well maintained, and cost-effective information technology products and services.

MHSA – IT Plan

Los Angeles County Department of Mental Health (LAC-DMH) developed its Mental Health Services Act (MHSA) Technological Needs Proposal (MHSA-IT Plan) through a comprehensive stakeholder process that began in September 2007. The MHA-IT Plan was approved by local stakeholders via a public hearing in August 2008. Subsequent to stakeholder approval, the MHSA-IT Plan was approved by the County Board of Supervisors in February 2009 and California Department of Mental Health in May 2009.

MHSA-IT Plan funds ($69,779,360) will be used to support technology projects that advance two overarching MHSA goals:

- Increasing Consumer and Family Empowerment by providing the tools for secure consumer and family access to health information and;
- Modernization and Transformation of clinical and administrative information systems to ensure quality of care, party, operational efficiency and cost effectiveness.

Although stated as distinct goals, LAC-DMH views the consumer as the focus of each technology project included in the MHSA-IT Plan. At the core of each is the desire to develop an integrated information systems infrastructure that improved the overall well-being of consumers receiving public mental health services in LAC.

The MHSA-IT Plan contains six projects:

I. Integrated Behavioral Health information System
II. Contract Provider Technology Projects
III. Consumer/Family Access to Computer Resources
IV. Personal Health Record Awareness and Education
V. Data Warehouse Re-Design
VI. Telepsychiatry Feasibility Study and Recommendations

Integrated Behavioral Health Information System (IBHIS): The IBHIS will provide integrated clinical, administrative and financial functionally to LAC-DMH in its role as a provider of mental health services and in its role as the Local Plan Administrator. The IBHIS will provide LAC-DMH clinicians access to consumer clinical records regardless of where each consumer was seen previously in the LAC-DMH directly-operated network. Clinicians will have access to medication history information, recent assessments, laboratory and psychological test results, and when appropriate, clinician notes of prior visits. Some basic information about visits to contract providers will also be available.

Contract Provider Technology Projects: The Contract Provider Technology Project is an umbrella project encompassing a mix of technology projects within the range of projects identified in the MHSA Capital facilities and Technological Needs Guidelines. The umbrella project is intended to provide a means for Contract Providers within the LAC-DMH provider network to obtain the funding necessary to fully participate in the Integrated Information Systems Infrastructure and address their technological needs consistent with the MHSA Capital Facilities and Technological Needs Guidelines.

Consumer/Family Access to Computing Resources Project: Mental health consumers and family members need access to computer resources and they should have access to computer training and technical assistance. Computer skills training and technical assistance are essential to ensure that consumers and family members are able to effectively use computer resources made available to them. Through this project LAC-DMH plans to set-up consumer/family dedicated computer workstations in selected service settings. Other settings are being considered. This project also includes technical assistance during normal business hours to consumer/family users.

Personal Health Record Awareness and Education Project (PHR): Through the stakeholder process LAC-DMH received considerable feedback suggesting that many mental health consumers have limited awareness of PHR(s) and how a PHR may be used as a recovery and wellness tool. LAC-DMH has received MHSA Information Technology funds to support the implementation of a PHR and to provide training in the appropriate use of a PHR.

Data Warehouse Re-Design: Implementation of the electronic health record necessitates re-designing the current LAC-DMH data warehouse. Along with new data collected in the IBHIS, other MHSA programs (Prevention and Early Intervention, Workforce Education and Training, and Innovation) will bring in additional new clinical, administrative, and financial data that must be stored in and made accessible via the data warehouse. This project will prepare LAC-DMH for warehousing data from disparate sources as well as establish appropriate resources for warehousing legacy data.

Telepsychiatry-Feasibility Study and Recommendations: LAC-DMH encompasses over 4,000 square miles and some areas are sparsely populated and remote from major medical centers and mental health service delivery resources. LAC-DMH received MHSA funding to support a feasibility study to identity opportunities for a variety of telepsychiatry programs; however, by the time the funding arrived, the feasibility had been firmly established and the project shifted to an implementation effort. Telepsychiatry is now an established program in LAC-DMH.

OBTAINING MORE INFORMATION ON INNOVATION SERVICES IN YOUR COMMUNITY

Contact your local Service Area Navigator for information on availability of Innovation services in communities across the county.

Antelope Valley, Service Area 1
Angela Coleman, (661) 223-3813

San Fernando Valley, Service Area 2
Darrel Scholte, (818) 610-6705

San Gabriel Valley, Service Area 3
Eugene Marquez, (626) 471-6535

Metro Los Angeles, Service Area 4
Phyllis Moore-Hayes, (323) 671-2626

West Los Angeles, Service Area 5
Carolyn Kaneko, (310) 482-6612

S. Central/Compton/Lynwood, Service Area 6
Kimberly Spears, (323) 290-5824

Southeast Los Angeles, Service Area 7
Tere Antoni, (213) 738-6150

Long Beach/South Bay, Service Area 8
Alicia Powell, (562) 435-2287

"Hope, Wellness and Recovery" through innovative models of care!

12/4/14

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County of Los Angeles
Department of Mental Health
Program Support Bureau
550 South Vermont Avenue
Los Angeles, CA 90020

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

MARVIN J. SOUTHARD, D.S.W.
DIRECTOR

MENTAL HEALTH SERVICES ACT (MHSA) INNOVATION PROGRAMS

http://dmh.lacounty.gov/wps/portal/dmh/about_dmh/mhsa

INNOVATION Programs Overview

What is the MHSA INNOVATION (INN) Program?
The MHSA Innovation (INN) program is focused on implementing and evaluating four models that integrate mental health, physical health and substance abuse services. The primary goal is to learn which are the best and most cost effective practices to meet the spectrum of needs of individuals who are uninsured/economically disadvantaged, homeless and members of underrepresented ethnic populations. By implementing new and innovative approaches, the goal is that this time-limited program will contribute to learning and inform future practice.

The Integrated Mobile Health Team Model

The **Integrated Mobile Health Team** (IMHT) service model is designed to improve and better coordinate the quality of care for individuals with a mental illness and their families, if appropriate, who are homeless or have recently moved into Permanent Supportive Housing (PSH) and have other vulnerabilities. Vulnerabilities include but are not limited to age, years homeless, co-occurring substance abuse disorders and/or physical health conditions. Improving the quality of care will be accomplished by having multidisciplinary staff that provide mental health, physical health and substance abuse services work as one team, under one point of supervision, operate under one set of administrative and operational policies and procedures and use an integrated medical record/chart. The program is designed to provide the level of services necessary to support clients to successfully transition from homelessness into PSH and to improve their mental health and co-occurring disorders.

The Community-Designed Integrated Service Management Model

The **Community-Designed Integrated Service Management Model** (ISM) envisions a holistic model of care whose components are defined by specific ethnic communities and also promotes collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support the recovery of consumers.

The five ethnic communities targeted are:

~ African Immigrant / African American

~ American Indian / Alaska Native

~ Asian Pacific Islander

~ Eastern European / Middle Eastern

~ Latino

The ISM model consists of discrete teams of specially-trained and culturally competent "service integrators" that help clients use the resources of both formal" (i.e., mental health, health, substance abuse, child welfare, and other formal service providers) and nontraditional" (i.e., community defined healers) networks of providers, who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations.

The Innovative Integrated Peer Run Model

The **Innovative Integrated Peer Run Model: Peer-Run Integrated Services Management** (PRISM**)** and **Peer-Run Respite Care Homes (**PRRCH) are peer-operated and member driven community based, recovery oriented, holistic alternatives to traditional mental health programs. **PRISM** offers linkage to health, mental health, substance abuse, and housing services as part of a program designed to empower individuals to sustain their own recovery. **PRRCH** offers guests a short-stay voluntary opportunity to grow through distress in a warm, safe, and healing environment while engaging in recovery focused supportive services as desired.

The Integrated Clinic Service Model

The **Integrated Clinic Model** (ICM) is designed to improve access to quality culturally competent services for individuals with physical health, mental health and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites. ICM's are staffed with multidisciplinary professional teams and specially trained peer counselors and paraprofessionals.

ICMs provide:

~ Recovery Oriented Assessments

~ Mental Health Treatment Services

~ Co-occurring Substance Use Services

~ Peer Counseling and Self Help

~ Primary Care Services

~ Homeless/Housing Services

~ Care Management

~ Wellness Activities

~ Outreach

Key Indicators of Success for INN Programs

Each of the model programs will be evaluated on the following indicators:

~ Level of service integration

~ Health status improvement

~ Mental Health status improvement

~ Substance use

~ Client satisfaction

~ Community satisfaction

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

System Leadership Team

Principles

The System Leadership Team's (SLT) success as a monitoring and advisory body rests on two key principles.

Diversity: The SLT includes a broad range of stakeholder perspectives that represent the different sectors that comprise the public mental health system, including contract providers, directly operates services, education, public agencies, commissions, and various advocacy groups to name a few. The list of stakeholder perspectives can be found at the end of this document.

Strong commitment: Creating hope, wellness, recovery and resiliency for clients, families and communities served by the County of Los Angeles public mental health system. Although SLT members come from different sectors, they explore and develop solutions that advance the purpose and intent of MHSA and the Department's mission of "enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency".

Service Area Advisory Committee

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

System Leadership Team

Functions

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

Expectations

- Voice the needs of specific stakeholder group(s) of the Los Angeles County public mental health system.
- Provide advice and negotiate solutions that balance the needs of specific stakeholder groups and needs of the broader public mental health system.
- Assist the Los Angeles county public mental health system in fulfilling its move towards the goals of hope, wellness and recovery.
- Adhere to meeting principles and norms conductive to safe and effective deliberation.
- Give recommendation free of conflict of interest of their specific organizations.
- Participate in the Issues Resolution Committee when their expertise has a bearing on the issue at hand.

Service Area Advisory Committee

- Actively participate in at least one committee (in addition to the Issues Resolution Committee): Budget Mitigation, Community Services and Support (CSS), Innovations (INN), Issue Resolution Prevention and Early Intervention (PEI), Workforce Education and Training (WET), or other ad hoc work groups.

Attendance

- SLT members represent a unique mix of stakeholder perspectives, and therefore alternates are not allowed to substitute for the SLT member.
- SLT members need to attend at least 9 out of 11 monthly meetings.
- If missing a meeting, SLT members should send a representative to keep the SLT member informed.

Term of Office

- SLT members serve a three-year term.
- This appointment is renewable.
- The inaugural SLT group will be assigned a staggered appointment based on a lottery system to ensure that approximately one-third of the seats are renewed each year.

System Leader Team Members
Roster

	Name of Nominee	Org. Affiliation
1	*Amerson, Vincent*	LAC-CEO
2	*Banks, Dorothy*	SAAC 6
3	*Bernstein, Karen*	LAC-DHS
4	*Boyce, Elizabeth*	LAC-CEO
5	*Candelario, Jury*	SAAC 4
6	*Carlson, Christopher*	SAAC 3
7	*Cavalheiro, Marcelo*	SAAC 7
8	*Colchado, Leticia*	LAC-DPSS
9	*Concannon, Diana*	Consultant
10	*DeBose, Herman*	LAC-MH Commission
11	*Dempsey, Charles*	LA Police Dept.
12	*Diaz, Carmen*	LAC-DMH
13	*Gallo, Dora*	Community of Friends
14	*Glover, John*	SA I
15	*Gordon, Andrea*	Probration
16	*Hollman, Ruth*	SHARE
17	*Uesugi-Hwan, Keith*	SAAC 5
18	*Inaba, Pamela*	LACCC
19	*Jackson, Cynthia*	Heritage Clinic
20	*Kahn, Mariko*	PACSLA
21	*Kaissi, Taif*	Medical Network Devoted to Service (MiNDS)
22	*Kochen, David*	LAC-CSS

System Leader Team Members

	Name of Nominee	Org. Affiliation
23	*Kubrin, Diane*	*Los Angeles LGBT Center*
24	*Lamon, Eddie*	SAAC 6
25	*LaPlace, Patti*	City of Long Beach
26	*Leggitt, Anthony*	LAC-DMH
27	*Lowe, Evy*	SAAC 2
28	*Luck, Alice*	Project Return
29	*Macedonio, Karen*	SAAC 5
30	*Mckenna, Teddy*	AFSCME
31	*McKnight, Carl*	LAC-DMH
32	*Nagle, Laura*	SA 1
33	*O'Connell, Jim*	COJAC
34	*Oshagan, Emma*	Pacific Clinics
35	*Parra, Mark*	American Indian/UREP
36	*Pelsman, Mara*	Hospital Association
37	*Preis, Jim*	MH Advocacy
38	*Pulido, Ricardo*	NAMI
39	*Ramos, Cecilia*	LAUSD
40	*Retana, Paco*	Green Dot Pubic Schools
41	*Rizzo, Mike*	L.A. Gay & Lesbian Center
42	*Rotstein, Joanne*	LAC-Public Defender
43	*Rueda, Lisa*	Junior Blind
44	*Russell, Patricia*	SAAC 2

System Leader Team Members

	Name of Nominee	Org. Affiliation
45	*Saltzer, Bruce*	ACHSA
46	*Shepard, Curtis*	L.A. Gay & Lesbian Center
47	*Sorensen, Lisa*	LAC-DCFS
48	*Sorkin, Nina*	Commission on Children & Families
49	*Suarez, Ana*	LAC-DMH
50	*Sugita, Wayne*	LAC-Public Health
51	*Taylor, Romalis*	UREP
52	*Thomas, Renee*	GLAD
53	*Van Horn, Richard*	MHALA
54	*Vega, William*	USC-Universities
55	*Young, Marlon*	SEIU
56	*Ximenez, Leticia*	CCC

Los Angeles County Department of Mental Health
System Leadership Team (SLT)
Meeting Schedule
January – December 2015

Date		Time		Location
1/21/2015		**9:30 am - 12:30 pm**		**To Be Determined**
2/18/2015		**9:30 am - 12:30 pm**		**To Be Determined**
3/25/2015		**9:30 am - 12:30 pm**		**To Be Determined**
4/15/2015		**9:30 am - 12:30 pm**		**To Be Determined**
5/20/2015		**9:30 am - 12:30 pm**		**To Be Determined**
6/17/2015		**9:30 am - 12:30 pm**		**To Be Determined**
7/22/2015		**9:30 am - 12:30 pm**		**To Be Determined**
8/19/2015		**9:30 am - 12:30 pm**		**To Be Determined**
9/23/2015		**9:30 am - 12:30 pm**		**To Be Determined**
10/21/2015		**9:30 am - 12:30 pm**		**To Be Determined**
11/18/2015		**9:30 am - 12:30 pm**		**To Be Determined**
12/16/2015		**9:30 am - 12:30 pm**		**To Be Determined**

California Community Mental Health Funding

Evolution and Policy Implications

Patricia Ryan, MPA
Executive Director
California Mental Health Directors Association

California Institute for Mental Health
Financial Leadership Institute

April 25, 2012

1

Major CA Historical Fiscal/Policy Milestones

- 1969: Community Mental Health Services Act, Deinstitutionalization, Short/Doyle Act
- 1991: Realignment 1991
- 1993: Medi-Cal Rehabilitation Option
- 1995-97: Medi-Cal Specialty Mental Health Consolidation
- 2004: Prop. 63 – Mental Health Services Act
- 2008: Federal Mental Health Parity
- 2009-10 Federal Health Care Reform/CA 1115 Waiver
- 2011: AB 100/MHSA Changes
- 2011: Realignment 2011/Public Safety Realignment

2

Community Mental Health Services Act/Deinstitutionalization (1969)

* The California Community Mental Health Services Act 1969 was a national model of mental health legislation that "deinstitutionalized" mental health services, serving people with mental disabilities in the community rather than in state hospitals.

Short-Doyle Act (1969)

* The Short-Doyle Act was the funding mechanism intended to build the community mental health system. Legislative intent language called for funding to shift from state hospitals to community programs.

* However, the state failed to distribute the full savings achieved through the closures of state hospitals to the community mental health system.

No Entitlement for Mental Health Services

* Unlike services to persons with developmental disabilities, ***the mental health system was never conceived as an "entitlement."***
* Mental health services were to be provided ***"to the extent resources are available."***
* This essential difference built rationing of services into the framework of mental health service delivery…

Community Mental Health System in Crisis

1970-1990

* Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 80s.
* In 1990, California faced a $15 billion state budget shortfall which would certainly have resulted in even more drastic cuts to mental health.
* Community mental health programs were already near collapse and overwhelmed with unmet need. This crisis propelled the enactment of "Realignment."

Realignment
(1991)

- "Realignment" was enacted in 1991 with passage of the Bronzan-McCorquodale Act.
- *It represented a major shift of authority from the state to counties for mental health programs.*
- Realignment 1991 created a new dedicated revenue source for counties.
- Instead of community mental health being funded by the State General Fund (and thus subject to the annual state budget process), new "Realigned" revenues would flow directly to counties.

Realignment 1991 Funding Sources

- Realignment included two dedicated revenue streams:
  - ½ cent increase in state sales tax
  - State Vehicle License Fee (VLF)

Mental Health Programs Realigned from the State to Counties

* All community-based mental health services
* State hospital services for civil commitments
* Mental health services for those in "Institutions for Mental Disease (IMDs)," which provide long-term psychiatric nursing facility care

Benefits of 1991 Realignment

* Realignment has generally provided counties with many advantages, including:
  * A stable funding source for programs, which made a long-term investment in mental health infrastructure financially practical.
  * The ability to use funds to reduce high-cost restrictive placements, and to serve clients appropriately in the community.
  * Greater fiscal flexibility, discretion and control, including the ability to "roll-over" funds from one year to the next, enabling long-term planning and multi-year funding of projects.
  * Emphasis on a clear mission and defined target populations.

Public Health and Social Services Were also Realigned in 1991

- Although it was initially begun as an effort to reform mental health financing, public health programs and some social services (such as In-Home Supportive Services and Foster Care) were also added to the Realignment mix.
- Because the social services programs were "entitlement" programs, they were given priority for any "growth" in Realignment revenues.
- ***Over time, this structure contributed to many of the shortcomings of 1991 Realignment for mental health– revenues dedicated to mental health did not keep pace with community needs.***

11

Realignment Funds Distributed by Formula[1]

- Annually, Realignment revenues were[1] distributed to counties on a monthly basis until each county received funds equal to the previous year's total.

[1] Realignment 2011 has made changes to 1991 distribution amounts and methodologies that will be explained later under 2011 Realignment.

- Funds received above that amount were placed into growth accounts: Sales Tax and VLF.
- Realignment "growth" funds were distributed annually, and ***the first claim on the Sales Tax Growth Account went to caseload-driven social services entitlement programs (IHSS and child welfare).***
- Any remaining growth from the Sales Tax Account and all VLF growth were then distributed according to a formula developed in statute.

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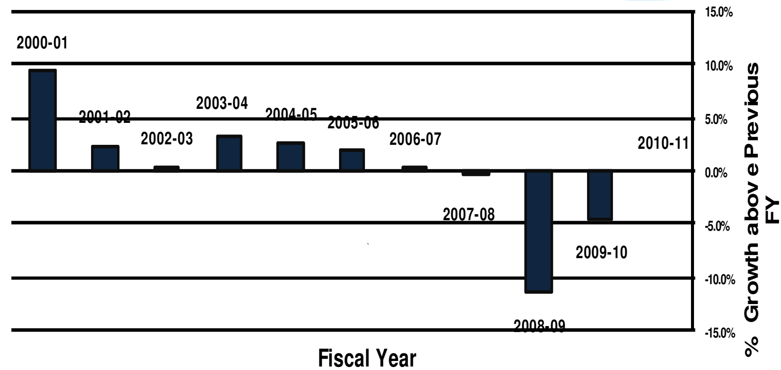
Realignment Formula Flawed – Insufficient Growth for Mental Health

* ***Under Realignment 1991, mental health received no Sales Tax growth since FY 2005/06.***
* *In Fiscal Years 2007/08, 2008/09 and 2009/10, mental health did not even make the prior year's base.*
* ***FY 2009/10 and FY 2010/11, Mental Health Sales Tax revenues approximated the original baseline amounts from FY 1991/92.***
* FY 2010/11 VLF revenues were approximately the same as FY 2003/04 amounts.

Realignment Mental Health Growth Insufficient

* Mental Health Sales Tax revenues declined:
  * Down 13% in FY 2008/09
  * Down 4% in FY 2009/10
  * Unchanged in FY 2010/11
* Mental Health VLF revenues declined:
  * Down 8% in FY 2008/09
  * Down 7% in FY 2009/10
  * Unchanged in FY 2010/11
* Overall decline in FY 2009/10 total Mental Health Realignment of approximately 5%.

Realignment Growth for MH: Fiscal Year 2000/01 to 2010/11



Medi-Cal Mental Health Services

Understanding the changes in California's Mental Health Medi-Cal program since Realignment, and the interaction of Medi-Cal revenues with Realignment, is critical to analyzing the current structure and status of public mental health services in California…

Medi-Cal Mental Health Services History in California

* The Fee-for-Service "clinic option" Medi-Cal program originally consisted of "physical" health care benefits, with mental health treatment making up only a small part of the program.
* Mental health services were limited to treatment provided by physicians (psychiatrists), psychologists, hospitals, and nursing facilities, and were reimbursed through the Fee-For-Service Medi-Cal system (FFS/MC).

Medi-Cal Mental Health Services

* Short-Doyle/Medi-Cal (SD/MC) started as a pilot project in 1971, and counties were able to obtain FFP to match their own funding to provide certain mental health services to Medi-Cal eligible individuals.
* The SD/MC program offered a broader range of mental health services than those provided by the original FFS Medi-Cal program.

Medi-Cal Rehabilitation Option
(1993)

- A CA Medicaid State Plan Amendment in 1993 added more services under the federal Medicaid "Rehab Option" to the scope of benefits, including:
  - Community based (non-clinic) services
  - Expanded service provider types
  - Additional service types
  - Expanded acute care model to include long term community care model

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Medi-Cal EPSDT
(1995)

- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) represents an expansion of services resulting from a successful class action lawsuit against the state.
- The state's settlement agreement resulted in increased state responsibility for funding for Medi-Cal specialty mental health services for full scope Medi-Cal beneficiaries under age 21.

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Medi-Cal Specialty Mental Health Consolidation (1995-1997)

* From 1995 through 1998, the state consolidated Fee-for- Service and Short-Doyle programs into one "carved out" specialty mental health managed care program, under a Medicaid 1915(b) "Freedom of Choice" waiver.
* Counties were given the "right of first refusal" for taking on this new responsibility of managing specialty mental health care.
* Under this system, all Medi-Cal beneficiaries must receive their specialty mental health services through the county Mental Health Plan (MHP).

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Medi-Cal Consolidation

* General mental health care needs for Medi-Cal beneficiaries remain under the responsibility of non-specialty fee-for-service providers and Medi-Cal Managed Care plans.
* DHCS fee-for-service is still responsible for all pharmaceutical costs for specialty mental health MHP beneficiaries.

22

Medi-Cal Consolidation

* Upon consolidation, the state DHCS transferred the funds it had been spending under the FFS system for inpatient psychiatric and outpatient physician and psychologist services to county Mental Health Plans (MHPs).
* It was assumed (by counties) that MHPs would receive additional funds yearly beyond the base allocation for increases in Medi-Cal beneficiary caseloads, and for COLAs.
* ***Any costs beyond that allocation were to come from county 1991 Realignment revenues.***

23

Medi-Cal Consolidation

* In other words, the risk for this entitlement program shifted from the state to the counties…

24

Impact of Medi-Cal on Realignment Funds

* After Medi-Cal Consolidation, administrative requirements by DMH grew dramatically.
* Counties have not received COLAs for the Medi-Cal program since 2000.
* The FY 2011/12 Managed Care Allocation is approximately **the same amount** as the FY 2000/01 Managed Care Allocation.

25

EPSDT and Medi-Cal Consolidation

* County MHPs were originally reimbursed the entire non-federal expenditure for all EPSDT eligible services in excess of expenditures made in the baseline year (FY94/95), adjusted for inflation.
* However, in FY01/02, county MHPs became responsible to fund 10% of the growth in the state/local match above FY01/02 cost-settled amounts of state/local match.

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Federal Medi-Cal Changes Since Consolidation

- CMS determined that county mental health plans are managed care prepaid inpatient health plans (PIHP)
- CMS determined that the counties are responsible for certifying the required public expenditure (CPE)
- CMS required the state to update the fiscal and coverage provisions of the 1915 (b) waiver and state plan amendments
- CMS required changes to the cost report to meet government accounting requirements
- AB 1297 (sponsored by CMHDA) required the replacement of the Statewide Maximum Allowance (SMA) with a federal UPL in FY 12/13

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Medi-Cal Reimbursement Under Consolidation Now

- County MHPs are reimbursed a percentage of their actual expenditures based on the Federal Medical Assistance Percentage (FMAP)
- County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
- County MHPs and the State reconcile the interim amounts to actual expenditures through the year end cost report settlement process
- The State audits the cost reports to determine final Medi-Cal entitlement

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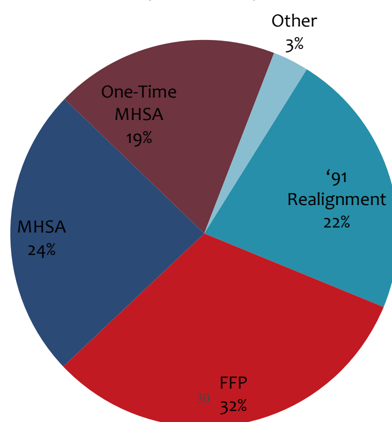
Medi-Cal Specialty Mental Health

* Federal Medicaid dollars (FFP) currently constitute the largest revenue source for county mental health programs.

Current Community Mental Health Funding Sources



Proposition 63
The Mental Health Services Act (MHSA) (2004)

* Proposition 63 – a California voters' ballot initiative
* Passed by majority vote on November 2, 2004
* Became effective as statute -- the Mental Health Services Act (MHSA) -- on January 1, 2005

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MHSA: What Is it?

* 1% tax on personal income in excess of $1M
* Purpose is to reduce the long-term adverse impact of untreated mental illness
* Intent is to ***expand*** mental health services
  * Recovery/wellness
  * Stakeholder involvement
  * Focus on un-served and underserved
  * Focus on effective services and cost-effective expenditures

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MHSA Is Community-Driven

"The most important change that the MHSA brought forward is to bring the voice of the person receiving services and the families – across ethnicity – to the center of the conversation rather than at the margins of the conversation." (Dr. Marvin J. Southard, Los Angeles County Mental Health Director)

33

MHSA: AB 100
(2011)

* Facing another major budget deficit in FY 2011-12, the Governor proposed and the Legislature adopted AB 100, which fundamentally changed the landscape of the MHSA – in both positive and not so positive ways…

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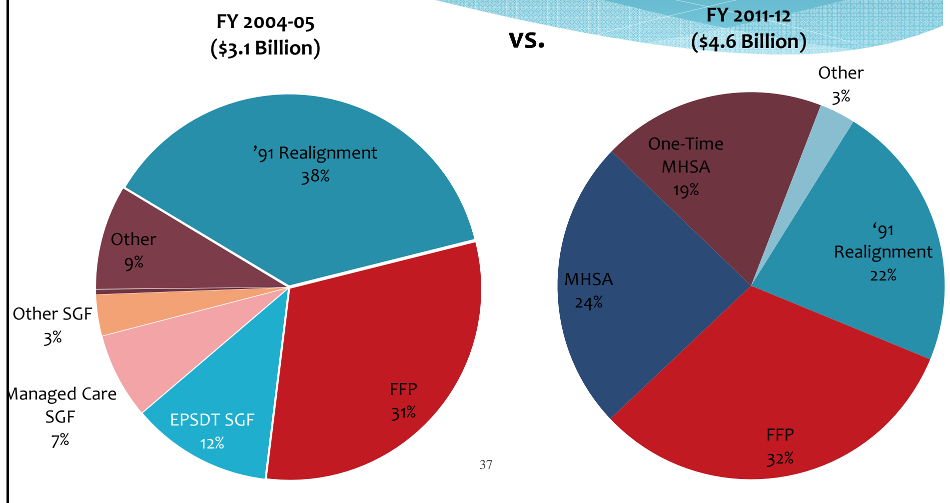
MHSA/AB 100

- **Not so positive:**
  - *Diverted $862 million on a one-time basis from the MHS Fund to backfill SGF obligations for EPSDT, Medi-Cal managed care and Educationally-Related Mental Health Services (formerly AB 3632).*
- **Positive:**
  - Eliminated State approval of MHSA Plans (thus eliminating significant state-level bureaucracy)
  - Created continuous MHSA appropriation to counties
  - Changed accounting from cash to accrual (thus eliminating big cash reserves at the State)
  - Maintained community-driven local stakeholder process

AB 100 Changes to State Role in MHSA Administration

- Reduced the state administrative funds reserved for DMH, MHSOAC, California Mental Health Planning Council and other state agencies from five percent (5%) to three and half percent (3.5%) (the difference goes to counties for services).
- Deleted requirement that DMH and the MHSOAC annually review and approve county plans and updates.
- Deleted requirement that a county annually update the 3-year plan, but updates are still required.
- Specified that the "state," instead of DMH specifically, will administer the Mental Health Services Fund (MHSF), and issue regulations.

The MHSA is a Significant Source, While State General Funds Have Been Eliminated



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Federal Mental Health Parity
(2008)

- MH & SU services must be provided at parity with general healthcare services, including in these areas:
  - **Coverage restrictions (copayments, deductibles, etc.)**
  - **Lifetime limits/costs**
  - **Treatment limits (number of visits/days covered)**

- Parity applies to:
  - **Large Employers**
  - **Medicaid**
  - **Health Insurance Exchanges for Individual and Small Group Policies**

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Health Care Reform Federal Affordable Care Act (2009)

* Employers with 50+ employees will be fined if they don't offer health insurance. Small companies that offer coverage can receive tax credits.
* Medicaid expansion in 2014 will be 100% federally funded to cover single adults up to 133 % of federal poverty
  * $14,404 individual income, $29,326 family of four income.
  * An estimated 16 million new people nationally, at least one-fifth of whom are likely to have mental illness and/or substance use disorder service needs.
* The Congressional Budget Office estimates almost one-quarter of Americans who lack health insurance today will be covered under Medicaid over the next 10 years.

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California's 1115(b) Waiver: A Bridge to Health Reform

* California has received approval for a new 5-year Medicaid waiver (2010-2015) as a "bridge to federal reform"
* If savings are achieved and milestones met, it could bring as much as $10 billion in new federal funds.

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1115(b) Waiver
Low Income Health Program (LIHP)

* County option to participate
* Counties provide match to expand coverage to individuals up to 133% of federal poverty before 2014
* Receive 50% federal matching dollars.
* Counties may set their own eligibility levels up to 133%.

1115(b) Waiver
Low Income Health Program (LIHP)

Low Income Health Program (LIHP) – two components:

1. Medicaid Coverage Expansion (MCE)
   - Up to 133% FPL
   - Mental Health Minimum Benefit Required
   - FFP not capped
   - May be CPE or capitated
2. Health Care Coverage Initiative (HCCI)
   - 134% to 200% FPL
   - Mental Health Minimum Benefit Not Required
   - FFP is capped – county will get an allocation
   - Financed through Inter-Governmental Transfer (IGT)

Minimum MH Benefits in 1115(b) Waiver

- **For MCE enrollees (under 133% of FPL), each participating county must provide the following minimum package of mental health benefits:**
  - Up to 10 days/year acute inpatient hospitalization in an acute care hospital, psychiatric hospital, or psychiatric health facility.
  - Psychiatric pharmaceuticals.
  - Up to 12 outpatient encounters/year, including assessment, individual/group therapy, crisis intervention, medication support and assessment. If a medically necessary need to extend treatment to an enrollee exists, the plan can optionally expand the service(s).
  - Substance Use Services are **Optional** in MCEs.

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Bottom Line:

- Realignment 1991, which never fully funded mental health needs, was intended to grow over time. That growth did not occur as expected.
- Under Realignment 1991, counties were using an increasing amount of Realignment funding as Medi-Cal match, leaving little, if any, for indigent services.
- MHSA helped significantly, but cannot fill all the gaps and continues to be a major budget target.
- Time for another MAJOR Policy Shift – Realignment 2011!

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Lead up to Realignment 2011

* **$25.4 Billion Budget Problem**
  * $8.2 Billion deficit for FY 2010-11
  * $17.2 Billion deficit for FY 2011-12

Why the continued deficit?

1. Various one-time budget solutions used in previous years
2. Not enough federal funding obtained as hoped
3. Continued weak economy
4. Previous program cuts did not create enough savings

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Realignment 2011

* Pressured by continuing deficits, Governor Brown proposed realigning many public safety and health and human services programs from the state to counties.
* He wanted to move responsibility for these services so that they could be more efficiently managed and provided at a level that was "closer to the people."
* The plan was to create a *new, dedicated, constitutionally protected* revenue source for counties that was approved by voters by ballot initiative.

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No Constitutional Protection -- Yet

* Unfortunately, the plan that the Legislature ultimately adopted did not include support for a ballot initiative. The Governor remains committed to ongoing funding and to achieving Constitutional protection.
* He has filed a ballot initiative with the Secretary of State that includes Constitutional protections for counties, and hopes to qualify it for the November 2012 ballot.

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Realignment 2011
2011-12 Funding Structure

* Several FY 2011-12 budget trailer bills included components of realignment financing, recognizing that additional work to refine the financing structure will take place this year.
* The primary vehicle for the 2011 Realignment provisions was AB 118, which transferred the equivalent of $5.559 million of annual state fiscal responsibilities for "public safety programs" to counties.
* This bill also creates the account structure and allocations for some of this funding, and dedicates 1.0625% of existing state sales tax revenue to fund these local costs in FY 2011-12.

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AB 118

- AB 118 establishes a reserve account should revenues come in higher than anticipated, and funds will be allocated from that reserve account to entitlement programs (Foster Care, Drug Medi-Cal, and Adoption Assistance).

- *The bill is silent as to what happens should funds come in lower than expected.*

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"Public Safety" Realignment 2011-12 – What is Included?

- Trial Court Security Account
- Local Community Corrections Account
- Local Law Enforcement Services Account
- **Mental Health Account (1991 Realignment)****
- District Attorney and Public Defender Account
- Juvenile Justice Account, including the following subaccounts:
  - Youthful Offender Block Grant
  - Juvenile Reentry Grant

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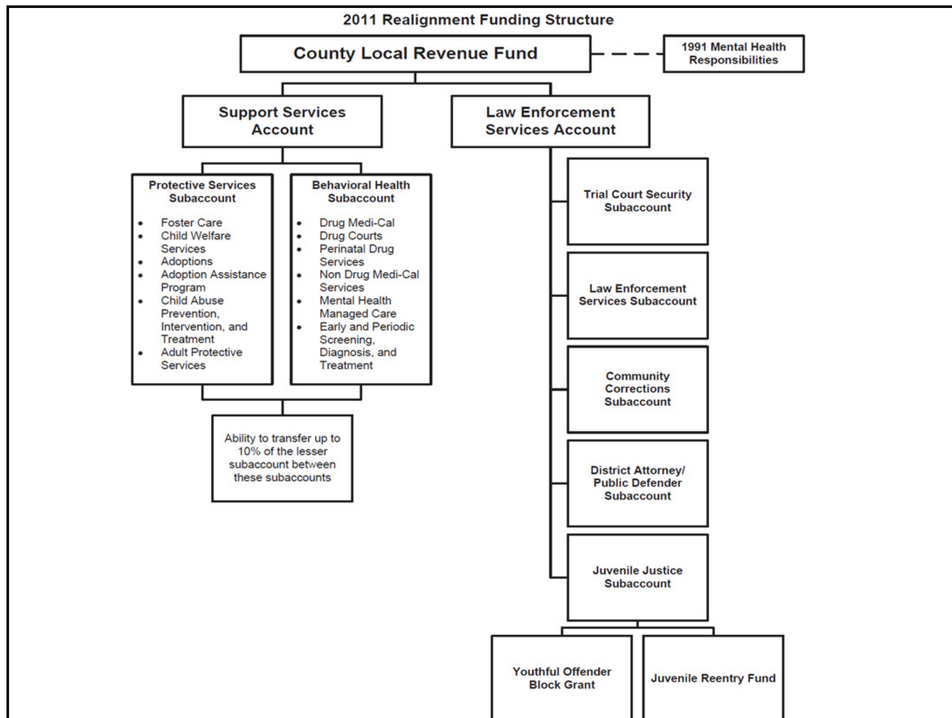
Realignment 2011-12 – What is included?

* **Health and Human Services Account**, including:**
  * Adult Protective Services
  * Foster Care
  * Child Welfare
  * Adoptions Assistance
  * Child Abuse Prevention and Treatment
  * Woman and Children's Residential Treatment Services
  * Drug Court
  * Drug Medi-Cal
  * Reserve Account

**EPSDT and Medi-Cal Specialty Mental Health Managed Care are realigned, but not until 2012-13.



Governor's Budget Proposed Expenditures for 2011 Realignment

(In Millions)

	2011–12	2012–13	2013–14	2014–15
Adult offenders and parolees	$1,587	$858	$1,016	$950
Local public safety grant programs	490	490	490	490
Court security	496	496	496	496
Pre–2011 juvenile justice realignment	95	99	100	101
EPSDT	579	544	544	544
Mental health managed care	184	189	189	189
Drug and alcohol programs	180	180	180	180
Foster care and child welfare services	1,562	1,562	1,562	1,562
Adult Protective Services	55	55	55	55
CalWORKs/mental health transfer	1,105	1,164	1,164	1,164
Unallocated revenue growth	—	180	444	989
Totals	**$6,332**	**$5,816**	**$6,240**	**$6,720**

EPSDT = Early and Periodic Screening, Diagnosis, and Treatment program.

Source: Legislative Analysts Office (LAO)

Realignment Funding for Mental Health**

	2011-12	2012-13 (Forward)
EPSDT	0 (AB 100)	$629 million
Medi-Cal MH Managed Care	0 (AB 100)	$183.7 million
1991 Community MH Realignment	$1.083 billion	$1.119 billion

- Since AB 100 is providing MHSF in 2011-12, Medi-Cal Specialty Mental Health is not realigned until 2012-13.
- Only the funding source for 1991 community mental health realignment is changing. Funds will be deposited monthly. ***The 2011-12 amount is 5.9% higher than would be anticipated without the 2011 Public Safety Realignment.***

New Proposed FY 12-13 Baseline Allocations for Realigned Mental Health Programs

- In total, reduced by $34.9 M in new figures.
- Critical to determine adequacy of baseline figures.
- EPSDT impacted by Katie A. and Healthy Families proposal.

	2011-12		2012-13		2013-14		2014-15	
	Original Figures	**New Figures**	Original Figures	**New Figures**	Original Figures	**New Figures**	Original Figures	**New Figures**
Mental Health Managed Care	-	-	$183.7	**$188.8**	$183.7	**$188.8**	$183.7	**$188.8**
EPSDT	-	-	$629	**$544**	$629	**$544**	$629	**$544**
1991 MH Responsibilities	$1,083.6	**$1,104.8**	$1,119.4	**$1,164.4**	$1,119.4	**$1,164.4**	$1,119.4	**$1,164.4**

Public Safety Realignment (AB 109)

- **While AB 118 provides the funding structure, AB 109 specifies the operative provisions of "Public Safety" realignment.**
- Under AB 109, certain offenders are being held under local rather than state custody. They include:
  - 1) Non-violent offenders;
  - 2) Non-serious offenders; and
  - 3) Non-sex offenders.

Mental Health/AOD Directors Critical to Success of AB 109

- AB 109 created an "Executive Committee" from the "Community Corrections Partnership (CCP)" members, and includes a representative from either the county department of social services, mental health, or alcohol and substance abuse programs, as appointed by the County Board of Supervisors.
- MH/AOD Services are an essential ingredient to the success of "Public Safety" realignment, if we are to finally break the cycle of incarceration.
- To the extent possible, using AB 109 public safety realignment funds to match Medi-Cal services for parolees who can be enrolled under the LIHP should be a win-win for public safety and counties in general.

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Key Issues for Realignment of Medi-Cal Specialty Mental Health

1) Medi-Cal Specialty Mental Health MHP Contract: Right of First Refusal, Mandates Issues
2) Revenue Growth Proposal Issues for Behavioral Health Subaccount
3) Base Realignment Funding Issues for Behavioral Health Subaccount
4) Structure and Risk of Behavioral Health Subaccount (including Drug Medi-Cal)

Current "Knowns" about Community MH Financing

* 2011 Realignment of MH Managed Care and EPSDT will start in FY 12/13
* AB 1297 requires the replacement of the SMAs with a CMS approved UPL protocol
* The county is responsible for the Medi-Cal "full funds" expenditure required under the federal CPE requirements
* The county will be required to contract with DHCS under the provisions of the 1915 (b) waiver as a managed care prepaid inpatient health plan (PIHP)
* The county will be responsible for the Medi-Cal coverage and expenditure obligations specified in the waiver, SPAs and the MHP Contract
* The 1991 realignment provisions for the transferred MH programs will remain in place

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Current Unknowns for Community MH Financing

* What the FY 12/13 and beyond base and growth will be for Health and Human Services Subaccounts.
* The amount of the monthly transfers to be made by the state to each county's account for 2011 realignment and MHSA in FY 12/13
* Whether there will be Constitutional mandate protections and remedies available to the county for the entitlement programs transferred
* The impact of the tax revenue volatility on base and growth
* The ultimate impact of Katie A and Emily Q on EPSDT cost on a county by county and statewide basis
* The impact of the transfer of the Healthy Families Program to Medi-Cal

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Discussion Questions: Realignment 2011

- Now that the state's role has significantly diminished, and counties' has increased, how do counties collectively manage both intra-county issues (such as funding distributions) and external relations: state, stakeholders, CSAC, etc.?
- How can counties ensure that they have sufficient funds to meet Medi-Cal entitlement obligations for EPSDT, Medi-Cal Managed Care, and Drug Medi-Cal with so many other realigned programs competing for funding?
- How can the LIHP programs be used to leverage federal funds for parolees returning to our communities?
- **Other questions for local MH/AOD leaders?**

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Discussion Questions /Health Care Reform

- How will HCR, Parity and the 1115 Waiver impact our capacity as providers of mental health and substance use service providers?
- How will administration, contracting, and reimbursement of services change through the 1115 waiver and HCR?
- How will MH/SU advocates ensure that sufficient resources, providers and progressive models of service remain available for the populations that we serve?
- How will we develop our competencies as mental health providers working in primary care settings?

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Our/your Future: How can you provide leadership in these major policy areas?

- Realignment 2011, including full risk for Medi-Cal behavioral health services
- Federal Health Care Reform
- Federal Mental Health Parity
- Community Corrections – continued shift from state to counties
- Elimination of DMH/ADP

It is clear that counties will need to be the leaders, with the full engagement of stakeholders in their communities, in the development of behavioral health policy in California.

Are you ready??

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COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Office of the Legislative Analyst

Susan Von Cannon Rajlal, MPA

Update on Passage of Proposition 30

The passage of Proposition 30 by California voters funds the effort to solve the California budget crisis by increasing the sales tax rate by one quarter of one percent for four years and by increasing personal income taxes for upper income taxpayers for 7 years. It will raise an additional $6 billion annually from 2013 to 2017 and is projected to raise slightly smaller annual amounts from 2017 to 2019.

Proposition 30 will:

1. Help balance the State Budget and continue to meet the Prop 98 mandate to fund education.

2. Will produce a further dedicated funding stream from tax revenue for the Public Safety Realignment which includes Mental Health.

3. Will back fill $200 million in funding to DFCS programs for 2 years.

4. After 2 years is projected to produce increased funding for county mental health programs.

5. Restrict the State's authority to implement any new state laws that increase local costs for administration of the programs without providing the funds to pay for the increased costs.

6. Requires the State to pay any new local costs to the realigned programs that result from court actions or federal changes in regulations or statutes.

7. Eliminates the State's potential responsibility for "mandate funding" liability of the realigned programs.

8. Eliminates State reimbursement for open meetings per the Brown Act.

Talking the Talk: A Glossary

The terms included in this glossary are commonly used in the legislative process. To locate a word or phrase, see the index on page 17, where they are listed alphabetically.

Bill-related Terms

Author
The legislator who is "carrying" the bill and who is credited with creating the bill. Although at times the author may also be the sponsor, it is very important to distinguish between author and sponsor because they play distinctly different roles in a bill's development.

Sponsor
The organization or individual that requests a legislator to author a bill. The League sponsors bills, as do other organizations and individuals. While a bill also may have co-sponsors, the sponsor has the primary responsibility for gathering support, seeing it through the legislative process and making decisions on amendments. The author, however, always has the final say on strategy, process and amendments.

Legislative (Leg) Counsel
The Legislative Counsel, also known as Leg (pronounced "ledge") Counsel, is the Legislature's attorney and his or her staff of attorneys who write bill language. While a lobbyist or legislative staff may prepare preliminary drafts of language, all proposed bills and amendments must be written by Leg Counsel before they can be put across the desk and inserted into the bill. Only legislators or their staff may have contact with Leg Counsel. However, legislative staff may "authorize" a lobbyist to work with Leg Counsel on a bill, especially if the lobbyist represents the sponsoring organization. Work with Leg Counsel is protected by attorney-client privilege.

An urgency measure requires passage by an affirmative vote of two-thirds of both houses to pass, but needs only a majority vote to pass a committee.

Spot bill
A legislative placeholder. Often, sponsors or authors know they want to introduce a bill on a specific topic, but don't have the exact language. Therefore, they will prepare and introduce what is commonly referred to as a "spot bill" to serve as a placeholder. Spot bills generally are amended before the first committee hearing, but often the full-blown bill does not emerge until much later in the process. The classic spot bill is one that amends "that" to "which" or adds a comma, although this practice is less common in recent years. However, a spot bill must make a more substantive change to the law than simply changing "that" to "which," before it can be referred by the Rules Committee to a policy committee for a hearing, following its introduction. The initial change may not be what the author or sponsor ultimately has in mind for the bill. Spot bills are crucial for those sponsoring the bill, but challenging for those tracking bills, since it is impossible to tell from a spot bill whether it will be a good bill or a bad bill.

Unbacked bill
A bill that has been drafted by Leg Counsel but has no author identified. An unbacked bill is one that is drafted as a placeholder while the sponsor searches for an author.

Backed bill
Once the sponsor has secured an author for the unbacked bill, the draft language is returned to Leg Counsel to have the author's name officially included in the text of the bill.

Bill number
Bills are given sequential numbers during the two-year session when they are introduced and put across the desk. When the Leg Counsel version of a bill is put across the desk, a clerk stamps a number on the document, thereby assigning it a bill number. Occasionally some authors wait to introduce a bill with a specific focus until a specific number is available.

Legislation passed in previous years often is known by its bill number, rather than the official title or content of the bill. Examples are AB 939 (solid waste and recycling), AB 13 (smoking and tobacco control), AB 1600 (developer fees) and AB 2020 (beverage container recycling). When inquiring about a bill, always reference the year in which it was enacted. AB 123 of 1998 is not the same bill as AB 123 of 1989.

Across the desk
The physical act of handing Leg Counsel language to a Senate or Assembly clerk at the desk in the front of the Senate or Assembly chamber. This can be done only by a legislator or staff member. Amendments are put across the desk, as are newly introduced bills. When a bill is introduced it is immediately given a number. Bill numbers run consecutively through the two-year session and start again at "1" at the beginning of the next two-year session.

Good bill
A bill that the League likes. Reasons to like a bill include support for a measure that solves a problem confronting cities (e.g., regulation of sexually oriented businesses), increases city authority over provision of city services (e.g., regulation of hazardous materials), or increases city revenues. Whether or not the League likes a bill is determined by existing League policy and/or the League's policy development process.

A bill is never really dead. Some bills, like cats, have nine lives.

Bad bill
A bill that the League dislikes. Reasons to dislike a bill include objections that the bill pre-empts local land use or regulatory authority, restricts local revenue raising authority or interferes with local home rule authority. Whether or not the League likes a bill is determined by existing League policy and/or the League's policy development process.

Trailer bill
A bill, almost always used in the budget process, which is written in a way that implements the spending parameters or levels established in a funding bill. A trailer bill can also be used for nonbudget issues.

Urgency measure/bill
A bill that goes into effect immediately upon the governor's signature, rather than on Jan. 1 of the following year. An urgency measure requires passage by an affirmative vote of two-thirds of both houses to pass, but needs only a majority vote to pass a committee.

Fiscal bill
A bill that has a fiscal impact on the state and must therefore be heard by the Senate and Assembly fiscal committees. Leg Counsel determines whether or not a bill is "keyed," (or designated) fiscal. A bill is fiscal if it meets one or more of three criteria: it appropriates money, it affects the operation of a state agency or it creates a mandated local program. Fiscal bills must meet the fiscal bill deadline.

Nonfiscal bill
A bill that is not a fiscal bill and is not heard by a fiscal committee.

Two-year bill
A bill that is "dead," "stalled," "held" or simply "not moved" by the author in the first year of a two-year session and cannot be heard again until the second year of the session. Generally a bill becomes a two-year bill when it fails to meet a legislative deadline, such as a fiscal committee or policy committee deadline. A bill cannot become a two-year bill in the second year of the session, since there is no additional year to which the bill would be carried over.

Chaptered bill
After a bill is signed by the governor, it is "chaptered" by the secretary of state. It is assigned what is called a chapter number and may be subsequently referred to, for example, as Chapter 3, Statutes of 1998. That is, it was the third bill signed by the governor for the statutes enacted in 1998. A bill's chapter number is useful to know if, for example, five years after its enactment someone wants to read the entire bill text. While one can find the various sections of the bill included in the different code books (e.g., Government Code, Revenue and Taxation Code, Public Resources Code), the entire bill text can be found in a book published each legislative year that includes bills by chapter number.

To tombstone a bill
"Tombstoning" a bill means the author is prominently listed in the official statutory title of the bill. Common tombstoning language includes, "This act may be known as the Assembly Member Jones Good Government Act of 1999." Sometimes tombstoning is the ultimate example of ego, especially if it is inserted by the author. Other times, however, tombstoning is appropriate and an indication of the author's expertise and long-term interest in a subject. This type of tombstoning is often included at the suggestion of the bill's sponsor as a genuine tribute to the author. Tombstoning generally is rare.

Process Terms

Granted reconsideration
A procedure by which a bill that has failed passage (i.e., is defeated in committee or on the floor) may be granted reconsideration to be heard and voted upon at a subsequent hearing. Often in a committee, bills that have been granted reconsideration are heard "for vote only," with no testimony permitted. Reconsideration may be granted only one time.

Occasionally, a call is placed as a way of slowing down or defeating a bill that has received enough votes for passage.

Concurrence
A bill that has been amended in the second house must return to the house of origin for a floor vote to concur with the amendments included by the Senate and Assembly. Conversely, a bill that is not amended in the second house goes straight to the governor from the second house, if it passes.

Suspense file
Bills that will cost the state more than a previously established amount (generally $150,000 annually) are placed on the fiscal committee's suspense file. At a subsequent meeting, bills may be removed from the suspense file due to changes in cost estimates, amendments that remove the cost to the state, or political decisions. In recent years, moving a bill to the suspense file has been handled equitably without regard to political party or issue. While the suspense file is a good management tool to evaluate fiscal issues and their impacts on the state budget, it also is a great place to see bad bills die and, unfortunately, to see good bills die because of fiscal impacts. The term "suspense" probably refers to the concept of holding a bill in limbo or a place where one is not sure what will happen to it ("I'll keep you in suspense until I decide").

On call
A waiting place for bills after they have been voted upon in a committee or on the floor. Putting a bill on call is a routine procedure. Often, all members may not be in a committee room when a vote is taken and therefore the bill is short of passage by one or two votes. At the request of the author, the bill is "placed on call" while the committee considers other business. Later in the hearing the "call is lifted" and the vote is taken again. If there are not enough votes, the bill can be placed on call again (the call is "replaced"). Usually a call is placed when there are not enough votes to pass a bill. Occasionally, a call is placed as a way of slowing down or defeating a bill that has received enough votes for passage. A call must be placed before the vote is announced (see "announce the vote," below). While a bill is on call, lobbyists, legislators and staff lobby legislators to secure missing votes or attempt to convince members to change a previously cast vote. For lobbyists, who are not permitted on the floor or beyond a certain point in committee hearing rooms, this type of lobbying is done by sending in cards. (See "Send in cards," Miscellaneous Terms of the Trade, page 16.)

Announce the vote
What the chair of the committee or presiding officer of the Senate or Assembly does when the final vote has been taken. Once the vote has been announced, the bill has either passed or failed. After the vote has been announced, votes cannot be changed or added; however, in the Assembly, sometimes votes may be added if the outcome will not change. A bill must be placed on call before the vote is announced, often requiring good to excellent reflexes. On the Senate or Assembly floor, the presiding officer generally states, "I am prepared to announce the vote," as a way of alerting the author or other members to have the bill placed on call, or "to place a call."

Pending
A term used to refer to the fact that no hearing date has been set, but the bill is waiting to be heard at some future date, in a legislative committee or on the floor. For example, a bill that has just passed the Assembly Appropriations Committee can be referred to as now "pending on the Assembly floor."

continued

First reading
After a bill is placed across the desk and has been numbered, the bill is read for the first time.

Second reading
A bill is "read" three times during its travels through each house. This term is a holdover from earlier times when not all legislators could read or when printing multiple copies of a bill was not feasible. Thus, the entire content of the bill was actually read to all the legislators. This does not happen today. When a bill is in the second reading file, it has been amended in either a legislative committee or on the floor. Once a bill is amended, it returns to second reading. A bill can be in the second reading file numerous times during a session.

All amendments must be passed by the majority of those members present and voting, as opposed to a majority of the members serving on a committee.

Third reading
When a bill is on the Assembly or Senate floor, it is on the third reading file. Only the bill number and title are read. The presiding officer will say, "File item number 123; read the bill." The clerk will say, "AB 456 by Senator Smith, a bill dealing with taxation." Following this statement, the testimony and debate begin.

To enrollment
Few people actually understand what "to enrollment" means. After a bill passes both houses of the Legislature, it goes to the governor for either signature or veto. In between, it pauses at a mysterious place called "enrollment." After a bill has passed both houses, it is printed in enrolled form, omitting symbols indicating amendments, and compared by the Engrossing and Enrolling clerk of the house where it originated, to make sure it is in the form approved by the houses. The enrolled bill is then signed by the secretary of the Senate and the chief clerk of the Assembly, and presented to the governor. "To enrollment" may take several days. (Some Capitol observers honestly believe that enrollment actually is an obscure Polynesian island where bills go for a brief respite prior to landing on the governor's desk.)

Defeated bill
A bill is defeated if it is brought up for a vote by the author and does not receive enough votes in committee or on the floor to pass. For example, a bill is defeated in a legislative committee if the majority of members serving on a committee do not vote for the bill. This is in contrast to the majority of those present and voting. A defeated bill is different from a bill that is not moved forward by the author, or misses a deadline and becomes a two-year bill.

Failed passage
A nice way of saying that a bill was killed or defeated.

Kill a bill
The act of defeating a bill. Lobbyists who defeat a bill they oppose have been observed to jump up and exclaim, "We killed the bill!" (The adult, professional and polite way to do this is out of view of the sponsors and supporters of the bill. However, under some circumstances, taking such action in front of supporters is accepted behavior.)

Dead bill
A bill is never *really* dead. Some bills, like cats, have nine lives. Because a bill is never dead, lobbyists always say, "It's not over until it's over." (See "gut and amend," page 15.)

Votes to pass
A nonfiscal, non-urgency bill requires 21 votes to pass in the Senate and 41 votes to pass in the Assembly. A fiscal or urgency bill, which requires a two-thirds vote, takes 27 votes to pass in the Senate and 54 votes to pass in the Assembly. All bills require a majority vote of those members serving on a committee to pass, even if one member is absent that day. Committee and floor amendments must be adopted by a majority of those present and voting.

Put over
When the author pulls a bill from the committee agenda or does not take it up on the Senate or Assembly floor file so that it will not be heard that day. Bills are generally put over in order to negotiate with the opposition or if the legislator thinks he or she does not have the votes to pass the bill. There is a limit to the number of times a bill can be put over and reset for hearing. Generally, if a bill has been put over in committee, one can conclude there may be a problem.

House of origin
The house of origin refers to the legislative house (Assembly or Senate) in which a bill is introduced. For example, the house of origin for AB 123 is the Assembly. The house of origin for SB 456 is the Senate. A "house of origin deadline" is the date by which an Assembly bill must pass the Assembly, or the date by which a Senate bill must pass the Senate.

Second house
If a bill is introduced in the Assembly (its house of origin), it is in the second house when it reaches the Senate, and vice versa.

Third house
No, this is not an additional legislative chamber. The third house is used to refer to the lobbyist corps.

On the floor
This refers to activities occurring in the Assembly or Senate chamber. Examples of how it is used are: "The bill is on the Assembly floor," or "Send in your card and we'll ask Senator Jones to come off the floor."

Floor vote
When the Senate or Assembly votes on a bill. For example, when a bill is on third reading, it is on the Senate/Assembly floor for a floor vote.

Rule waiver
A process to suspend or ignore established procedural rules in order to achieve a specific goal. During each two-year session, both the Assembly and Senate vote on and publish written procedural rules. At times, rules must be waived in order for both houses to conduct business. Different rule waivers require different procedures. Rules are commonly waived for many different reasons, such as:
- To hear a bill after a specific deadline has passed;
- To hear a bill on the floor in mock-up form, as opposed to when it is in print; and
- To hear a bill in a committee even if it has not been included in the daily file four days prior to the hearing.

Committee- and Floor-related Terms

Policy committees
The standing committees of the Senate and Assembly that discuss the policy implications of a bill, such as the Senate Natural Resources Committee or the Assembly Local Government Committee.

Fiscal committees
The two policy committees within the Senate and Assembly (the Senate Appropriations Committee and the Assembly Appropriations Committee) that discuss the fiscal implications of a bill.

Agenda
The schedule of events for a committee, commonly referred to as "the file" (see also "daily file," below. The terms "agenda," "daily file" and "committee file" often are used interchangeably.) The agenda, or file, can include as few as one or two bills or as many as 50–300. Although a committee hearing may be scheduled from 9:00 a.m. until noon, there is no certainty about when a particular bill will be heard. Some committees hear bills "in order of file" (in order of their position on the agenda) and some by "author sign in" (in order of when the author signs a list in the committee hearing room). However, if a bill was authored by a committee member, it is heard last, regardless of its place on the agenda or file. Only one thing is certain: if a witness or lobbyist has been waiting all morning for a bill to "come up," it will be heard immediately after the individual leaves the room for a quick and desperate trip to the restroom.

Daily file
Both the Senate and Assembly publish daily files. These contain the times, locations and agendas for committee hearings as well as Senate or Assembly floor sessions.

File number
Each bill that is scheduled to be heard on the Senate or Assembly floor has a file number. Generally, bills are heard in numerical order, based upon their file number, on both the Senate and Assembly floor.

Special order
Occasionally a committee or the full Senate or Assembly may schedule a specific bill to be heard by "special order." When this happens, the bill is scheduled and noticed in the daily file to be heard at a specific time. Special orders are usually reserved for bills about which there is considerable controversy, with large numbers of witnesses expected to testify.

Committee analysis
Committees in the Senate and Assembly have committee consultants who are required to provide substantive analyses of the bills heard in the committee. The committee analysis generally contains an impartial explanation of existing law, what the bill does, and potential impacts or issues that might be considered by the committee members. However, in the real world, sometimes an analysis may have a political slant.

It is common for lobbyists representing both supporters and opponents of a bill to talk with the committee consultant prior to the writing of the analysis, so that the consultant is aware of the interest group's perspective. Often, a committee analysis will include a statement that refers to a supporter's or opponent's position, such as "The League of California Cities opposes AB 123 because ..." However, it is common for both supporters and opponents of bills to complain that their position was not fairly covered. What is one person's great analysis is another person's hatchet job. Since most analyses also contain a list of the supporters and opponents of the bill, it is important that letters sent to the committee arrive far enough in advance to be included on the analysis. (Of course, letters should also be sent to the author.) Committee analyses are available prior to the hearing as well as on the Internet. Committee analyses should not be confused with analyses prepared by both the Republican and Democratic caucuses, which generally are not available to the public.

Terms of Amendments

Amendment
An amendment is a change to a bill; there are various types of amendments. A bill can be amended either by the author, by a committee or by the full Senate or Assembly. However, since all bills are technically the possession of the Senate or Assembly, only the Senate or Assembly can actually amend the bill — even though the amendment comes from the author or committee. The procedure for amending a bill is slightly different, depending upon how and where it is amended. Any time a bill is amended, it is held briefly for a second reading. All amendments must be passed by the majority of those members present and voting, as opposed to a majority of the members serving on a committee.

How to read an amended bill
Additions are shown in *italics*, while deletions are shown in ~~strikeout text~~. However, these italics and strikeouts relate only to the previous version of the bill, not to existing law. Therefore, in order to understand how a bill changes existing law, it is critically important to review all versions of the bill that amend a specific code section, or add a new code section to existing law. Looking for italics or strikeouts only in the latest version will not identify the changes if the bill has been amended five times since its introduction.

Author's amendment
A change to a bill made by the bill's author. This can be done prior to a committee hearing or during a hearing. An author can amend the bill while in committee, in response to questions or issues raised during testimony. When this is done, the chair will say, "We will accept this as an author's amendment."

Committee amendment
Occasionally the author will not wish to have the bill amended as an author's amendment, for various reasons, but will not object to an amendment offered by someone on the committee. This differs from a hostile amendment.

Hostile amendment
An amendment that the bill's author does not want. Hostile amendments can be inserted into a bill, over the objections of the author, by a vote of the majority of those present and voting in a committee, or by a majority of those present and voting in the full Senate or Assembly.

Floor amendments
Amending a bill on the Senate or Assembly floor is different and more complicated than amending a bill in committee. Amendments must be in written Legislative Counsel form and be at the desk prior to a member taking up the bill for amendment. Unless a rule waiver is given, a bill is amended one day and voted on in its amended form another day. (In other words, it is put out to print and back on file.) Prior to taking up any amendment on the floor, an analysis of the proposed amendment must be available to all members. Like the analysis of the bill itself, this analysis is prepared by legislative staff. It is common to hear a legislator request that the author wait to take up an amendment because the analysis is not yet available. In the last few years, the Legislature has been more rigorous in applying the requirement that an analysis of an amendment be available prior to voting on the amendment.

Gut and amend
This is a technique in which the original language of a bill is entirely removed and new language is inserted. That is to say, the bill has been "gutted and amended." Usually this is done to revive a bill that has stalled or been defeated. Often the newly amended bill is lo-

continued

Budget-related Terms

Governor's Budget
This is a complete accounting of expenditures in the state, and is typically the size of a large telephone directory. It provides past-year-actual, current-year-revised, and budget-year-proposed appropriations and expenditures for every organization by fund.

Governor's Budget Summary
This is the policy narrative that accompanies the governor's budget. It highlights the state of the economy as well as policy initiatives and major budget changes proposed by the governor.

Governor's Budget Highlights
This is a briefer review of the budget than the summary, and includes facts and figures summarizing the budget's most important features.

Budget Bill
Identical budget bills are introduced in the Senate and Assembly and authored by the respective budget committees. This is the document that the Legislature officially takes action on.

Finance Letter
A letter from the Department of Finance to the chairpersons of the Senate and Assembly Budget Committees and/or the Joint Legislative Budget Committee, requesting that the Legislature consider a change in one or more budget items contained in a current year budget or in the governor's budget proposal for the next fiscal year.

The Big Five
During the state budget debates, one often hears about meetings of "The Big Five," which consists of the governor, the speaker of the Assembly, the minority leader of the Assembly, the president pro tem of the Senate and the minority leader of the Senate.

May Revise
The governor's May 14 revisions to the state budget.

cated in the second house, while the stalled bill is located in the house of origin. Many times a bill is "gutted and amended" because the author never intended to use the bill for its introduced purpose (see "spot bill," page 9). Occasionally a bill is gutted and amended for less sinister reasons, such as to serve as a budget trailer bill vehicle or to provide technical clarification to a bill already enacted (see "germane," below).

Germane
Technically, the amendments to a bill must be germane to the subject of the original bill. For example, a bill dealing with solid waste technically cannot be amended ("gutted and amended") to delete those provisions and subsequently address public libraries, since the two subjects are found in different statutory code sections (e.g., the Public Resources Code and the Education Code).

Ideally, when looking for a legislative vehicle in which to place a late-breaking amendment, one looks for a bill that is germane — one in the appropriate code section. However, when bills are gutted and amended, the question of "germaneness" is routinely waived. If the question is raised on the Senate or Assembly floor, usually the presiding officer (either the president pro tem of the Senate or the speaker of the Assembly) will rule on the question. However, the ultimate arbiter of what is and is not germane is the full Senate or Assembly, although raising the issue to that level rarely occurs.

Out to print and back on file
This phrase is used to describe the process that occurs after a bill has been amended. Literally, the bill will be amended, put out to print, made available to the public (including legislators, lobbyists and staff) and returned to the file for discussion at a later date. During this process, the bill briefly pauses in second reading. Many times legislative committee members are reluctant to vote on a bill that has been heavily amended in committee without seeing the new version in print. Therefore, the chair will direct that the bill "go out to print and back on file." The bill will be heard at the committee's next hearing in its newly amended version.

Miscellaneous Terms of the Trade

Hurry up and wait
What lobbyists do when waiting for their bills to come up in committee or on the floor.

Across the street
At the state Capitol.

Send in cards
How lobbyists send messages to legislators in committee or on the floor. Business cards, with short notes, are given to the sergeant-at-arms to give to the legislator. Often, if one is lucky, the legislator will come out to talk about the issue with the lobbyist. Unlike the Assembly, the Senate's rules do not permit notes to lobby a member on the floor, so cards submitted in the Senate can only say, "The League supports/opposes this bill." A card that breaches this protocol will be returned by the sergeant-at-arms or deposited in the circular file.

The gate
The side entrance of the Senate or Assembly chamber where lobbyists swarm while the Legislature is in session. Because lobbyists are not permitted on the floor, they must wait patiently at the gate. Lobbyists compose notes on their cards at the gate and give them to the sergeant-at-arms. When legislators come out to speak to the lobbyists, they do so at the gate. Today there is only a door or passageway at the gate. In the past, there really was a gate at the back entrance to the Assembly.

Sergeant-at-arms
Sergeants-at-arms are the individuals who guard the gate located at the side entrance of the Senate or Assembly chamber to prevent unauthorized individuals from entering while legislators are on the floor. The sergeant-at-arms delivers messages from lobbyists who send in cards to legislators. Sergeants-at-arms also have similar responsibilities in the committee hearing rooms.

Veto message
The governor either signs or vetoes the bills that reach his or her desk. If he signs it, it becomes law. If he vetoes it, it does not become law. (Note: If he does not veto the bill but does not sign it, the bill is allowed to become law without his signature.) When the governor vetoes a bill, he includes a veto message that states the reasons for the veto. The veto message may indicate what revised version of a bill the governor would consider signing, if it is reintroduced the next year.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HEALTH REFORM WORKGROUP

PRINCIPLES FOR THE COVERAGE OF BEHAVIORAL HEALTH FOR MEDICAID EXPANSION AND HEALTH EXCHANGE COVERED INDIVIDUALS

Currently, and over the next fourteen months, the State of California will consider the scope and range of mental health and substance abuse benefits that will be available to California residents under the Affordable Care Act (ACA). Individuals with mental illness and substance use disorders have the opportunity to significantly benefit from the health care law, as insufficient insurance health care coverage for these conditions have traditionally prevented countless people from obtaining needed treatment. If applied correctly, the health care reform law has the opportunity to ensure that clients, families and communities struggling with mental illness and substance abuse disorders have access to culturally competent prevention and treatment opportunities that are covered fully under the ACA.

The following are some of the opportunities for this population under the ACA:

- The ACA establishes minimum standards for health insurance policies that can be purchased by businesses and individuals through the California Health Exchange, now called Covered California;

- The ACA will significantly expand the number of people – especially adults - who can qualify for the mental health services that Medicaid covers, allowing childless adults who are not classified as having a disability to qualify for the program;

- The ACA authorizes – and funds – demonstration projects and tests of new approaches that it is hoped will improve the quality of health care in this country;

- The ACA creates opportunities for improved coordination between primary care, mental health and substance use disorder services for people using the public mental health system;

- The ACA encourages the use care coordination strategies that address a person's total health care needs, including mental health and substance use disorder needs;

- The ACA expands the Medicaid state option for home and community based services for people with disabilities, including those with serious mental illnesses, and expands Medicaid's focus on home and community based care in many ways.

In addition, through these, and other, coverage opportunities, we also have the opportunity to ensure that individuals struggling with mental illness and substance abuse conditions have access to health insurance that covers mental health and substance abuse services on a par with the coverage of medical and surgical care.

Given the tremendous opportunities that the ACA affords this population, we believe that consideration of health benefits must be grounded in the following principles to ensure access to the highest quality mental and behavioral health care services for these populations:

1. **Recovery and resiliency-driven services must be the standard for covered mental health benefits available to California's Medicaid Expansion population.** We must ensure that there is one, uniform mental health benefit package for California's Medicaid Expansion population that mirrors the targeted case management and rehabilitation option benefits already established in the California Approved Rehabilitation Option State Plan Amendment. This includes coverage of consumer- and family-directed case management and mental health rehabilitation services that reflect the cultural, ethnic and racial diversity of mental health consumers and that addresses each consumer's individual needs.

    2011-12 County Legislative Agenda Mental Health 8.1: Support legislation to require health plans to pay for mental health care and substance abuse disorders on par with coverage for physical disorders including specific penalties or consequences for non-compliance.

    2011-12 County Legislative Agenda Mental Health 8.19: Support efforts to provide cultural and linguistic competence standards for all mental health programs in order to provide culturally and linguistically appropriate care.

    2011-12 County Legislative Agenda Mental Health 8.20: Support proposals to increase the utilization of mental health services in ethnic communities through the development of culturally appropriate outreach messaging and marketing campaigns.

2. **Eligibility for mental health and substance use disorder benefits for both the Medicaid Expansion population and for individuals covered through the California Health Exchange should be based upon the current, established Medi-Cal medical necessity criteria for specialty mental health services.** This is essential to ensure seamless continuity of care and consistent access to services regardless of change in economic status or type of health care coverage.

   2011-12 County Legislative Agenda Medi-Cal 4.3.1: Support proposals that reduce the number of uninsured persons, and expand Medi-Cal and Healthy Families coverage to low-income persons such as In-Home Supportive Services workers and juveniles with county probations systems. Note: CEO recommends policy be revised to delete reference to Healthy Families and instead reference expansion of Medi-Cal to include mental health and substance use disorder benefits to revised policy.

3. **County community mental health systems must have the autonomy to design the care options available for treatment within the system, for treatment planning for assigned consumers and authority for all care management decisions for purposes of authorizing system provider reimbursement.** This is the only manner in which such systems can effectively meet their safety net responsibilities through use of unique provider expertise. County mental health departments operate a network of carefully designed services, and must have authority to effectively manage and reimburse those services that it determines to be medically necessary. Ultimately, LACDMH is responsible for treatment as the county managed care entity. If the consumer is not appropriately treated within the managed Medi-Cal mental health system, he/she will often require treatment in the county-managed safety net system. Cost shifting or shifting of clients has the potential to undermine the financial stability of the community mental health safety net.

   2011-2012 County Legislative Agenda Mental Health 8.1: Support legislation to require health plans to pay for mental health care and substance abuse disorders on a par with coverage for physical disorders including specific penalties or consequences for non-compliance.

2011-2012 County Legislative Agenda Mental Health 8.11: Support proposals that require managed care plans to contract with and/or reimburse counties for crisis mental health services provided to managed care beneficiaries at the full cost of providing the service.

2011-2012 County Legislative Agenda Mental Health 8.12: Support proposals to adequately fund county-operated Medi-Cal managed mental health plans, and support the establishment of regulations that effectively support the provision and monitoring of high-quality mental health services.

4. **Prevention and Early Intervention must be fully integrated as part of the spectrum of reimbursable services in any benefit package provided to the Medicaid Expansion population or individuals covered through the California Health Exchange.** The prevention of disease is a central tenet of the ACA; this should apply no less to mental health and substance use disorder services as it does for health. Research and experience has proven that prevention services, delivered by specialty behavioral health professionals, play an essential role in cost effective treatment and positive health outcomes.

   2011-12 County Legislative Agenda Mental Health 8.5: Support legislation to fully fund mental health services for children including Prevention and Early Intervention, multi-disciplinary approaches and training, children's systems of care, Community Treatment Facilities, treatment for juvenile offenders, coordination of transitional youth services, and school-based mental health services.

5. **Specialty mental health services provided in field and non-traditional settings must be considered a fully covered and reimbursable benefit under all coverage programs and opportunities.** Effectively addressing the needs of children, youth, adults and older adults with serious mental illness and substance use disorders requires assertive, proactive outreach in field settings by specialty providers who have the expertise in engaging individuals at the earliest possible point in an episode of mental illness or substance use.

   2011-12 County Legislative Agenda 4.7 1: Support proposals to increase funding for alcohol and drug prevention, treatment, and recovery services that provide local flexibility and discretion based on the local planning process.

2011-12 County Legislative Agenda 4.7 .4: Support proposals that provide funding for health, mental health, homeless assistance, child welfare services, social services, as well as adult and juvenile criminal justice programs that provide or make accessible substance abuse prevention, treatment, and recovery services as part of its continuum of services.

6. **Mental health and substance use benefit packages must continue to support the delivery of existing safety net**. This includes but is not limited to mobile response programs, services to children and youth in specialized foster care, public guardian and conservatorship services, field-based services, and service programs for older adults, etc.

   2011-12 County Legislative Agenda Mental Health 8.5: Support legislation to fully fund mental health services for children including prevention and early intervention, multi-disciplinary approaches and training, children's systems of care, Community Treatment Facilities, treatment for juvenile offenders, coordination of transitional youth services, and school based mental health services.

   2011-12 County Legislative Agenda Mental Health 8.6: Support legislation to provide increased funding for mental health services for adults and older adults including adult and homeless systems of care, Adult Protective Services, Public Guardian and Conservatorship Services**,** substance abuse treatment, Institutions for Mental Disease reform, joint law enforcement and mental health teams, and expansion of the Healthy Families Program to include parent.

7. **Safety net funding for residually uninsured populations must be preserved**. As healthcare reforms take hold and insurance coverage gradually expands, we must ensure that a shifting or reduction in safety net funding does not diminish access to mental and substance use disorder services for residually uninsured populations.

   2011-12 County Legislative Agenda 4.11.2: Oppose legislation that would result in the reduction of the County's funding as a safety net provider of health care to the uninsured, emergency and trauma care services and medical education programs in order to implement Federal health care reform.

2011-12 County Legislative Agenda 4.11.1 : Support legislation that would implement provisions of Federal health care reform by increasing access to care while maintaining and/or expanding the County's funding as a safety net provider to continue health care, emergency and trauma care services, and medical education programs through the existing infrastructure of hospitals, Multi-Service Ambulatory Care Centers, health centers, and public-private partnerships.

NAMI Partners

National Alliance on Mental Illness (NAMI) California is a grass roots organization of families and individuals whose lives have been affected by serious mental illness. We advocate for lives of quality and respect, without discrimination and stigma, for all our constituents. We provide leadership in advocacy, legislation, policy development, education and support throughout California.

For more information:

www.namicalifornia.org

Or in LA County call:

(213) 386-3615

(310) 567-0748 (Spanish)

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Los Angeles County-
Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Los Angeles County-
Department of Mental Health
Family Engagement

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(213) 738-3948
(213) 738-2910 (Spanish)
(213) 351-7207 (Chinese)
FamilyAdvocate@dmh.lacounty.gov

Los Angeles County- Department of Mental Health

Family Engagement

"Family means no one gets left behind or forgotten."
-David Ogden Stiers

Family Engagement

Family Perspective and System Approach

Families often are the first and most reliable recovery support resource for people with mental illness. Family provide continuity of care from one system to another. Giving families a voice within the mental health system is essential to maintaining vibrant and relevant care. Family Engagement strives to strengthen relationships of the family members as a means to sustaining the highest standards of treatment in order for consumers to utilize support services that enable them to live in their home communities.

Vision

The thoughts, opinions, resiliency, feelings, strengths, values, and expertise of each client, their family members, and the multidisciplinary team partners involved in the treatment of mental illness will be equally valued as indispensable on the journey to Hope, Wellness, and Recovery.

Mission

To strengthen the voice of families throughout the mental health systems.

To facilitate communication between and within the treatment team, inclusive of family, consumer, and staff, in order to advance the practical encouragement of recovery.

To assist and enable family members to gain knowledge, self-help tools, awareness, and support in working with the team to cope with the challenges of mental illness.

Strengthening Families to cope with the effects of mental illness on their loved one and themselves.

To empower the family to skillfully navigate the treatment systems with knowledge of appropriate resources, while understanding the limitations they may encounter.

To provide resources, contacts, programs, and explanations of available services.

To create avenues and utilize opportunities to improve programs, policies, and system approaches between entities involved in care and treatment.

To explore current treatment options and future promising practices while fostering avenues for family members to voice their needs and concerns.

To advocate for meaningful family involvement and inclusion in program development and treatment.

To represent the family perspective in various meetings throughout Los Angeles County - Department of Mental Health.

To engage family members when appropriate in treatment teams.

To be a voice for families.

DMH Family Advocates

(213) 738-3948

What is NAMI?

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. ***NAMI*** has over 1,100 affiliates in communities across the country who engage in advocacy, research, support and education.

Members of ***NAMI*** are families, friends and people living with mental illness such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and borderline personality disorder.

For more information on available NAMI programs in your location contact one of the NAMI affiliates listed or contact:

NAMI Los Angeles County
Council Headquarters
3250 Wilshire Blvd. Suite 1501
Los Angeles, CA 90010

Brittney Weismann
Executive Director
Brittney@namilaccc.org

NAMI PROGRAMS

Family-to-Family a 12-week course for families, partners and friends of individuals with serious mental illness taught by trained NAMI family members and caregivers of individuals living with mental illness.

De Famila a Familia es un curso gratutio de 12 semanas, dirigido por miembros capacitados de NAMI que han vivido la experiencia. Este programa ofrece educación y apoyo para familiars y amigos de personas con enfermedades mentales severas. Los participantes del curso adquieren información vital, conocimiento profundo y comprension de su ser querido que muchos describen como una experiencia transformadora de vida.

Family Support Group A support group for meeting of caregivers of individuals with a mental illness where family members can talk frankly about their challenges and help one another their challenges through their learned wisdom.

Basics is a 6 session education program developed specifically for parents and other family caregivers of children and adolescents.

Peer to Peer is a peer-facilitated nine week education class for person with lived experience who have been diagnosed with a mental illness.

NAMI PROGRAMS

Connections is a peer-facilitated recovery support group for those diagnosed with mental illness, enabling them to learn from each others' experiences.

Provider Education is a 5 session course for mental health workers and professionals. Providers learn what it is like to live with mental illness from the individual and family perspective.

In Our Own Voice is a public education program in which two trained consumer speakers share their stories of living with mental illness and achieving recovery.

Parents and Teachers as Allies is an In-service program that helps school professionals and families understand the early warning signs of mental illness in children and adolescents.

Ending the Silence is a 50 minute presentation designed to give students an opportunity to learn about mental illness through an informative presentation.

NAMIWalks is the largest anti-stigma walk-a-thon in America. This team event raises public awareness and supports NAMI Signature Programs outlined above. Los Angeles County schedules this walk annually during the early part of October.

Find Help. Find Hope.
www.nami.org
www.namicalifornia.org

NAMI Los Angeles County Council Resources

Department of Mental Health
Los Angeles County
Family Engagement

(213) 738-3948
FamilyAdvocate@dmh.lacounty.gov

Hablamos Espanol
para más informacion llame:
Ricardo Pulido
Rick@namilaccc.org
(310) 567-0748

For more information contact:
(213) 386-3615
(213) 386-1109 fax

Los Angeles County Affiliates

NAMI Antelope Valley
www.nami.org/sites/nami-av
(661) 341-8041 Message phone
name-av@nami-av.org

NAMI East San Gabriel Valley
(626) 974-8702

First United Methodist Church
Park in rear, 15701 E. Hill, LaPuente, CA 91744 Every Thur. 7:30-9 pm

4th Thurs. Speaker Night
Pacific Clinics Sierra Family Center
1160 S Grand Ave., Glendora, CA 91740
(2nd & 3rd Tues, 6:30 pm -8:00 pm)
626-252-5884 Ricky Encinas

For Caregivers & Family: 4th Sat. of every month, 9:30-11:00 am
West Covina Christian Church Library
1100 E Cameron Ave., Covina 91790

NAMI Glendale
www.namiglendale.org
namiglendale@gmail.com
(323) 478-1656

NAMI Long Beach Area
namilba@aol.com
(562) 435-2264
PO Box 91206
Long Beach, CA 90809

Los Angeles County Affiliates

NAMI Pomona Valley
www.namipv.org
Info Helpline: 909-399-0305
(909) 625-2383 Office
Executive Director - Heidi Bonadie
Ed.namipv@verizon.net

NAMI San Fernando Valley
www.namisfv.org
InfoLine (818) 994-6747

NAMI San Gabriel Valley
www.nami.sangabrielvalley.com
sgvnami@pacificclinics.org
(626) 577-6697
Office: 2550 East Foothill Blvd. #135, Pasadena, CA 91107

NAMI South Bay
www.namisouthbay.com
(310) 533-0705
NAMI Office
PO Box 5295
Torrance, CA
pstans5@aol.com

NAMI Los Angeles South Central
namisocentral@gmail.com
(310) 668-4721
Margie Harper
1006 West Century Blvd. Suite #271
Los Angeles, CA 90044

Los Angeles County Affiliates

NAMI Urban Los Angeles
www.namiurbanla.org
(323) 294-7814
(323) 294-1534 fax
info@namiurbanla.org
4305 Degnan Blvd. Suite 104
Los Angeles, CA 90008

NAMI Westside
www.namila.org
Phone (310) 889-7200
Fax: (310) 889-1133
921 Westwood Blvd. # 236
Los Angeles, CA 90024

NAMI Whittier
Email: namiwhittier@aol.com
(562) 692-8006
Rita Murray

Asian Support Group
NAMI Asian Pacific Family Center
9353 E Valley Blvd.,
Rosemead, CA 91770

Additional NAMI Resources:
Annette Tarsky
(213) 632-0782

NAMI Los Angeles County Council is a charitable 501(c)(3) tax-exempt corporation. (Tax ID#95-4049720) affiliated with NAMI California and NAMI National

1/15/15

The Los Angeles County Client Coalition is also known as the General Coalition. There are several chapters of the LACCC, two of which are the Latino Coalition and the Asian Coalition. The one Affiliate of the LACCC is BLACCC. The Black Los Angeles County Client Coalition is incorporated in California with nonprofit status. All the Coalitions share a basic focus on supporting their members to achieve their goals through advocacy efforts.

Los Angeles County Client Coalition (LACCC)

Betty Dandino, Chair (626) 688-3601

dandino@att.net

Los Angeles Asian Client Coalition (LAACC)

Emily Wu, Chair (213) 738 – 4501

ewu@dmh.lacounty.gov

BLACK LOS ANGELES COUNTY CLIENT COALITION, INC

"Juneteenth" by Synthia SAINT JAMES

Black Los Angeles County Client Coalition (BLACCC)

Osbee Sangster, Chair (323) 684-4390

slapp4390@yahoo.com

Latino Coalition / Coalición Latina

David Sanchez, President, (213) 739-631

Service Area Advisory Committee

Mission Statement

The Los Angeles County Client Coalition is an association of current or former mental health clients who carry the message of hope, recovery, wellness and self-determination to our peers and to our communities, including the mental health community, through our advocacy efforts.

Current Strategic Goals

1. To promote recovery principles and practices for people receiving mental health services
2. To combat discrimination and foster social inclusion for ourselves and our peers
3. To network with other groups to improve the quality of life for people like ourselves
4. To increase membership and involvement through outreach and education
5. To develop a yearly budget and fundraising plan related to our goals

10/29/14

We have a new Website!!
It's www.lacclientcoalition.org
Check it out!!

Current Chair of LACCC
Betty Dandino
(626) 688-3601
dandino@att.net

LACCC

LA County of Department of Mental Health
550 S. Vermont Avenue, Suite 502
Los Angeles, CA 90020
Office (213) 738-2216
Email: bdandino@dmh.lacounty.gov

LACCC

Los Angeles County Client Coalition

Mental Health Advocacy

LOS ANGELES COUNTY CLIENT COALITION

A SOCIAL ACTION / ADVOCACY GROUP FOR MENTAL HEALTH CLIENTS

Membership

Any past or present mental health client, consumer, or survivor can become a regular member of LACCC by attending the monthly meetings which are held on the third Friday of each month in different locations.

Vision Statement

The Los Angeles County Client Coalition (LACCC), its affiliate BLACCC, and its chapters, including the Latino Coalition and Asian Coalition, are dedicated to championing diversity and inclusion to create a just society that embraces people with disabilities

“nothing about us without us”

Stand up and be Counted!

We need your voice!

LACCC welcomes your participation or support.

LACCC exists to

- Enhance clients’ self esteem;
- Increase clients’ knowledge of the structure and functions of the Department of Mental Health;
- Inform clients of political and social factors which affect their well being;
- Promote Cultural competence in mental health services;
- Advocate for empowerment and self-actualization of all mental health clients in Los Angeles County

Los Angeles County Client Coalition
2015 Meeting Schedule

Day	Date	Time	Location
Friday	January 23	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	February 27	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	March 20	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	April 10	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	May 15	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	June 19	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	July 17	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	August 21	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	September 18	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	October 16	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	November 13	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room
Friday	December 11	9:00 a.m. – 12:00 p.m.	DMH 550 S. Vermont Avenue, 2nd Floor Conference Room

**All meetings are held on designated Friday of every month, unless otherwise noted*

Directors 2014-2015

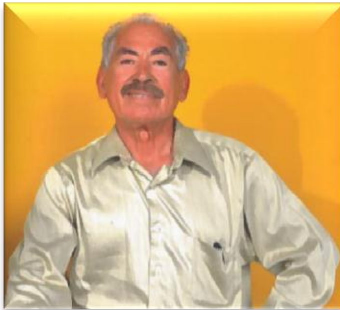
President
David Sanchez, Sr.

Vice President
Emmanuel Martinez

Secretary
Haydee Guevara

Treasurer
Gaby Alhambra

Sergeant at Arms
Carlos Ludena



Latino Coalition

Latino Coalition

550 S. Vermont Avenue
2nd Floor Conference Room
Los Angeles CA 90020

What is The Latino Coalition?

The Latino Coalition of the Department of Mental Health is an organization of consumers and family members with the same objectives, which leads to working together to promote a better quality of life and care. Those who face challenges with mental illness can recover and establish with a strong advocacy based on mental health.

The Latino Coalition is here to serve with respect equally to everyone in the same language and culture, through support, information, education and trainings.

Our Objectives

- Establish an office of Consumer Affairs to provide advocacy to clients, consumers and family members within the Los Angeles County Department of Mental Health (DMH).
- To improve the conditions of the centers that provides treatment, care and residence to customers with disabilities.
- Client representation in planning committees to prioritize the existing needs and resources that benefit everyone equally.
- Consumers advocating for housing, employment, patients' rights, resources and optional services for themselves.
- Provide scholarships so that consumers and their families can attend workshops, conferences and trainings related and focused on mental health.

Membership

Any person who was or is a consumer or family member with mental health can be a member by completing an application and attending the monthly meetings.

Monthly Meetings

Attend the monthly meetings where we will provide training, information and support.

Meetings are held on Fridays (Dates vary)
1:00 pm – 3:00 pm
Lunch is provided

Department of Mental Health
550 S. Vermont Avenue
2nd Floor Conference Room
Los Angeles CA 90020

For more information or to obtain a Membership Application call
(213) 739-6311

LATINO COALITION

2015 MEETING SCHEDULE

DAY	DATE	TIME	LOCATION
Friday	January 23	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	February 27	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	March 20	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	April 10	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
The meeting for May is cancelled due to the Latino Coalition Conference held at the California Endowment Center on May 26, 2015 celebrating May is Mental Health Month			
Friday	June 19	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	July 17	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	August 21	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	September 18	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	October 16	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	November 13	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room
Friday	December 11	1:00 pm – 3:00 pm	DMH 550 S. Vermont Ave. 2nd Floor Conference Room

Date and time changes were made by DMH and not by the Latino Coalition

BLACK LOS ANGELES COUNTY CLIENT COALITION, INC. (BLACCC)

A SOCIAL ACTION & ADVOCACY COALITION

For

MENTAL HEALTH SERVICE CONSUMERS AND OTHER PERSONS INTERESTED IN MENTAL HEALTH SERVICES AND RESOURCES

Membership

Any past or present mental health service consumers, stakeholders or other interested persons can become a member of BLACCC by attending our monthly meeting held on *the second Wednesday of each month at the Department of Mental Health (DMH).* All interested persons call: (323) 684-4390 for additional information and meeting location.

BLACCC, Inc. welcomes your participation and support!

12/11/14

About BLACCC, Inc.

In order to ensure the African American mental health services needs were being met, the Los Angeles County black mental health stakeholders formed the Black Los Angeles County Client Coalition (BLACCC) in 2006 to advocate for mental health service delivery for the underserved/unserved African American population.

Accomplishments

- Annual Community Mental Health Recovery and Wellness Cultural Forums since December 2007
- Advocacy training opportunities for members of BLACCC
- Participation in the African/African American Under-represented Ethnic Population (UREP) committee
- Participation in the Mental Health Housing Trust Fund
- Facilitated attendance for mental health consumers at mental health conferences and trainings
- Participation in DMH-California Reducing Disparities Project (CRDP): African American Focus Group
- Website launched October 2011
- Year Two-Integrated Recovery Network, Department of Labor Consortium Member

Future Plans

- 8th Annual Community Mental Health Recovery and Wellness Cultural Forum Saturday, February 28, 2015, at the California African American Museum, Exposition Park, Los Angeles
- Conduct outreach and services with special emphasis on homelessness for African Americans
- Implement an effective self-help peer advocacy network which focuses on the needs of the underserved/unserved African Americans
- Continue to reduce stigma and discrimination campaigns by educating the public about mental health and the importance of mental health treatment and services
- The Los Angeles County Black Client Coalition (BLACCC) proposes to implement a client-driven Cross-Sector Collaborative (CSC) to increase service effectiveness in mental health by proactively and systematically promoting interagency/cross-agency collaborations and assisting mental health consumers to resolve issues around access and quality of mental health services to improve client outcomes.

STAND UP AND BE COUNTED!

NOTHING ABOUT US/ WITHOUT US

WE NEED YOUR VOICE

Membership Application BLACCC

Name: ______________________________
Address: ____________________________
____

Tel: ________________________________

Email: ______________________________

Areas of interest:
____
____
____

Optional: Please mark the following special needs that you may have:

______ Mental Health Services
______ Housing
______ Disability
______ Substance abuse
______ Adults
______ Older adults
______ TAY - Transitional Age Youth (16-25)
______ HIV/AIDS
______ GLBT (Gay, Lesbian, Bisexual Trans-sexual)
______ Legal Issues
______ Other - Specify ____________
____
____
____

Please mail this application to:
BLACCC, Inc. Headquarters
550 S. Vermont Ave., 5th Floor, Suite 502
Los Angeles, CA 90020

Mission Statement

The **B**lack **L**os **A**ngeles **C**ounty **C**lient **C**oalition, Inc. (**BLACCC)** is a client controlled, client run 501(c) (3) community–based coalition. Our mission is to improve and secure the quality of life, leading to the physical, mental health recovery and the wellness of African American clients.

Vision

- To provide literacy, education and advocacy regarding the mental health care disparities that occur, particularly in the Los Angeles County African American communities.
- To be accountable, responsive and committed to reducing stigma associated with mental illness by educating the public and continuing to educate our members in the areas of leadership, advocacy, mental health and policy making issues.
- To develop an effective self-help mental health peer advocacy network to address the needs of African American mental health consumers.

BLACK LOS ANGELES COUNTY CLIENT COALITION, INC

"Juneteenth" by Synthia SAINT JAMES

This is our hope. This is the faith, with this faith we will be able to hew out of the mountain of despair a stone of hope. With this faith we will be able to transform the jangling discords of our nation into a beautiful symphony of brotherhood. With this faith we will be able to work together, pray together, and struggle together, stand up for freedom together, knowing that we will be free one day."

Dr. Martin Luther King Jr.

BLACCC, Inc. Headquarters
550 S. Vermont Ave., 5th Floor, Ste. 502
Los Angeles, CA 90020
Tel. (323) 684-4390
Fax: Available upon request

www.blaccc.org
www.blacklosangelescountyclientcoalition.org

Black Los Angeles County Client Coalition

2015 Meeting Schedule

Day	Date	Time	Location
Wednesday	January 14	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	February 11	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	March 11	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	April 08	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	May 13	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	June 10	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	July 08	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	August 12	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	September 09	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	October 14	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	November 11	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room
Wednesday	December 09	10:00 a.m. – 2:00 p.m.	DMH 550 S. Vermont Avenue, 4th Floor Conference Room

** All meetings are held on the 2nd Wednesday of every month, unless otherwise noted*

Membership Application

Name

Mailing Address

City, State and Zip

Telephone

E-mail Address

Asian Coalition Officers 2013—2014

Emily Wu, *Chair*
Nami Roberts, *Vice Chair*
Maria Tan*, Secretary*
Sawako Nitao *Treasurer*
Phil Cho*, Sgt.at Arms*

10/29/14

Get Involved

Join Us at Our Next Membership Meeting

Every 3rd Monday of the month
1:30 pm—3:30 pm

Department of Mental Health
Los Angeles County
550 S. Vermont Avenue
Los Angeles, CA 90020
2nd Floor Conference Room

Be Part of the Solution by Becoming a Member

Questions? Please contact Emily Wu at ewu@dmh.lacounty.gov

Asian Coalition

550 S. Vermont Avenue
5th Floor
Los Angeles, CA 90020
Phone: 213-738-4501
E-mail: ewu@dmh.lacounty.gov

Asian Coalition

Helping All Consumers and their Families Recover So That They Can Lead Healthy and Successful Lives

Who We Are

Asian Coalition

The Asian Coalition is an association of current or former mental health clients who carry the message of hope, recovery, wellness, and self-determination to our peers, the Asian community and the community at large through our advocacy efforts.

We are working together to enhance the quality of life and the quality of care of the Asian mental health community and the mental health community at large. We are also advocating social, political, economical and cultural inclusion for the Asian mental health clients and for all mental health clients.

Through empowerment, the coalition wishes to achieve these goals including cultural competence which is a crucial aspect in the Asian community. Our ultimate goal is for all consumers and their families to recover so we can all lead healthy and successful life.

What We Advocate

- Promote recovery principles and practices for people receiving mental health services.
- Combat discrimination and stigma by fostering social inclusion for ourselves and our peers.
- Network with other groups like the Los Angeles County Client Coalition, the Black Los Angeles County Client Coalition and the Latino Coalition to enhance the quality of life for people like ourselves.
- Increase membership and involve the Asian community and community at large in mental health issues.
- Outreach and educate the community about mental illness in order to reduce stigma.

Asian Coalition

550 S. Vermont Avenue
5th Floor
Los Angeles, CA 90020

Phone: 213-738-4501
E-mail: ewu@dmh.lacounty.gov

Why Should We Join?

The Asian Coalition exists to insure culturally competent treatment for all Asian clients and to increase the knowledge of the structure and function of the Department of Mental Health. And also to work with DMH to insure successful treatment of Asian mental health clients.

The Asian Coalition exists to be politically active and effective so we can effect changes that are need in the Asian mental health community

Who Should Join?

- Consumers in Mental Health
- Families
- Friends

Resources

- DMH (1-800-854-7771; www.dmh.lacounty.gov)
- 211 LA County (Call 2-1-1; www.211la.org)
- Healthy City (www.healthycity.org)
- Project Return Peer Support Network (1-888-448-4055; www.prpsn.org)

Asian Coalition

Emily Wu, Chair
Nami Roberts, Vice Chair
Maria Tan, Secretary
Sawako Nitao, Treasurer
Phil Cho, Sgt.at Arms

Wellness is Everyone's Right

Our Mission

To bring information and hope to people, especially to people who come from Asian and Pacific Islander cultures, about the ways in which we can grow and heal from trauma and find health in body, mind, and spirit.

- Many of us know how trauma can hurt people mentally and physically.
- We are here to learn how to live better, healthier lives.
- We are here to speak up for people like us who have difficulty speaking up.
- We are members of our communities, just like you.
- We want to make a difference in how our communities see us and treat us.

JOIN US – BECOME A MEMBER OF THE ASIAN COALITION

For Information about Our Monthly Meetings
Contact Emily Wu, Chair
(213) 738-4501
ewu@dmh.lacounty.gov

10/29/14

Asian Coalition

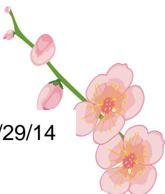
The Asian Coalition is comprised of current or former mental health consumers who live or work in Los Angeles who carry the message of hope, recovery, wellness and self-determination to our peers and the Asian community.

We plan to enhance the quality of life and mental health care for those experiencing emotional distress in the Asian communities in Los Angeles County. We believe that in coming together to advocate for social inclusion and the acceptance of diversity we can make a difference in our lives and the lives of our peers.

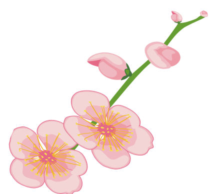
You Are Invited to Join Us at Our Next Membership Meeting

Be Part of the Solution by Becoming a Member

For further information contact Emily Wu, Chair of the Asian Coalition
ewu@dmh.lacounty.gov



550 South Vermont Avenue, 5th Floor, Los Angeles, California 90005



ASIAN COALITION
2015 MEETING SCHEDULE

DAY	DATE	TIME	LOCATION
Friday	January 23	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	February 27	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	March 20	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	April 10	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	May 15	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	June 19	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	July 17	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	August 21	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	September 18	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	October 16	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	November 13	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room
Friday	December 11	1:30 p.m. – 3:30 p.m.	DMH 550 S. Vermont Avenue, 3rd Floor Conference Room

**All meetings are held on the 3rd Friday of the month, unless otherwise noted*

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

Program Support Bureau – MHSA Implementation and Outcomes Division

COUNTYWIDE CLIENT ACTIVITY FUND (CCAF)

PURPOSE

The purpose of the CCAF is to facilitate participation of clients, family members and parents/caregivers in all aspects of planning and evaluation of mental health services in Los Angeles County and to promote opportunities for ongoing training, learning and meaningful participation.

The guidelines in this policy shall be followed when requesting reimbursement for expenses associated with participation in meetings, conferences, trainings and performance of outreach activities.

PROGRAM ELIGIBILITY

Recipients

The CCAF is intended for persons who are or have been recipients of Los Angeles County mental health services and their family members including parents/caregivers. Eligibility and reimbursement processes vary by program component as outlined below.

PROGRAM COMPONENTS

Mental Health Planning and Advisory Group Participation

The goal is to facilitate participation of clients, family members and parents/caregivers in all aspects of planning and evaluation of mental health services in Los Angeles County and to promote ongoing training and learning by reimbursing clients for their active participation in local meetings, including but not limited to:

- Service Area Advisory Meetings (SAACs)
- Department planning meetings
- MHSA Stakeholders and ad hoc committees
- Advisory committees of other mental health agencies and related community organizations
- Under-Represented Ethnic Population meetings

Reimbursement:

Reimbursement rate for approved meetings is $25 per meeting with a limit of 3 meetings per month. Reimbursement is via the completion of an invoice.

Note: Client Coalition meetings are not reimbursable.

Eligibility:

Persons interested must submit a completed application to the MHSA Implementation and Outcomes Division. All applications are reviewed by CCAF Oversight Team. Applicants are selected based on their expressed interest in meaningful participation in committees and workgroups. All participants must complete a mandatory orientation. Selected participants will be eligible for reimbursement for 1 year terms, starting on the date of orientation completion.

Training and Conference Attendance

The goal is to provide opportunities for clients and family members' participation in trainings, seminars and other mental health leadership activities, including local, state and national conferences. These activities include, but are not limited to, attendance in the following conferences, training workshops and seminars:

- California Network of Mental Health Clients
- Advocacy

- NAMI Conferences
- California Association of Social Rehabilitation Agencies
- Other conferences as approved by the CCAF committee

Participants must submit a scholarship application to access the CCAF for expenses incurred in attending trainings and conferences as pre-approved by the CCAF committee.

Expenses eligible for reimbursement include:

- Conference registration
- Airfare
- Ground transportation and parking
- Lodging
- Meals
- Incidentals (as approved by the CCAF Oversight Team)

For more information, please contact Cheryl Peterson @ (213) 251-6827 or via email cpeterson@dmh.lacounty.gov or Phyllis Griddine-Tate at (213) 251-6802 or via email pgriddine@dmh.lacounty.gov.

THE CLIENT CONGRESS

"Many Voices – A Shared Vision"

WHAT

The Client Congress of the County of Los Angeles Department of Mental Health is an association composed of groups and individuals dedicated to enhancing and enriching the experience of hope, wellness and recovery/resilience through promoting social inclusion. The Client Congress is the vehicle for linking members and groups, integrating advocacy efforts, organizing countywide public service activities, and developing an annual community event dedicated to exploring issues important to mental health clients and their families.

WHY

In an age of health care reform it becomes vital that people with a psychiatric diagnosis become informed about the issues that affect them and develop a unified voice so that their values can be communicated effectively. The Client Congress can provide a way that clients and others who support them can connect with one another and with the communities in which they live, support issues related to public mental health, and make a difference in people's understanding of what it means to be a person who illustrates hope, wellness and recovery/resilience.

WHO

Members of the Client Congress Past or present clients of the County of Los Angeles Department of Mental Health who are interested in empowering themselves and others and contributing to their communities, including the mental health community. **Friends of the Client Congress** Family members and parents of people diagnosed with a mental disorder, and people who work in public mental health who want to support the Client Congress and its members.

clientcongress@dmh.lacounty.gov
County of Los Angeles Department of Mental Health
Office of Consumer and Family Affairs

Mental Health Services Act *In Action*

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

COMMUNITY LEADERSHIP TRAINING

The Community Leadership Training (CLT) – Unlock Your Potential is a personal development training course offered over a course of four (4) sessions which meet one (1) day per month, over a sequence of four (4) months. This program empowers participants to develop as individuals and as leaders to proactively serve their local communities. Since 2011, CLT has successfully assisted individuals to advocate overcoming stigma and promote social inclusion in a volunteer capacity.

This series of trainings will strengthen individual leadership skills by assisting participants with identifying personal development goals and barriers to achieving their goals. Additionally, the training will focus on helping individuals use their newly learned leadership skills to develop and implement an advocacy plan that facilitates integration into their local community in a fully participatory/ leadership role. Within the structure of the training series, participants will identify a community project where they will be an active volunteer. Through this project they will unlock their leadership potential and contribute positively to the committee.

In addition to training individuals receiving mental health services, the program has recently extended (2014) to include training individuals associated with Faith Based Organizations (FBO's). The Department of Mental Health recognizes that, to serve members of the community in a culturally competent manner, it must consider personal belief systems such as spirituality and other supports. Partnering with faith based organizations has become a key part of the strategic aim to promote health neighborhoods. It is for these reasons that this leadership training has broadened its enrollment to FBO's and caregivers/family members.

Service Area Advisory Committee

COMMUNITY LEADERSHIP TRAINING 101 (ENGLISH)

FACILITATED BY

Jim Silva, Ph.D.

LEADERSHIP DEVELOPMENT PROFESSIONAL

SPACE IS LIMITED…SIGN UP NOW!

Location:

Department of Military & Veterans Affairs
Bob Hope Patriotic Hall
1816 S. Figueroa Street
Los Angeles, CA 90015
Purple Heart Room - Basement

Parking Options:

Free limited parking
First come, first served
Public Access: Metro Blue Line & Dash F

Thursdays

- March 19, 2015
- April 23, 2015
- May 21, 2015
- June 18, 2015

- People who want to attend must get a referral from someone who works for LACDMH
- The class meets 4 times, once a month for 8 hours from 8:30 am – 4:00 pm
- People who complete the class qualify for a certificate
- Participants class will develop their skills as leaders of others and leaders of themselves
- Graduates are expected to volunteer in LACDMH or their community to fulfill the class requirements

Contact Hera Patail at hpatail@dmh.lacounty.gov or (213) 351-7206 for more information and to request an application. Only people who have not attended this class in the past are eligible to apply.

Mental Health Services Act *In Action*

THIS TRAINING IS COORDINATED and SPONSORED BY
LACDMH / CONSUMER AND FAMILY AFFAIRS

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
OFFICE OF CONSUMER AND FAMILY AFFAIRS

Contact Information:

Name: ____
LAST NAME FIRST NAME

Address: ____
STREET NUMBER

____
CITY ZIP CODE

Telephone: ____
HOME CELL OTHER

E-mail: ____
HOW OFTEN DO YOU CHECK YOUR E-MAIL?

Reference (mental health professional recommending you for this program)

Name: ____
LAST NAME FIRST NAME

E-mail: ______________________________ Telephone: ________________

Eligibility: Spring 2015, English – Thursdays

This training is for individuals who have not participated in past Community Leadership trainings. It is designed for clients who are working on their path to recovery, and doing well. You must be willing to commit to the following requirements:

- Work on a project in your community or in LACDMH (directly-operated or contract agency) where you can put to use the skills you learn in this training.
- Attend all four sessions, and actively participate
- Complete homework assignments
- Answer the questions listed on the back of this form

SUBMIT YOUR APPLICATION TO: e-mail: hpatail@dmh.lacounty.gov or fax: (213) 252-8767

MENTAL HEALTH SERVICES ACT *IN ACTION*

Please answer the questions below in the space provided.

1. What are three words that describe “leadership” potential?

2. Where have you thought about becoming a volunteer? (such as wellness, library, etc)

   b. What do you like about this location?

3. Are you willing to work on your personal leadership skills by completing assignments from “Unlock Your Potential” between classes?

Name: ______________________________ ______________________________

PRINT SIGNATURE

Date: ______________________________ Date of Birth:__________________

SUBMIT YOUR APPLICATION IMMEDIATELY TO: Hera Patail
E-mail: *hpatail@dmh.lacounty.gov* or fax: (213) 252-8767

You will be contacted by phone and/or email when you are accepted into the class. If the class is full, you will be given priority enrollment for an upcoming session.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

HOPE AND RECOVERY CONFERENCE VISION

The original vision of the Hope & Recovery Conferences was to produce an event in English that would encourage clients to feel more hopeful by gaining inspiration from the stories of others like themselves who have learned how to enhance their own recovery and live full and meaningful lives.

Now the Hope and Recovery conferences are offered in English, Spanish, and with interpreters, in a variety of Asian and Pacific Islander languages. The focus is on wellness in all its aspects and includes workshops as well as panels and keynote speakers. Without losing its original focus, participants in the Hope and Recovery conference, in whatever language it is offered, learn from one another how better to embrace recovery as a path to wellness in mind, body, and spirit.

The Conferences are developed by committees of people in recovery and people on the path to recovery with the assistance of staff from the Program Support Bureau and the Office of Consumer and Family Affairs. Those who develop the program and those who attend the conference do so looking forward to a future in which diversity is accepted and inclusion is celebrated in a just society that recognizes that a healthy society is one where everyone has a place.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

PEER SUPPORT TRAINING

Project Return Peer Support Network (PRPSN) offers an intensive series for individuals interested in working as peer advocates or supporters in the mental health field. Held over a five week period, the series covers mental health support and recovery techniques, medications and side effects, and engagement skills. It includes topics such as the history and roles of peer supporters, advocating for others, group facilitation, listening skills and success in the workplace.

Advanced Peer Advocate Training

This training offers currently employed peers with an opportunity to learned more advanced skills for workplace application. Held over three days topics include motivational interviewing, client centered approaches, advanced advocacy skills, recovery oriented documentation, decision making, professionalism and additional opportunities to create a learning environment.

Train the Trainers

The purpose of the Train the Trainer training series is designed to provide peers with a comprehensive approach to training and public speaking. Practice sessions occur during the class (for a minimum of 6 practice trainings per participant). The training covers: content, basic speaking and presentation style, training structure, techniques for interactive exercises, trainee engagement skills, facilitation and classroom management skills, storytelling, skills for integrating lessons and techniques for helping participants take the lessons to the next step. This has helped increase the number of trainers and speakers who can spread the message of recovery and recovery skills trainings.

SUGGESTED RESOURCES FROM OFFICE OF CONSUMER AND FAMILY AFFAIRS

Bazelon Center for Mental Health Law
http://www.bazelon.org/
The nation's leading legal advocate for people with mental disabilities. Their precedent-setting litigation has outlawed institutional abuse and won protections against arbitrary confinement.

California Association of Mental Health Patient Rights Advocates (CAMPHRA)
http://www.camphra.org
A membership organization working to promote public policy furthering the rights and well-being of mental health consumers

Depression and Bipolar Support Alliance (DBSA)
http://www.dbsallaince.org/
The leading patient-directed national organization focusing on mood disorders with face-to-face and online support groups in all 50 states

Disability Rights California (DRC) – formerly called Protection & Advocacy (PAI)
http://disabilityrightsca.org
Provides legal advocacy and peer advocacy for Californians with developmental and mental disabilities

Mental Health America (MHA)
http://www.mentalhealthamerica.net/
This nation's largest and oldest community-based network dedicated to helping all Americans live mentally healthier lives

MindFreedom International
http://www.mindfreedom.org/
Organization of independent united mental health advocates offering mental health alternatives and supporting personal choice in mental health care.

National Alliance on Mental Illness (NAMI)
http://www.nami.org
Mental health advocacy organization offering support groups and education on mental illness for people with mental illness and their families

National Empowerment Center (NEC)
http://www.power2u.org
Federally funded technical assistance center carrying the message of empowerment, hope, and healing to people who have been labeled with a mental illness

National Mental Health Consumers' Self-Help Clearinghouse
http://www.mhselfhelp.org
A national consumer-run technical assistance center to help foster the growth of consumer-run self-help groups and programs throughout the nation

People Who
http://www.peoplewho.org
Advocacy and support website for people who experience mood swings, fear, voices, and visions. Resource for information on people-first language

Substance Abuse & Mental Health Services Administration (SAMHSA)
http://www.samhsa.gov/
Part of the United States Department of Health and Human Services, SAMHSA provides information and technical support in order to reduce the impact of substance abuse and mental illness on America's communities

Los Angeles County Department of Mental Health

Glossary of Terms

A helpful text for mental health advocacy

June 2013 Edition

Los Angeles County Department of Mental Health

Glossary of Terms

This glossary was created under the Community and Government Relations Division (CGRD) of the Los Angeles County Department of Mental Health. Beginning in 2008, as a project of UCLA MSW Intern, Stephanie Bartsch, this document has since then been updated by the following MSW interns:

Kimberly Ngiangia, UCLA **Alicia Powell, CSULB**	**2009**
Alex Raskin, UCLA **Nadia Wright, USC**	**2010**
Suzanne Cheatham, USC **Rachel Gannon UCLA**	**2011**
Anastasia V. Lebedeva, CSUN **Luis E. Quintanilla, UCLA**	**2012**
Antonio Chapa, USC **Betzabel Estudillo, UCLA** **Asja Hall, CSUDH**	**2013**

This text was envisioned to help persons interested in mental health advocacy to understand the terminologies and concepts used within the mental health system and to have a working knowledge of certain policies that affect the system. The definitions in this text are taken from various sources including existing documents, personnel, and committees.

The 2013 edition was planned to include the Spanish translation of the terms but the translation has not yet been completed so an update will be posted at a later time. Our gratitude goes to Sr. Mary Yun, MSW and Luis Orozco, LCSW of the Community and Government Relations Division for their assistance in editing this document.

This is a living document and it is open to the addition/deletion of terms or feedback. Please send comments or suggestions to Adrienne Cedro Hament, LCSW at ahament@dmh.lacounty.gov.

Directory of Terms

#

1115 Waiver
200% Poverty
5150

A

AB 100 (Mental Health Services Act (See MHSA for definition of MHSA)
AB130 (California Dream Act)
AB131 (California Dream Act)
AB 2034
AB3632 (Mental Health Services for Special Education)
AB540
Access
ACCESS Center
ADA
Advance Directive
Alternate Crisis Services (ACS)
Annual Liability
Assessment
Assisted Outpatient Treatment (AOT)
Association of Community Human Service Agencies (ACHSA)
At Risk for Suicide
At Risk Mental State (ARMS)
Auditor-Controller

B

Block Grant
Benefits Establishment
Board letter
BOS
Bundling and Unbundling of Service Codes

C

California Dream Act
CAMP
CAO
Cash Flow Advance
CBO
Central Authorization Unit
CCAC (Cultural Competence Advisory Committee)
CCC
CCHIT.
CDAD
CDE
CEO
CGRD
Children and Youth in Stressed Families
Children's Countywide Case Management
Children’s System of Care Program
CiMH
Client Congress
Client Supportive Services
CMHDA
CMHPC
CMS
COD
COS
Community Capacity
Community Clinic
Community-Designed Integrated Service Management Model (ISM)
Community Outreach Service
Community Treatment Facility
Conservatorship
Consumer
Consumer-run
Contract Discrepancy Report
Contract Providers
Co-occurring/Comorbidity
Coordination of Benefits
Cost Reimbursement (CR)
County Counsel
Countywide Resource Management
CORS
Court Liaison Program (CLP)
Credentialing

CSAC
CSS
Culture
Cultural Competency
CW

D

Day Treatment Rehabilitation
DBH
DCEO
DCFS
Deferred Action for Childhood Arrivals (DACA)
Delegated Authority
Delegates
Department of Health and Human Services (HHS)
Department of State Hospitals
Deputy Chief Executive Officer (DCEO)
Deputy Director
Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition, Text Revision Manual (DSM-IV-TR
Differential Response
Directly Operated Facility(ies)
Duration of Untreated Psychosis (DUP)
Division of Empowerment and Advocacy
DMH
Drop-In Centers
Dual Diagnosis

E

Early Intervention
Electronic Data Interchange
Electronic Health Record
Empowerment & Advocacy (E&A)
EMT
Emerging Best Practices
Enhanced Emergency Shelter Program (ESSP)
EOB
Episode Data
Episode of Care
EPSDT
ERT
Established Maximum Allowable Rate
Evidence-based Practices (EBP)
Explanation of Balance

F

Facility
Family to Family
Family Specialist
FAQ
Federal Financial Participation
Fee-for-Service
Field Capable Clinical Services (FCCS)
First 5 California
First Onset (or First Break)
Fiscal Intermediary
Fiscal Year (FY)
Full Service Partnerships (FSP)
Full-time equivalent (FTE)
Fully Served

G

Gatekeeper
Grant-in-aid
Greater Avenues for Independence (GAIN)"
Gross Program Budget
GROW
Guide to Procedure Codes

H

Head of Service
Health-based Interventions
Health Center
Healthcare Common Procedure Coding System (HCPCS)
Health Deputies
Health Level Seven (HL7)
Healthy Families
Healthy Families Procedures Manual
HealthyWay LA
HIPAA
HIPAA Final Security Rules
Historical Trauma
HOPE
HOT
Housing Specialists

I

ICD-9
IIHI
IMD
IMP
INN (Innovations)
Inappropriately served
Independent Living Program (ILP)
Indigent
Indigent Medication Program (IMP)
Individuals Experiencing Onset of Serious Psychiatric Illness
Information System (IS)
Inpatient Fee-for-Services
Intake Period
Integrated Plan
Integrated System (IS)
Integrated Clinic Model
Integrated Mobile Health Team (IMHT)
Interagency Placement Screening Committee
Internal Services Department (ISD)
International Organization for Standardization (ISO)
Intervention
Invitation for Bid (IFB)

J

Juvenile Justice Facility
Juvenile Justice Transition Aftercare Services (JJTAS) Program

K

Katie A.

L

LACDHM
LAC PPP
LAHSA
Laura's Law
LCSW
Licensed Clinical Social Worker (LCSW)
Legal Entity
LGBTQIA
Lived Experience
Los Angeles Mental Health Plan System (LAMHPS)
Los Angeles Public Administration/Guardian Information Systems (LAPIS)
LPS

M

Managed Care
Managed Risk Medical Insurance Board
Management Inquiries
Master Agreement List
MCA
Medi-Cal
Medi-Cal Eligibility Data System (MEDS)
Medical Director
Medical Model
Medical Necessity
Medicare
Medicaid Waivers
Medicare Fiscal Intermediary
Megan's Law
Member or Title XXI Healthy Families Program Member (HFPM)
MET
Mental Health Disorder
Mental Health Fee-for-Service (MHFFS)
Mental Health Management Information System (MHMIS)
Mental Health Integration
Mental Health Problem
Mental Health Promotion
MFT
MHC
Mental Health Professional Shortage Area (MHPSA)
MHPSA Designation
MHSA
MHSOAC
Mission
MOU

N

NAMI

National Council for Prescription Drug Programs (NCPDP)
National Drug Code (NDC)
National Provider Identifier (NPI)
National Registry of Evidence-based Programs and Practices (NREPP)
Negotiation Package
Negotiated Rate (NR)
Net Program Budget
Non-governmental Agency (NGA)
Non-repudiation
Non-traditional Mental Health Settings
Notice of Action (NOA)

O

OCA
Office of Family Advocate (OFA)
OMA
Office of the Medical Director (OMD)
Office of Multicultural Services (OMS)
Onset
Oral Presentation
Outcome Measures Application (OMA)
Outreach & Engagement (O&E)
Over Threshold Authorization Request (OTAR)
Over-Threshold Specialty Mental Health Services

P

PAI
PAP
Parent Partner
Parity
Patient's Rights Office
PBC
Peer
Peer Bridger
Peer to Peer
Peer Model/Peer Support Model
Peer-Run
Peer Specialist
PEI
PEI Principles
PEI Project
PET
Pharmacy Benefits Manager (PBM)
PhD
Point of Service
Posttraumatic Stress Disorder (PTSD)
Pre-Screen Proposals
Prescription Authorization and Tracking System (PATS)
Prevention
PRCH
Primary Care
Primary Contact
PRISM
Priority Population
Probation Camp Services
Prodrome (Prodromal Syndrome)
Professional Services Unit
Program Head
Project 50
Projects for Assistance in Transition from Homelessness Federal grant funds (PATH)
Project Management Methodology (PMM)
Promising Practice
Promotores de Salud
Proposition 63 (Prop. 63)
Protected Health Information (PHI)
Protection and Advocacy Inc (PAI)
Proselytize
Provider
Provider Director
Prudent Reserve
PsyD
Psychotropic Medication Authorization (PMA)
Psychiatric Advance Directive
Psychiatric Health Facility (PHF)
Psychiatric Mobile Response Team (PMRT)
Public Guardian
Public Guardian Office (PGO)

Q

Quality Assurance Activities
Quality Improvement Program
Qualified Proposer

R

RCL Certification Unit (RCL)
Re-alignment Money
Recovery
Recovery Model
Referral
Religion
Rendering Provider
RFI
RFP
RFS
RFSQ
Residential & Bridging Services
Resilience

S

SAMHSA
Schiff Cardenas Crime Prevention Act
School-based Interventions
School Failure
School Threat Assessment Response Team (START)
Screening
SD
SDMH
Serious Emotional Disturbance (SED)
Serious Mental Illness (SMI) or Disorder
Service Area Advisory Council (SAAC)
Service Area District Chief
Service Coordination Inquiries
Service Extenders
Service Function Code (SFC)
Service Area Navigators
Service Planning Areas (SPA)
Share of Cost
Short-Doyle Act
Single Fixed Point of Responsibility (SFPR)
Skilled Nursing Facility (SNF-STP)
Sliding Fee Schedule
Small County
SMART
SOC
Social Inclusion
Specialized Intensive Foster Care
Spirituality
SSDI
SSI
Stakeholder
State General Fund (SGF)
Statement of Qualifications (SOQ)
Statement of Work (SOW)
Stigma and Discrimination
Substance Abuse
Supportive Residential Programs (Enriched Residential and IMD Step-Down)
Supportive and Therapeutic Options Program (STOP)
System for Treatment Authorization Request (STAR)
System Leadership Team (SLT)
System of Care

T

Tarasoff
TAY
Target Community
The Project-Based Operational Subsidy
Therapeutic Behavioral Services (TBS)
Threshold Language
Title IV
Title XXI
Traditionally Underserved Populations
Transformation
Trauma-Exposed Individuals
Treatment Authorization Request (TAR)
Triage

U

Underserved/Inappropriately Served
Undocumented Youth
Uniform Bill-04 (UB-04)
Uniform Bill-92 (UB-92)
Uniform Method of Determining Ability to Pay (UMDAP)
Unit of Service
Unserved
UREP
Urgent Care Centers (UCCs)

V

Very Small County
Vision

W

Welfare and Institutions Code (WIC)
Wellness Center
WET
Whatever It Takes
WRAP
Wraparound

X
Y
Z

"1115 Waiver" known as the "Bridge to Reform," waiver proposal approved by Centers for Medicare and Medicaid Services (CMS) on November 2, 2010. Through the Section 1115 waiver, California aims to advance Medi-Cal program changes (using 10 billion dollars) that will help the state transition to the federal health reforms that will take effect in January 2014. Changes under the waiver involve expanding coverage today for those who will become "newly eligible" in 2014 under health care reform, implementing models for more comprehensive and coordinated care for some of California's most vulnerable residents, and testing various strategies to strengthen and transform the state's public hospital health care delivery system to prepare for the additional numbers of people who will have access to health care once health care reform is fully implemented.

"200% Poverty" references the Federal Poverty Level. 200% poverty means those making less than twice the poverty level. See diagram below.

2013 200% of Federal Poverty Level

Persons in Family/Household	Gross Annual Income	Gross Monthly Income
1	$22,980	$1,915
2	$31,020	$2,585
3	$39,060	$3,255
4	$47,100	$3,925
5	$55,140	$4,595
6	$63,180	$5,265
7	$71,220	$5,935
8	$79,260	$6,605

SOURCE: *Federal Register*, 78 FR 5182, 5182 -5183, January 24, 2013

"5150" refers to Section 5150 is a section of California's Welfare and Institutions Code (specifically, the Lanterman-Petris- Short Act or "LPS") which allows a qualified officer or clinician to involuntarily confine a person deemed a danger to himself, herself, and/or others[1] and/or gravely disabled. A qualified officer, includes any California peace officer, as well as any specifically designated county clinician, can request the confinement after signing a written declaration. When used as a term, 5150 can informally refer to the person being confined or to the declaration itself.

A

AB 100 (Mental Health Services Act (See MHSA for definition of MHSA) This bill would require the state, instead of the department, to administer the fund. The bill would authorize continued financial support for mental health programs to come from the Local Revenue Fund 2011 in the State Treasury, and would, commencing July 1, 2012, require the Controller to distribute to the counties all unexpended and unreserved funds on deposit in the Mental Health Services Fund monthly. The bill, for the 2011-2012 fiscal year, would allocate specified funds in the Mental Health Services Fund for new purposes: Medi-Cal specialty mental health services, mental health services for special education pupils, and the Early and Periodic Screening, Diagnosis, and Treatment program.

"AB130" (California Dream Act) Assembly Bill 130 provides undocumented students, who qualify for AB 540, to receive scholarships derived from non-state funds for the purpose of attending a credited college (i.e. UC, CSU, and Community College). This bill gives undocumented students the ability to receive private scholarships through the University.

"AB131" (California Dream Act) Assembly Bill 131 provides undocumented students, who qualify for AB 540, to receive state financial aid such as Cal Grants, the Board of Governors Fee Waiver, and departmental and institutional scholarships.
This bill provides access to higher education for low-income undocumented students. Undocumented students who qualify for AB 131 must complete an application, meet deadlines and follow through with requirements. For more information please visit www.csac.ca.gov

"AB 2034" Assembly Bill No. 2034 provided State general funds that allowed localities to provide comprehensive, integrated services to adults who have serious mental illness and who are homeless or at risk of becoming homeless; or who have recently been released from a county jail or state prison; or who are at significant risk of incarceration or homelessness and do not have access to needed services and supports. Funding for this program was eliminated from the Fiscal Year 07/08 state budget in a line-item veto by the Governor. The AB 2034 program was honored as a model program for individuals with mental illness who are homeless under the President's New Freedom Commission. The program's success provided both inspiration and data on effective practices and helped spur public support for the Proposition 63 ballot initiative enacted into law as the Mental Health Service Act of 2004 (MHSA).

"AB3632 (Mental Health Services for Special Education)" Assembly Bill 3632 aligns with the Individuals with Disabilities Education Act (IDEA), which ensures that children with disabilities are entitled to a free, appropriate public education in the least restrictive environment. Special education pupils may require mental health services in any of the 13 disability categories. To be eligible to receive services, they must have a current individualized education program (IEP) on file. Services are free to all eligible students regardless of family income or resources.

"AB540"Assembly Bill 540 is a bill that provides California in-state tuition for nonresident students (including legal permanent residents, U.S. citizens and undocumented students) who have attended a CA high school and have received a high school diploma or equivalent. Often, undocumented students are referred as AB540 students to identify them in a safe manner.

"Access" is the extent to which an individual who needs mental health services is able to receive them, based on conditions such as availability of services, cultural and language appropriateness, transportation needs, and cost of services.

“ACCESS Center” operates 24 hours/day, 7 days/week as the entry point for mental health services in Los Angeles County. Services include deployment of crisis evaluation teams, information and referrals, gatekeeping of acute inpatient psychiatric beds, interpreter services and patient transport.

"ADA" known as the Americans with Disabilities Act (ADA) was signed into law under President George H. W. Bush in 1990. It applies to all private and state-run businesses, employment agencies and unions with more than fifteen employees. The goal of the ADA is to make sure that no qualified person with any kind of disability is turned down for a job or promotion, or refused entry to a public-access area.

"Advance Directive" Legal documents or statements, including a living will, which are witnessed and allow an individual to convey in expressed instructions or desires concerning any aspect of an individual's health care, such as the designation of a health care surrogate, the making of an anatomical gift, or decisions about end-of-life care ahead of time. An Advance Directive provides a way for an individual to communicate wishes to family, friends and health care professionals, and to avoid confusion about end-of-life care ahead of time.

"Alternate Crisis Services (ACS)" provides a comprehensive range of services and supports for mentally ill individuals that are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration.

"Annual Liability" The Annual Liability, also known as UMDAP liability, is based on a sliding scale fee and applies to services extended to the client and dependent family members. The annual liability is determined by using the adjusted monthly income amount and the number dependent on the adjusted monthly income. A client is responsible for the annual liability amount or the actual cost of care, whichever is less. The annual liability period runs from the date of the client's first visit through end of the subsequent eleven calendar months (e.g. An initial liability determination made of Jan 5, 2012 would be valid through December 31, 2012) and each 12-month period thereafter during which the client continues to receive services. It is renewed annually, provided the client continues to receive services, with the new 12-month period beginning on the 1st day of the month during which liability was originally determined (e.g. using the earlier example, the next annual liability period would run from Jan 1, 2013 through December 31, 2013). Note: Admissions and/or readmissions during the 12-month period do not change the sliding scale fee period.

“Assessment” means a professional review and evaluation of an individual’s mental health needs and conditions, in order to determine the most appropriate course of treatment, if indicated, and may ascertain eligibility for specific entitlement or mandated programs.

"Assisted Outpatient Treatment (AOT)" Assisted outpatient treatment is sustained and intensive court-ordered treatment in the community for those most overcome by the symptoms of severe mental illness. The treatment mechanism is only used until a person is well enough to maintain his or her own treatment regimen. Serving as a bridge to recovery for those released from inpatient facilities as well as an alternative to hospitalization, assisted outpatient treatment can stop the "revolving door" of repeated hospitalizations, jailings, and homelessness

"Association of Community Human Service Agencies (ACHSA)" represents more than 75 nonprofit community agencies that provide a wide range of child welfare, mental health, and juvenile justice services for vulnerable individuals and families in Los Angeles County. The mission is to promote the role of the private nonprofit sector in mental health and child welfare service delivery and to provide mutual support in pursuit of a more effective community.

"At Risk for Suicide" means those individuals or population groups who demonstrate a higher likelihood than average to commit suicide.

"At Risk Mental State (ARMS)" "At Risk Mental State" means the condition of individuals who are at risk for developing a psychotic illness and are experiencing signs or symptoms that are indicative of high risk for psychotic illness. These individuals have not yet been diagnosed with a psychotic illness.

"Auditor-Controller" is the department within the County that is responsible for auditing business operations and paying debts.

B

"Block Grant" In a federal system of government, a block grant is a large sum of money granted by the national government to a regional government with only general provisions as to the way it is to be spent. This can be contrasted with a categorical grant which has more strict and specific provisions on the way it is to be spent. An advantage of block grants is that they allow regional governments to experiment with different ways of spending money with the same goal in mind.

"Benefits Establishment" is a program of the Comprehensive Community Care plan (CCC). It was discovered that many clients of LACDMH are eligible for MediCal but did not apply for it. It was resolved that clients would be screened and given help in applying for MediCal so that LACDMH could receive income for providing services to these clients and thereby increase income for the county.

"Board letter" This is the official proposal/request to the Board of Supervisors to use department funding for a specific purpose. The Board Letter must be approved by the Supervisors in order for any funding to be released.

"BOS" stands for Board of Supervisors and refers to the Los Angeles County Board of Supervisors that oversee all county departments, including LACDMH. This Board is an elected body

"Bundling and Unbundling of Service Codes" bundling or unbundling that occurs when the actual services performed and reported for payment on a claim can be represented by a different group of procedure codes.

C

"California Dream Act" (please see AB 130 and AB 131)

"CAMP" is the Los Angeles Police *Department Case Assessment and Management* Program.

"CAO" is the Chief Administrative Officer. This position was replaced by the CEO in the restructuring of 2007.

"Cash Flow Advance" County General Funds (CGF) furnished by County to Contractor for cash flow purposes in expectation of Contractor repayment pending Contractor's rendering and billing of eligible services/activities.

"CBO" is a Community-based organization.

"Central Authorization Unit" a unit of the managed care division in the DMH Office of the Medical Director that conducts monitoring and authorization of services. Specific service authorizations include Over Threshold Authorization, psychological testing, Day Treatment/TBS Authorization and requests for authorization of out-of-county services.

"CCAC (Cultural Competence Advisory Committee)" The California Department of Mental Health (CDMH) Director established the Cultural Competence Advisory Committee (CCAC) as a statewide advisory group to CDMH Office of Multicultural Services as mandated in the Federal Waiver Request. This group plays a critical role in supporting the Department in the development and direction of cultural competency standards. The CCAC is comprised of representatives from the California Mental Health Directors Association, mental health consumers and family members, cultural competency consultants, ethnic-specific programs, and university affiliates.

"CCC" is the Comprehensive Community Care plan developed in 2000 under the direction of Dr. Southard. This plan focused on redesigning the current system to become a client and family focused system through changes in both philosophy (Client focused model) and structure (more community involvement, changes in delivery of services).

"CCHIT" Certification Commission for Healthcare Information Technology is a recognized certification authority for electronic health record products in the United States, setting the industry bar for functionality, interoperability of products and networks, and security.

"CDAD" Department of Mental Health Contracts and Development Administrative Division.

"CDE" stands for Community-defined Evidence. CDE is defined as a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community.

"CEO" is the Chief Executive Officer. Currently, this position is held by Bill Fujioka.

"CGRD" is the Community and Government Relations Division. This division reports directly to Dr. Southard and Kumar Menon is the head of this division.

"Children and Youth in Stressed Families" means children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses, or lack of care-giving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

"Children's Countywide Case Management" is a division within the DMH Child, Youth and Family Programs Administration oversees a variety of Countywide

"Children's System of Care Program" This program provides mental health services through interagency collaboratives and intergrated services system that provides case management, outpatient and day treatment. Collaborating partners are the Department of Mental Health, Department of Children and Family Services, Group Homes, School Districts, Parent Advvocates, Vocational agencies, and Substance Abuse Agencies. Children from birth to age 19 are served.

“CiMH” is the California Institute for Mental Health. The mission of CiMH is to promote excellence in mental health services through training, technical assistance, research, and policy development.

“Client Congress” the Client Congress of the County of Los Angeles Department of Mental Health is an association composed of groups and individuals dedicated to enhancing and enriching the experience of hope, wellness and recovery/resilience through promoting social inclusion. The Client Congress is the vehicle for linking members and groups, integrating advocacy efforts, organizing countywide public service activities, and developing an annual community event dedicated to exploring issues important to mental health clients and their families.

“Client Supportive Services” are essential services that may not be reimbursable under Medi-Cal or other benefits programs (e.g., outreach and engagement services, housing services, employment services, transportation, etc.).

“CMHDA” is the California Mental Health Director’s Association. CMHDA provides assistance, information, training, and advocacy to the public mental health agencies that are its members. The mission of the Association is to provide leadership, advocacy, expertise and support to California's county and city mental health programs (and their system partners) that will assist them in serving persons with serious mental illness and serious emotional disturbance.

“CMHPC” is the California Mental Health Planning Council. PL 106-310 re-authorized the Community Mental Health Services Block Grant and reaffirmed the requirement that each state must have a mental health planning council in order to receive the block grant. Federal law requires the Planning Council to perform the following functions: Review the State mental health plan and the annual implementation report and submit to the State any recommendations for modification. Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems. Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State.

“CMS” stands for the Centers for Medicare and Medicaid Services, the US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

“**COD**” Co-occurring disorders means two or more disorders occurring to one individual simultaneously. Clients said to have COD have more than one mental, developmental, or substance-related disorder, or a combination of such disorders. COD exists when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.

"COS" Stands for Community Outreach Services.

"Community Capacity" (growing) the community's knowledge of and active support for practices that support consumers' social inclusion free of stigma and support consumers' good mental health.

"Community Clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported in whole or in part by donations, bequests, gifts, grants, government funds, or contributions. Any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. These clinics provide essential health services to primarily uninsured and under-served men, women, and children.

"Community-Designed Integrated Service Management Model (ISM)" envisions a holistic model of care whose components are defined by specific ethnic communities and also promotes collaboration and community based partnerships to integrate health, mental health, and substance abuse services together with other needed non-traditional care to support the recovery of consumers. The five ethnic communities targeted are: **African Immigrant / African American, American Indian / Alaska Native, Asian Pacific Islander, Eastern European / Middle Eastern and Latino.** The ISM model consists of discrete teams of specially-trained and culturally competent "service integrators" that help clients use the resources of both formal" (i.e., mental health, health, substance abuse, child welfare, and other formal service providers) and nontraditional" (i.e., community defined healers) networks of providers, who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations

"Community Outreach Service" services provided to the community-at-large, who include special population groups, human service agencies, and individuals and families who are not clients of the mental health system.

"Community Treatment Facility" the specific licensing term associated with a high level residential treatment facility for youth. A CTF facility is a higher level of care than an RCL 14 facility.

"Conservatorship" is granted when an individual is "gravely disabled" meaning they are unable to provide for their basic personal needs of food, clothing, or shelter. A person or entity is charged with the responsibility of making decisions on behalf of the conserved individual. For Mental Health (LSP) Conservatorships, a mental disorder is required and referrals are made through the Public Guardian's Office (PGO).

"Consumer" refers to people who are or have received services for serious mental illness and who disclose this voluntarily. The terms are intended to include people who may

not be ordinarily associated with the terms consumer or client, or who do not identify with these labels, such as high school youth who speak with peers about feeling suicidal, celebrities or leaders who disclose mental health struggles, etc.

"Consumer-run" refers to agencies, programs, services or supports provided by people who are or have received services for serious mental illness ('consumers') and who disclose this history voluntarily.

"Contract Discrepancy Report" a written report prepared by the County to identify Contractor's specific failures in meeting contract standards.

"Contract Providers" LACDMH contracts with community based providers for the delivery of mental health services and supports. Contract providers offer services throughout the county and for all ages.

"Co-occurring/Comorbidity" In general, the existence of two or more illnesses – whether physical or mental – at the same time in a single individual. With SAMHSA, the term usually means the co-existence of mental illness and substance abuse.

"Coordination of Benefits" a process for determining the respective responsibilities and priority order of two or more insuring entities that have some financial responsibility for a medical claim.

"Cost Reimbursement (CR)" the arrangement for the provision of mental health services based on the reasonable actual and allowable costs of services provided under this Agreement, less all fees paid by or on behalf of patients/clients and all other revenue, interest and return resulting from the same services.

"County Counsel" is the legal body of the county. This department provides legal counsel for the county. Every plan must go through the council to make sure that it is not in violation of the law.

"Countywide Resource Management" an organizational division within the DMH that centrally tracks capacity and prospectively authorizes access to approximately one thousand, three hundred (1,300) beds distributed across institutes for Mental Disease, a Psychiatric Health Facility, state hospitals, intensive residential facilities, and inpatient facilities servicing indigent clients.

"CORS" or Crisis-oriented recovery services is the department's newest strategy for mental health care delivery, offering short-term services for clients in crisis.

"Court Liaison Program (CLP)" is a collaboration between the Los Angeles County Department of Mental Health (DMH) and the Los Angeles County Superior Court. It is staffed by a team of 14 mental health clinicians who are co-located at 23 courts countywide. This recovery based program serves adults with a mental illness or co-occurring mental health and substance abuse disorder who are involved with the criminal justice system. The program is part of DMH's system of supports and services offered throughout the criminal justice continuum from arrest to release. This program incorporates the "no wrong door" philosophy by offering the courtroom as an entry point for services. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The **CLP** further aims to provide ongoing support to families and to educate the court and the community at large regarding the specific needs of these individuals. Participation is voluntary and available to those 18 and above.

"Credentialing" is a process of review to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan. **CSAC"** is the California State Association of Counties. The primary purpose of CSAC is to represent county government before the California Legislature, administrative agencies and the federal government. CSAC places a strong emphasis on educating the public about the value and need for county programs and services.

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"**CSS**" is Community Services and Supports. The Community Services and Supports Plan, in general, references planned community-based mental health services and support programs funded under the Mental Health Services Act. The plan must demonstrate community collaboration, cultural competence, client- and family-driven mental health systems and other components that support a recovery and resilience oriented system of care. The CSS plan is the first of five (5) plans that is funded through the California Department of Mental Health for the MHSA.

"**Culture**" The integrated pattern of human behavior that includes though, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. (Cross, et al, 1989). Culture defines the preferred ways for meeting needs. Culture may include parameters such as ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disability, religious and

spiritual beliefs, and sexual orientation (California Department of Mental Health, 2002)

"**Cultural Competency**" is the practice of continuous self-assessment and community awareness by service providers to ensure a focus on the specific needs regarding linguistic, socioeconomic, educational, spiritual and ethnic experiences of consumers and their families/support systems relative to their care.

"CW" stands for Countywide.

D

"Day Treatment Rehabilitation" is a structured program of therapeutic services and activities, in the context of a therapeutic milieu, designed to improve, maintain and restore personal independence and functioning consistent with age-appropriate learning and development. It provides services to a distinct group of clients. Day Rehabilitation is a packaged program with services available at least three (3) hours and less than twenty-four (24) hours each day the program is open. In Los Angeles County these services must be authorized by the Central Authorization Unit**.**

"DBH" is the Department of Behavioral Health.

"DCEO" stands for Deputy Chief Executive Officer. In the restructuring of 2007 the CAO was replaced by the CEO. DCEO positions were created to oversee different county clusters. The cluster that LACDMH is in reports to DCEO Sheila Shima.

"DCFS" is the Department of Children and Family Services.

"Deferred Action for Childhood Arrivals" (DACA) grants some undocumented youth temporary protection from removal proceedings and work authorization for a period of two years. Those who qualify must complete an application, go through a biometrics screening process ("background check"), and pay fees for biometric services. For more information visit www.uscis.gov

"Delegated Authority" Contractor providers are allowed delegated authority to adjust their budget within 20% of their MCA without the approval from the Board of Supervisors.

"Delegates" The Delegates are an advisory group made up of over 100 stakeholders from the community, service providers, consumers, family members and LACDMH staff who together formulated the first MHSA plan, the Community Supports and Services

(CSS) plan. This advisory group is currently working on the next MHSA plan, the Prevention and Early Intervention (PEI) plan.

“Department of Health and Human Services (HHS)” is the United States government’s principal agency for protecting the health of all Americans and providing essential human series, especially for those who are least able to help themselves.

“Department of State Hospitals” will eliminate the DMH at the state level to streamline administrative policies, procedures and reporting by staff to increase focus on the provision of care. In addition, the new structure would provide the flexibility to hospitals to target staffing based on patient need. The new DSH structure will be implemented at California’s five mental health hospitals: Metro, Atascadero, Napa, Coalinga and Patton, along with two psychiatric programs at Vacaville and Salinas Valley state prisons.

“Deputy Chief Executive Officer (DCEO)” in the restructuring of 2007 the CAO was replaced by the CEO and DCEO positions were created to oversee different county clusters. The cluster that DMH reports to is the DCEO.

“Deputy Director” an executive management position in the DMH that may have responsibility for multiple Service Areas (of which DMH has 8) as well as provide oversight for a particular type of Countywide program (e.g. Adult Systems of Care); and alternatively, may have responsibility for certain administrative functions (e.g., Program Support, Planning, and Training).

“Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition, Text Revision Manual (DSM-IV-TR)” that is published by the American Psychiatric Association and provides diagnostic criteria and other information related to all psychiatric disorders.

“Differential Response” means a process by which counties respond commensurate to the individual reports of abuse and neglect that child welfare agencies receive each year. This approach improves a community’s ability to keep children safe. This is accomplished by responding earlier and more meaningfully to reports of abuse and neglect, before family difficulties escalate to the point of harm.

“Directly Operated Facility(ies)” County mental health service delivery site that operates under the DMH’s jurisdiction, and are staffed by County employees.

“Duration of Untreated Psychosis (DUP)” means the period of time that may range from days to years (depending on recognition of the illness and access to services) between the time an individual experiences symptoms for a psychotic illness and the time

when they first receive treatment. (This is an important measure, as studies indicate that a lower DUP will provide better overall outcomes for the individual.)

“Division of Empowerment and Advocacy” the mission of the Division of Empowerment & Advocacy (E&A) is to expand the range of the client voice in the Department of Mental Health to be more representative of the diversity found in the County of Los Angeles, and to achieve greater empowerment and social inclusion through advocacy. Current goals include reaching out to existing client groups within DMH and inviting them to form alliances around a common vision (Client Congress), interacting with programs that serve children, transition age youth, adults and older adults in order to engage in mutually beneficial empowerment and advocacy efforts, and supporting peer advocates and other people with lived experience in their development in their jobs and in their careers.

“DMH” the California Department of Mental Health or CDMH regulated portions of the delivery of mental health services. In December of 2011, the CDMH announced its blueprint to establish the Department of State Hospital (DSH). As of July 1, 2012 the mental health programs within CDMH were transitioned into the Department of Health Care Services (DHCS) while the long term care programs were transitioned into DSH.

“Drop-In Centers” Drop-In Centers provide temporary safety and basic supports for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are living on the streets or in unstable living situations. Drop-In Centers provide “low-demand, high tolerance” environments in which TAY can make new friends, participate in social activities, access computers, books, music, and games. As the youth is ready, staff persons can connect them to the services and supports they needs in order to work toward stability and recovery.

“Dual Diagnosis” occurs when an individual has two separate but interrelated diagnoses of a mental illness and a chemical dependency.

E

“Early Intervention” in mental health, stands for diagnosing and treating metal illnesses early in their development. Studies have shown that early intervention can result in higher recovery rates. However, many individuals do not have the advantage of early intervention because the stigma of mental illness and other factors keep them from pursuing help until later in the illness’ development.

“Electronic Data Interchange” a set of standards for structuring information to be electronically exchanged between and within businesses, organizations, government entities and other groups.

"Electronic Health Record" an electronic health record provides secure, real-time, patient-centric information to aid clinical decision-making by providing access to a patient's health information at the point of care.

"Empowerment & Advocacy (E&A)" advances the realization of consumer-centered, family-focused system of mental health services and supports by promoting wellness, eliminating stigma and discrimination associated with mental illnesses, removing barriers to recovery and community integration and improving the quality of life of the citizens of Los Angeles County through comprehensive implementation of the recovery model in county mental health services, policy and programming. E&A develops, promotes, and sustains recovery-based practices and policies to enhance advocacy, support systems change, expand peer support and foster consumer and family empowerment.

"EMT" stands for the Executive Management Team. This team includes Dr Southard (Director), Dr. Robin Kay (Chief Deputy Director), Dr. Roderick Shaner (Medical Director), Carlotta Childs-Seagle (Deputy Director, Older Adult Program Administration), Cathy A. Warner (Deputy Director, Adult Systems of Care), Dennis Murata (Deputy Director, Program Support Bureau), Dr. Karl S. Burgoyne (Critical Care), Dr. Kathleen Daly (Deputy Director, Adult Justice, Housing, Employment and Educational Services), Connie D. Draxler (Deputy Director of Public Guardian), Margo Morales (Administrative Deputy), Bryan Mershon (Deputy Director, Children and Youth Program Administration), Dr. Robert Greenless (Chief Information Officer), Sandra Thomas (Deputy Director, Specialize Children and Youth Services Bureau), Dr. Tony Beliz (Deputy Director, EOB), Kimberly Nall, (Chief Finance Officer, Financial Services Bureau), and Dr. Paul Arns (Chief, Clinical Informatics).

"Emerging Best Practices" means those treatments and services with a promising, but less thoroughly documented, evidentiary base.

"Enhanced Emergency Shelter Program (ESSP)" The Enhanced Emergency Shelter Program contained in the Mental Health Services Act (MHSA) Plan will serve the immediate and urgent housing needs of the Seriously Emotionally Disturbed (SED)/Severely Persistently Mentally Ill (SPMI) TAY population. The goal of this program is to ensure availability in all eight (8) Service Areas and to ensure countywide coverage and geographic accessibility. The primary objective of this program is to provide temporary shelter for TAY clients in a supportive housing environment for up to 29 nights (including extensions) while pursuing the long-term goals of secure, permanent housing.

"EOB" is the Emergency Outreach Bureau. The EOB is responsible for the administration and coordination of all mobile response services. These include: Psychiatric Mobile Response Teams, LACDMH-Law Enforcement Teams, Homeless Outreach Teams, Emergency Response Teams, MET, and SMART.

"Episode Data" information collected regarding a patient that is associated with an Episode of Care.

"Episode of Care" the time period between the opening and closing of a case within a mental health provider site and the services delivered during that time period through that provider site. It is possible for a client to have multiple episodes of care open at a given point of time.

"EPSDT" stands for the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, the child health component of Medi-Cal. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services.

"ERT" is the emergency response team. ERT provides on-scene consultation and crisis intervention for natural disasters, critical incidents, and terrorist acts.

"Established Maximum Allowable Rate" the Short-Doyle/Medi-Cal maximum reimbursement for a specific SFC unit as established by SDMH.

"Evidence-based Practices (EBP)" refers to practices that have quantitative and qualitative data showing positive outcomes. These practices have been subject to expert/peer review that has determined that a particular approach or program has a significant level of evidence of effectiveness in public health research literature.

"Explanation of Balance" for Title XIX Short-Doyle/Medi-Cal services which is the State Department of Health Services adjudicated claim data and `Explanation of Benefits' for Medicare which is the Federal designated Fiscal Intermediary's adjudicated Medicare claim data.

F

"Facility" a building or place that provides a particular service or is used for a particular industry.

"Family to Family" is the NAMI Family-to-Family Education Program. It is a free, 12-week course for family caregivers of individuals with severe mental illnesses. The course is taught by trained family members. All instruction and course materials are free to class participants. Over 115,000 family members have graduated from this national program.

“Family Specialist” is a person with lived experience as a family member of someone with mental illness who has been trained in the skills to utilize their experience in providing mental health recovery supports to other family members. Family Specialists must have completed at least one certified family advocacy or support training and completed a designated number of volunteer or service hours (as defined by LAC-DMH) in order to receive the Family Specialist designation.

“**FAQ**” stands for frequently asked questions.

“Federal Financial Participation” are the Short-Doyle/Medi-Cal services and/or Medi-Cal Administrative Activities as authorized by Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.

“Fee-for-Service” a funding mechanism whereby a provider is reimbursed based on services delivered.

“Field Capable Clinical Services (FCCS)” This “Mental Health Services Act” program (see MHSA below) embeds mental health services within primary care clinics. FCCS DMH mental health teams are physically located at Health Clinics and work hand-in hand with primary care doctors for screening and seamless care of the “whole person.”

“First 5 California” is funded by revenues under Proposition 10 and this group works to help children five and under to thrive. Programs funded through First 5 focus on building strong physical and emotional well-being. In 2003, First 5 identified children with mental health needs as a special needs target population.

“First Onset (or First Break)” means the first time an individual meets DSM-IV-TR criteria for a psychotic illness. (DSM-IV-TR diagnoses for psychotic illness include schizophrenia, schizoaffective disorder, brief reactive psychosis, schizophreniform disorder, bipolar disorder with psychotic features, and major depression with psychotic features. All of these diagnoses include symptoms of psychosis.).

“Fiscal Intermediary” County acting on behalf of the Contractor and the Federally designated agency in regard to and/or Title XIX Short-Doyle/Medi-Cal services, and/or Title XIX Medi-Cal Administrative Activities.

“Fiscal Year (FY)” for LACDMH starts July 1 and ends June 30.

“Full Service Partnerships (FSP)” is the primary category of funding in the Community Supports and Services (CSS) Plan that the MHSA enabled LA County to develop. Alliances between consumers, families and health professionals, FSPs do "whatever

it takes" to help consumers move from their illness to hope and then from recovery to wellness. FSPs help not just individuals but families break free from the sort of harmful dependent relationships that can lead to hardships such as homelessness, hospitalization and even incarceration.

"Full-time equivalent (FTE)" is a way to measure a worker's completed weekly hours. An FTE of 1.0 means that the person is equivalent to a full-time worker (40 hours/ week), while an FTE of 0.5 signals that the worker is only half-time (20 hours/week).

"Fully Served" Clients and their family members who receive the full spectrum of mental health services and other community services and supports needed to advance the client's recovery, wellness and resilience are considered to be fully served.

G

"Gatekeeper" means those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk for mental health problems or suicide and refer them to treatment or supporting services as appropriate.

"Grant-in-aid" monies allocated by one level of government to another level of government to be used for specific purposes.

"Greater Avenues for Independence (GAIN)" helps CalWORKs participants prepare for and find employment. Services include job finding workshops, supervised job search, vocational assessment, remedial education, vocational skills training, and work experience. Post employment services are also available to help employed participants retain their jobs, work toward a better one, and ultimately move to financial independence. GAIN also offers help with transportation, child care, special job-related expenses such as uniform and tools, as well as domestic violence, substance abuse and mental health counseling.

"Grievance" An expresión of dissatisfaction by beneficiary/client.

"Gross Program Budget" the sum total of the Net Program Budget and all "Third Party Revenues" shown in the Financial Summary.

"GROW" stands for General Relief Opportunities for Work. Provides employment and training services to help employable General Alivio (GR) participants obtain jobs and achieve self-sufficiency. Participants are assigned to a GROW Case Manager (GCM) who will work with them to achieve their employment goals.

"Guide to Procedure Codes" a manual created by DMH that defines specific mental health services covered under this contract and the acceptable codes that can be used to claim those services.

H

"Head of Service" identified at the Reporting Unit Level (defined in section 2.9.1), this is the licensed clinician who is clinically responsible at the provider level as listed on the Provider File Adjustment Request (PFAR) Form and the "LAC-DMH Head of Service Directory."

"Health-based Interventions" means mental health programs and interventions designed to be used within a healthcare setting to assist trained healthcare providers in identifying, screening, assessing, and treating or referring, individuals with, or at risk for, mental health problems.

"Health Center" means a health center serving as a non-profit organization that provides primary and preventive health care services for uninsured and underserved populations in collaboration with other community providers.

"Healthcare Common Procedure Coding System (HCPCS)" is a standardized coding system for describing the specific items and services provided in the delivery of health care for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner.

"Health Deputies" Each Supervisor's office has a deputy for each county department. The deputy reports to the Supervisor and is the eyes and ears for them on that topic. Each Supervisor has a Deputy for Health that reports to the Supervisory on mental health, public health, health and behavioral services.

"Health Level Seven (HL7)" are the standards for electronic interchange of clinical, financial, and administrative information among health care oriented computer s systems.

"Healthy Families" is the federally subsidized health insurance program administered by the State of California for the provision of comprehensive health services (including medical, dental and vision care) to children ages birth through 19th birthday from low income families.

"Healthy Families Procedures Manual" is DMH's Healthy Families Procedures Manual for providers. The HF Procedure Manual contains the formal requirements, policies and procedures governing Healthy Families and is incorporated into this Agreement by reference. Contractor hereby acknowledges receipt of the HF Procedures Manual upon execution of this Agreement.

"HealthyWay LA" is a no cost health program that provides health care coverage to low income uninsured adult citizens and legal residents. The County of Los Angeles - Department of Health Services (DHS) has a user friendly website to inform the public of the Healthy Way L.A. health program at: http://www.ladhs.org/wps/portal/HWLA.

"HIPAA" The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996. Title II of HIPAA defines numerous offenses relating to health care and sets civil and criminal penalties for them. It also creates several programs to control fraud and abuse within the health care system. However, the most significant provisions of Title II are its Administrative Simplification rules. Title II requires the Department of Health and Human Services (HHS) to draft rules aimed at increasing the efficiency of the health care system by creating standards for the use and dissemination of health care information.

"HIPAA Final Security Rules" are the rules dealing specifically with electronic protected health information, which lay out three types of security safeguards required for compliance: administrative, physical, and technical.

"Historical Trauma" means memories passed from one generation to the next; e.g., hardships experienced by Native American populations, Japanese internment or Holocaust victims, refugees escaping war, slavery descendents, etc. Also referred to as "intergenerational trauma."

"HOPE" is the Pasadena Police Department Homeless Outreach Psychiatric Evaluation team.

"HOT" is the Homeless Outreach Team. HOT is dedicated to assisting mentally ill homeless persons at risk for incarceration or involuntary psychiatric hospitalization.

"Housing Specialists" develop comprehensive housing resource lists, assist SED/SPMI TAY with completing applications for rental subsidies, and prepare consumers for the interview with prospective property owners or housing managers. One of the major functions of a Housing Specialist is to act as an advocate and negotiator for consumers with poor credit and poor housing histories while establishing a professional relationship with property owners and managers.

I

"ICD-9" stands for the International Classification of Diseases, Ninth Revision. The ICD-9 is used to provide a standard classification of diseases for the purpose of health records.

"IIHI" Individually Identifiable Health Information.

"IMD" stands for Institute for Mental Disease; defined under statue as hospitals, nursing facilities, or other institutions that diagnose, treat and care for persons with mental illness, including medical attention, nursing care and other related services. The federal Olmstead Act of 2000 required that individuals with mental illness be served in the least restrictive environment possible. Current federal law prohibits Medicaid reimbursement for any person over age 21 and under age 65 who resides in an IMD. This creates an incentive to develop and fund a variety of community-based mental health programs. Also, MHSA funds cannot be used to pay for IMD treatment.

"IMP" stands for Indigent Medication Program. Administered by the Medical Director, IMP indigent clients can participate in pharmaceutical companies' Patient Assistance Programs (PAP) to receive free medications if unable to afford out of pocket cost. LACDMH clinics are required to identify clients eligible for PAP in order to reduce indigent individuals' medication cost.

"INN (Innovations)" is focused on identifying new practices for the primary goal of learning and increasing the array of creative and effective approaches that can be applied to mental health services for specified populations under the Mental Health Services Act (MHSA). INN funded projects seek to further develop: (1) novel, creative and/or ingenious mental health practices and approaches that contribute to learning; (2) mental health practices and approaches through a community informed process that are representative of the communities to be served, especially unserved, underserved and inappropriately served communities; and (3) new mental health practices and approaches that can be replicated and adapted to other populations and other counties if proven successful with specific populations.

"Inappropriately Served" are clients currently receiving mental health services but services are not culturally appropriate to meet the client's needs.

"Independent Living Program (ILP)" provides financial assistance to current and former foster/probation youth, 16-20 years of age. You may receive the help you need as a student in high school, college, or a vocational program. You may also qualify for

services if you are working or need assistance with dorm or rent. To receive ILP assistance, you must be ILP eligible.

“Indigent” a person so poor and needy that he/she cannot provide the necessities of life (food, clothing, decent shelter) for himself/herself - uninsured adults who cannot afford care.

“Indigent Medication Program (IMP)” A program managed by DMH Pharmacy Services division that coordinates the enrollment of indigent clients in pharmaceutical company Patient Assistance Programs that enables indigent clients to receive free medications if they are unable to pay. Once an application is approved, replacement medications are shipped by the relevant pharmaceutical company PAP to DMH Pharmacy Services, which in turn ships those medications to the dispensing contract pharmacy.

“Individuals Experiencing Onset of Serious Psychiatric Illness” means those individuals identified by providers, including but not limited to primary health care, as presenting signs of mental illness “first onset” (or “first break”) including those who are unlikely to seek help from any traditional mental health service.

“Information System (IS)” is DMH’s integrated system, which services to track client care and money spent by the county on individual clients.

“Inpatient Fee-for-Services” are services provided at a FFS/Medi-Cal Hospital. Such hospitals submit reimbursement claims for Medi-Cal psychiatric inpatient hospital services through DMH as the fiscal intermediary. Within DMH, this process is managed by the Medi-Cal Inpatient Consolidation.

“Intake Period” (LAC-DMH Policy No. 104.9) Initial clinical evaluations must be completed within 60 days of intake for a new admission (no open episodes), or within 30 days when the client is being opened to a new service but has other open episodes.

“Integrated Plan” MHSA has five plans and each plan has its own timeline. However, all five plans will end at the same time (in five years) and one year before they end the County must create an integrated plan that combines all five plans. This new plan will be the “integrated plan” and will then be the only plan for MHSA funding.

“Integrated System (IS)” a custom-developed Web-based wrapper of the MHMIS developed in order to generate HIPAA-compliant claims. ISD hosts this application that runs on the Intel platform.

"Integrated Clinic Model (ICM)" combines physical health, mental health, and substance abuse services in a community-based site, such as a primary care clinic or mental health clinic, to more fully address the spectrum of needs of individuals who are homeless, uninsured, and/or members of under-represented ethnic populations (UREP). This strategy seeks to increase access to the aforementioned services to those for whom services are fragmented and resources limited. This strategy could potentially transform access in Los Angeles County as it increases the capacity for physical health, mental health, and substance abuse programs in organizations and systems where people in the community already go. It also seeks to increase the quality of services, including better physical health and mental health outcomes, as providers work together to coordinate care across practices. The utilization of existing infrastructure and the leveraging of other programs will create an efficient and cost-effective system that promotes interagency collaboration between Los Angeles County departments and providers.

"Integrated Mobile Health Team Model (IMHT)" is a client-centered, housing-first approach that uses harm reduction strategies across all modalities of mental health, physical health, and substance abuse treatment. In this model, the primary goal is to address the fragmentation of services to the homeless population, many of whom are uninsured and are members of UREP. This model proposes to deploy a mobile, enhanced, integrated, multi-disciplinary team that includes physical health, mental health, and substance abuse professionals and specially-trained peers and that is managed under one agency or under one point of supervision. This model will develop individualized client care plans that contains physical health, mental health, and substance abuse client-centered treatment goals and objectives. Another unique feature of this model is that individuals will have access to the Integrated Mobile Health Team services through multiple points of entry, whether initially seeking assistance with physical health, mental health, substance abuse, or housing. It will increase access to services and leverage multiple funding sources including capital for housing development and Federal Qualified Health Center funding.

"Interagency Placement Screening Committee" is a committee consisting of DMH and other community agencies that recommends and authorizes residential placement for children and adolescents with severe emotional disorders. This committee is coordinated by the DMH Countywide Children's Case Management Program.

"Internal Services Department (ISD)" provides wide area network services throughout the County and County-level information security oversight.

"International Organization for Standardization (ISO)" is an international organization that consists of member bodies that are the national standards bodies of most of the countries of the world. ISO is responsible for the development and publication of international standards in various technical.

“Intervention” means the act of intervening, interfering or interceding with the intent of modifying the outcome. In health and mental health, an intervention is usually undertaken to help treat or cure a condition.

“Invitation for Bid (IFB)” is a solicitation based on a very specific and non-negotiable Statement of Work.

J

“Juvenile Justice Facility” encompasses detention centers, shelters, reception or diagnostic centers, training schools, ranches, forestry camps or farms, halfway houses, group homes and residential treatment centers for young offenders.

”Juvenile Justice Transition Aftercare Services (JJTAS) Program” focuses on youth transitioning from Probation camp settings back to their home communities by utilizing Evidence Based Practices and linkage services.

K

“Katie A.” The National Center for Youth Law (NCYL) is co-counsel in the case of Katie A. v. Bontá, a child welfare reform class action against the California Department of Health Services (DHS), Los Angeles County’s Department of Children and Family Services (DCFS), and the California Department of Social Services (CDSS). Advocates seek the establishment and implementation of a community-based mental health service delivery system for California’s children in state foster care or at imminent risk of out-of-home placement. L.A. County entered into negotiations and settled in March of 2003. The settlement obligates the County to a number of comprehensive reforms, including better identification of mental health needs, enhancement of permanency planning, and prompt provision of individualized services designed to promote stability and ensure quality care for children in custody. Plaintiffs also succeeded in committing the County to offering family-based wraparound services to children with mental, emotional, or behavioral issues with the aim of facilitating family reunification and reducing multiple and arbitrary placements.

L

“LACDHM” stands for the Los Angeles County Department of Mental Health.

“LAC PPP” denotes Los Angeles County Department of Health Services Public-Private Partnership.

"LAHSA" The Los Angeles Homeless Services Authority (LAHSA) is a Joint Powers Authority established in 1993 as an independent agency by the County and the City of Los Angeles. LAHSA is the lead agency in the Los Angeles Continuum of Care, and coordinates and manages over $60 million dollars annually in Federal, State, County and City funds for programs providing shelter, housing and services to homeless persons in Los Angeles City and County.

"Laura's law" AB 1421 (also known as "Laura's law") makes assisted outpatient treatment (AOT) available in California. Assisted outpatient treatment's sustained and intensive court-mandated treatment in the community now can help those most overcome by the symptoms of a severe mental illness. The treatment mechanism is used until a person is well enough to again maintain his or her own treatment regimen. And eligibility for assisted outpatient treatment is not predicated solely on dangerousness. A progressive eligibility standard allows programs created under AB 1421 to help people who are vitally in need of care but who do not meet LPS' restrictive dangerousness threshold for inpatient hospitalization.

"LCSW" stands for Licensed Clinical Social Worker.

"Licensed Clinical Social Worker (LCSW)" A person with a license to practice as a clinical social worker granted by the State Board of Behavioral Science Examiners. A licensed clinical social worker candidate, who is registered or waivered, may assume certain roles and responsibilities of a licensed clinician, within scope of practice; e.g., provide therapy and develop and sign Client Care/Coordination Plans. Registered/waivered staff may document in the clinical record without co-signatures.

"Legal Entity" is the legal organization structure under California law.

"LGBTQIA" stands for lesbian, gay, bisexual, transgender, queer and questioning, intersex, ally and asexual.

"Lived Experience" refers to an individual who has or has had experiences of psychiatric distress and who has sought mental health professional help that has led to treatment of a mental health diagnosis. One outcome of this process can be a willingness to share these experiences in an effort to help people with similar experiences.

"Los Angeles Mental Health Plan System (LAMHPS)" is a browser-based system used by Provider Relations to assist in maintaining credentials for contract providers. The LAMHPS is on an SQL server that is located in the Provider Relations office. The system contains information on:

- Credentials
- Contracts
- Demographics

- Group Members/Staff
- Billing Address
- License Number
- Languages
- Specialties
- Contact Persons

The data for this system in keyed in by the Provider Relations staff. There is an external interface with the MHMIS. The provider ID and license number is extracted from LAMHPS and stored in a DB2 table on MHMIS.

"Los Angeles Public Administration/Guardian Information Systems (LAPIS)" is the information system that provides accounting, information management, and office automation for conservatorship, investigation and case management, placement tracking, funeral arrangement, and fiscal tracking.

"LPS" stands for the Lanterman-Petris-Short Act. This Act went into effect July 1, 1972 in California. The Act in effect ended all hospital commitments by the judiciary system, except in the case of criminal sentencing (e.g. convicted sexual offenders) and those who were "gravely disabled" defined as unable to obtain food, clothing, or housing. It expanded the evaluative power of psychiatrists and created provisions and criteria for holds.

M

"Managed Care" is the organized system for delivering comprehensive mental health services that allows the managed care entity to determine what services will be provided to an individual in return for a prearranged financial payment as defined by SAMHSA.

"Managed Risk Medical Insurance Board" is the State of California administrator of Healthy Families.

"Management Inquiries" inquiries regarding services or risk management issues regarding a client from sources such as LAC-DMH Managers, the Board of Supervisors, or juvenile delinquency court judges.

"Master Agreement List" is a list of contractors who have submitted a Statement of Qualifications (SOQ) in response to County's Request for Statement of Qualifications (FRSQ), have met the minimum qualifications listed in the RFSQ, and have an executed Master Agreement.

"MCA" stands for Maximum Contract Allowance. The predetermined budget agreed upon between LACDMH and contract providers. Providers are not allowed to bill over their MCA.

"Medi-Cal" is the name of the Medicaid program in the State of California. It is jointly administered by the California State Department of Health Services and the Centers for Medicare and Medicaid Services (CMS), operating as a Medical Assistance Program under Title XIX of the Social Security Act.

"Medi-Cal Eligibility Data System (MEDS)" is the data system maintained by the California Department of Health Services that contains information on Medi-Cal eligibility. This database is the authority for determining a beneficiary's eligibility for Medi-Cal specialty mental health services and the County responsible for authorization and payment of services.

"Medical Director" is the director responsible for the supervision of the psychiatric/medical service and leadership in the development and execution of clinical services provided under the DMH. The current medical director is Roderick Shaner, MD.

"Medical Model" describes the approach to illness which is dominant in Western medicine. It aims to find medical treatments for diagnosed symptoms and syndromes and treats the human body as a very complex mechanism. Critics state that because mental illness cannot be diagnosed like heart disease or broken bones with ancillary tests that it contradicts the medical model of diagnosis and treatment. In addition, this model focuses on the disease (pathology) and the treatment course is determined by the diagnosis.

"Medical Necessity" is a United States legal doctrine, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Medicare uses medical necessity as a way to determine if consumers should pay for goods or services. Medical necessity is used by mental health consumers to claim eligibility for Medicare.

"Medicare" is a health insurance program administered by the United States government, covering people who are either age 65 and over, or who meet other special criteria, such as a disabling illness (i.e. severe mental illness). It was originally signed into law on July 30, 1965 by President Lyndon B. Johnson as amendments to Social Security legislation.

"Medicaid Waivers" In 1995: LACDMH worked with federal and state officials to negotiate an "1115 Medicaid waiver" to help L.A. County do a number of things, including: increasing the efficacy of health care delivery to large numbers of uninsured and coping with the decreased ability of private hospitals to provide uncompensated care. In 2010, LACDMH worked with state and federal officials to

design a new waiver that would, ideally, balance Sacramento's desire to cut costs with LACDMH's mission to preserve the "whatever it takes" programs that are sometimes needed to ensure people's long-term mental health.

"Medicare Fiscal Intermediary" are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the administration of claims payment.

"Megan's law" California's Megan's Law provides the public with certain information on the whereabouts of sex offenders so that members of local communities may protect themselves and their children. Megan's Law is named after seven-year-old Megan Kanka, a New Jersey girl who was raped and killed by a known child molester who had moved across the street from the family without their knowledge. In the wake of the tragedy, the Kankas sought to have local communities warned about sex offenders in the area. All states now have a form of Megan's Law.

"Member or Title XXI Healthy Families Program Member (HFPM)" is an enrollee in any Healthy Families Health Plan through Healthy Families.

"MET" This is the Los Angeles County Sheriff's Department Mental Health Evaluation Team. This team responds to 911 or other calls requesting help with psychotic, suicidal or homicidal persons. They are authorized to hospitalize people against their will if they are too ill for outpatient treatment. The Long Beach Police Department also has a MET team called **LB MET**.

"Mental Health Disorder" means a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities.

"Mental Health Fee-for-Service (MHFFS)" is the back end system that applies edits to FFS claims before they are forwarded to the State as HIPAA compliant claims via the IS.

"Mental Health Management Information System (MHMIS)" Legacy mainframe based applications that encompass a number of distinct applications including PATS.

"Mental Health Integration" means to combine mental health prevention assessment intervention, treatment and referral into the primary health care system for the purpose of preventing the development of serious emotional disorders and mental illness and increasing access to mental health services for underserved populations.

"Mental Health Problem" means diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a mental disorder are met.

"Mental Health Promotion" means an action or series of actions taken to emphasize mental health and well-being in the community.

"MFT" is a Marriage and Family Therapist.

"MHC" is the Mental Health Commission. State law requires that each county have a Mental Health Board or Commission. Members are appointed by the Board of Supervisors for three-year terms. Those terms may be extended. Commissioners advise the Board of Supervisors and the Director of Mental Health on various aspects of local mental health programs.

"Mental Health Professional Shortage Area (MHPSA)" is a geographic area designated by the Federal Government as having a shortage of mental health staff, given a Population to Psychiatrist ratio that meets their threshold requirements.

"MHPSA Designation" is the designation required for an area to be eligible for the California state (offered by the Office of Statewide Health Planning and Development) and national (offered by the National Health Service Corps) educational loan repayment programs. If an MSSA receives the designation, any licensed mental health professional providing services at an eligible site to low income clients will be able to apply for the loan repayment programs.

"**MHSA**" stands for the Mental Health Services Act. Proposition 63, (MHSA), became effective on November 2004. Through a 1% tax on personal income above 1 million dollars, the MHSA provides increased funding, personnel and other resources to help county mental health programs deliver recovery, wellness and resilience-oriented services and supports.

"MHSOAC" is the Mental Health Services Oversight and Accountability Commission**.** This commission was created by the MHSA.

"Mission" refers to the Los Angeles County Department of Mental Health mission: Enriching lives through partnerships designed to strengthen the community's capacity to support recovery and resiliency.

"MOU" stands for Memorandum of Understanding. MOU's are drafted to distribute information to staff and other Departments. An MOU outlines in writing, a clear understanding of the purpose, commitment, expectations, and responsibilities of parties involved.

N

"NAMI" is the National Alliance on Mental Illness. Founded in 1979, NAMI has become the nation's voice on mental illness, serving as the nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. With the support of over 1100 state and local organizations across the country, NAMI is able to achieve its mission of advocacy, research, support, and education. The California chapter of NAMI is known as CAMI.

"National Council for Prescription Drug Programs (NCPDP)" is the American National Standards Institute accredited standards development organization. NCPDP creates and promotes standards for the transfer of data to and from the pharmacy services sector of the healthcare industry.

"National Drug Code (NDC)" is a medication-labeling mechanism used in the United States. A unique 10-digit, 3-segment number identifying the labeler, product, and trade package size that is assigned to each listed drug product.

"National Provider Identifier (NPI)" is a unique, ten-digit numeric identifier assigned to covered health care providers by the National Plan and Provider Enumeration System. This identifying number does not carry any information about health care providers, such as the state in which they practice or their provider type or specialization. The intent of the NPI is to improve the efficiency and effectiveness of electronic transmission by allowing providers and business entities to submit the same identification number(s) to all payers, such as insurance plans, clearinghouses, systems vendors, and billing services.

"National Registry of Evidence-based Programs and Practices (NREPP)" is a searchable online registry of more than 230 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment. For a list of EBPs visit: http://www.nationalregistry.samhsa.gov/idex.asp

"Negotiation Package" are detailed documents submitted by Contractor consisting of five major parts: Agency Identification; Program Description; Budget; Corporate Capability; and Required Supplemental Documentation.

"Negotiated Rate (NR)" is the total amount of reimbursement, including all revenue, interest and return, which is allowable for delivery of a SFC unit as defined by Director and which is shown on the Financial Summary. An NR is the gross rate of reimbursement which is generally determined by dividing Contractor's gross program cost of delivering a particular SFC by the number of such SFC units to be delivered.

All fees paid by or on behalf of patients/clients and all other revenue, interest and return resulting from the same service shall be deducted from the cost of providing the mental health services covered by the Negotiated Rate. A portion of the State-approved NR, which in some cases may be higher than the contracted NR, may be retained by County as County's share of reimbursement from SDMH.

"Net Program Budget" is the Maximum Contract Amount which is the sum total of all "Allocations" and "Pass Through" amounts shown in the Financial Summary. Unless otherwise provided in this Agreement, or separately agreed to in writing between the parties, it is the intent of the parties that the Net Program Budget shall be equal to the Maximum Contract Amount.

"Non-governmental Agency (NGA)" is any organization other than a unit of government or agency. Includes private profit and nonprofit organizations.

"Non-repudiation" is verification that the sender and the recipient were in fact the parties who claimed to send or receive the message.

"Non-traditional Mental Health Settings" means systems and organizations not traditionally defined as mental health; i.e., school and early childhood settings, primary health care systems including community clinics and health centers, and community settings with demonstrated track records of effectively serving ethnically diverse and unserved or underserved populations.

"Notice of Action (NOA)" is a required document that is given to Medi-Cal beneficiaries informing them of denials, terminations, reductions or modifications of requested specialty mental health services from the County of Los Angeles Department of Mental Health Local Mental Health Plan, and the beneficiary's right to appeal.

O

"OCA" was the Office of Consumer Affairs. This office was created seven years ago and predates MHSA. This office has been involved in client movement and has been an advocate for consumers who are receiving services and those who wish to work or volunteer in system. This office also created Client coalitions as a means to advocate for consumers. This office merged into the Division of Empowerment and Advocacy, in 2007.

"Office of Family Advocate (OFA)" The OFA addresses the needs of families as they seek to secure mental health services for their loved ones. OFA often works in collaboration with NAMI and has specifically done outreach to Spanish speaking

families in LA County. This office is now under the Division of Empowerment and Advocacy.

"OMA" is the Outcome Measure Application. OMA is used to measure client outcomes during intensive services such as FSP and FCCS.

"Office of the Medical Director (OMD)" is a division of DMH that has Department-wide professional responsibility for the design, implementation, and quality management of clinical services.

"Office of Multicultural Services (OMS)" the California Department of Mental Health (DMH) Office of Multicultural Services (OMS), was established in 1998. This provided leadership and direction to DMH in promoting and establishing culturally and linguistically competent mental health services within the public mental health system through actions targeted both within and external to DMH. OMS worked with community partners to eliminate racial, ethnic, cultural and language disparities in access and quality of care within mental health programs and services. With the support of the DMH Director, OMS coordinated efforts to reduce disparities in access and quality of care for California's racial, ethnic, and cultural unserved and underserved communities. OMS worked to foster change in policy, access, language, clinical practice, research, and intervention practices. With the elimination of the State Department of Mental Health, OMS was transitioned in 2012 to the Department of Public Health in its newly created Office of Health Equity (OHE).

"Onset" means the beginning of a serious psychiatric illness that can be diagnosed by the DSM IV. In this respect, onset can include the onset of depression in an older adult or a new mother experiencing the onset of post-partum depression. Onset can apply to any psychiatric illness. Individuals may experience onset of a serious psychiatric illness a number of times.

"Oral Presentation" is an explanation and/or clarification of information stated in the Proposal. Presentations may be requested by the Proposer or the Department.

"Outcome Measures Application (OMA)" is the Custom-developed system to capture and report MHSA-related outcome measures.

"Outreach & Engagement (O&E)" is a vital component within the Mental Health Services Act (MHSA), which aims to inform the public about MHSA, gather community input, and integrate feedback into the planning process. O&E activities focus on organizing the wide diversity of backgrounds and perspectives represented within the county, with a special emphasis on underserved and unserved populations. It seeks to facilitate the creation of an infrastructure that supports partnerships with historically

disenfranchised communities, faith based organizations, schools, community-based agencies, and other county departments.

"Over Threshold Authorization Request (OTAR)" is a custom developed application to track TAR requests for authorization of treatment beyond a threshold of services not requiring pre-authorization during a given trimester of care. OTAR is used by the DMH Medi-Cal Professional Services division to manage mental health care provided through the Fee-for-Service Outpatient network. County anticipates replacing this application with the IBHIS System.

"Over-Threshold Specialty Mental Health Services" are all services provided which exceed eight (8) sessions per trimester period are considered over-threshold and require prior authorization from the CAU. Over threshold limits and authorization are limited to specialty mental health services being delivered to Medi-Cal funded clients being served by Fee-for-Service Network providers.

P

"PAI" stands for Protection and Advocacy Inc. This is an organization of lawyers that advocate for the disenfranchised. This organization has been involved in suing the state to ensure funding for specific programs, including mental health programs.

"PAP" stands for Patient Assistance Program. PAP is a program by pharmaceutical companies to provide free medication to indigent clients that are unable to afford their prescriptions.

"Parent Partner" is a person who is a parent or former parent of children with Serious Emotional Disorders (SED) who disclose this lived experience voluntarily and who utilizes their skills and experience in providing mental health recovery support to other parents.

"Parity" On July 1, 2010, a new set of federal rules went into play to prohibit group health insurance plans—typically offered by employers—from restricting access to care by limiting mental health benefits and requiring higher patient costs than those that apply to general medical or surgical benefits. The new law requires that any group health plan that includes mental health and substance use disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out of-pocket costs, benefit limits and practices such as prior authorization and utilization review. But in May 2010, insurance companies and employer groups began lobbying the Obama Administration to delay and rework the rules on "mental health parity." Insurers and many employers supported the law, but they say the rules go far beyond the intent of Congress and would cripple their cost-control techniques while raising out-of-pocket costs for some patients. Advocates for patients generally support the

rules, saying they will eliminate many forms of insurance discrimination against people with mental illness. In California, AB 154 (Jim Beall) would require health plans and health insurers to provide coverage for mental health and substance abuse treatment at parity with other medical conditions. The bill currently stands in the Senate Health Committee.

“Patient’s Rights Office” The Patients’ Rights Office of the Los Angeles County Department of Mental Health was created in response to legislation requiring each county mental health director to appoint a patients’ rights advocate(s) to protect and further the Constitutional and statutory rights of mental health care recipients. Some of the duties of this office include; investigation of complaints, representation of patients at certification review and medication capacity hearings, beneficiary services program, residential care advocacy, minors’ rights program, jail advocacy program, LPS designation functions, training and consultation, monitoring Electroconvulsive treatment (ECT), data collection, legislative interaction, missing person locator and peer advocacy program.

“PBC” stands for Performance Based Contracting. PBC ties the contractor’s payment and contract extension to their achievements or program outcomes.

“Peer” Any individual who uses their personal or family lived experience related to mental health, mental illness services and treatment, to advance the well-being of others in a mental health supportive program setting. The term ‘peer’ is often used as synonymous with “consumer” or “client”. “Peer” can also be used as a reference to the relational quality of shared experience that fosters another’s recovery and wellness. Thus family members are peers to other family members, consumers to consumers, parents to parents etc.

“Peer Bridger” A consumer peer model services provider who focuses on assisting individuals transition between programs, communities and/or institutional settings. Peer bridgers serve to keep people connected in peer support to help manage the stress of major life, residential and other changes.

“Peer to Peer” is a unique, experiential learning program for people with any serious mental illness who are interested in establishing and maintaining their wellness and recovery. The course was written by Kathryn Cohan McNulty, a person with a psychiatric disability who is also a former provider and manager in the mental health field and a longtime mutual support group member and facilitator. The program is offered through NAMI.

“Peer Model/Peer Support Model” The mental health supports model that is based on peer supportive relationships that foster recovery, as opposed to traditional

provider/recipient relationships. Peer support services include a broad set of programs and personal interactions which emphasize empowerment, self determination and personal growth. In most cases peer model providers are trained and certified in intentional peer support services and certain practices specific to them.

"Peer-Run" The term 'peer-run' is often used as synonymous with "consumer-run". This term also refers to agencies, programs, services or supports provided by people who are or have received services for serious mental illness ('consumer') and/or Family members of such and/or current or former Parents of children with Serious Emotional Disorders (SED) who disclose this lived experience voluntarily.

"Peer Specialist" A person with lived experience of mental illness (as a consumer or client) who has been trained in the skills to utilize their experience in providing mental health recovery supports to others and to practice the Peer Model in program or community settings. Consumer peers must have completed at least one certified or certified training and completed a designated number of volunteer or service hours (as defined by LAC-DMH) in order to receive the Peer Specialist designation.

"PEI" stands for Prevention and Early Intervention. This is the second of the five Mental Health Services Act plans. MHSA requires that CDMH reaches out to five key areas, called "sectors," in making the plans for how to do prevention and early intervention for mental illness. The five required sectors are underserved communities, education, health, social services and law enforcement. The plan will contain programs for all ages groups, possibly some universal programs for all residents of LA County (ex: suicide prevention) and some programs that target specific groups at risk for mental illness (ex: childhood abuse survivors).

"PEI Principles" means the Prevention and Early Intervention Principles and Criteria defined in the MHSOAC PEI Recommendations paper, adopted in January 2007. These principles, which serve as the foundation for PEI, more information may be found at: http://www.cimh.org/Learning/Online-Learning/Webcasts/Prevention-and-Early-Intervention.aspx

"PEI Project" means a PEI program or combination of programs, policies and approaches that is designed to address one or more PEI Key Community Needs and one or more PEI Priority Populations, consistent with PEI Principles, to meet specific PEI individual/family and/or program/system outcomes.

"PET" is the psychiatric evaluation team. PET responds to calls to evaluate whether someone needs to be hospitalized. This term is not used as much in LACDMH anyone because the LA police department and the sheriff's department have their own names for these teams for example SMART and MET.

"Pharmacy Benefits Manager (PBM)" is a company that allows health plans to outsource the administration of their prescription drug benefit for plan members. This includes prescription claims adjudication, formulary/prior authorization management, manufacturer's rebate negotiation and data submission.

"PhD" denotes Doctor of Philosophy.

"Point of Service" is a Medi-Cal program that gives providers the most current information available on Medi-Cal client accounts.

"Posttraumatic Stress Disorder (PTSD)" means an anxiety disorder that develops as a result of witnessing or experiencing a traumatic occurrence, especially lifethreatening events.

"Pre-Screen Proposals" using the Pre-Evaluation tool, Contracts Division staff determines if the Proposer's documents demonstrate general responsiveness to the RFP and meet minimum requirements.

"Prescription Authorization and Tracking System (PATS)" is the electronic prescribing and pharmacy billing module hosted by ISD.

"Prevention" means the Prevention element of the MHSA PEI component includes programs and services defined by the Institute of Medicine (IOM) as Universal and Selective, both occurring prior to a diagnosis for a mental illness. (For MHSA purposes, IOM's indicated prevention category fits into the operational definition for Early Intervention, as explained in the next section).

"PRCH" stands for Peer-Run Crisis House program as through the Peer-Run Crisis House Project.

"Primary Care" means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

"Primary Contact" the individual at a Billing Provider who discusses specific client service needs with the client and/or Rendering Providers and is identified in the LAC-DMH electronic database at the episode level.

"PRISM" Peer-Run Integrated Services Management is a program that employs peer support and peer services to help integrate health, wellness and recovery resources for mental health clients.

"Priority Population" means a specific group of individuals defined by the OAC as a population who should receive priority consideration by counties when determining who will receive PEI services. Priority populations include:

- Underserved Cultural Populations
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children and Youth in Stressed Families
- Trauma-Exposed Individuals
- Children and Youth at Risk for School Failure
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement

"Probation Camp Services" provides services to youth ages 16 to 20 who are residing in Los Angeles County Probation Camps; particularly youth with SED, SPMI, those with co-occurring substance disorders and/or those who have suffered trauma. Services in the Probation Camps are critical in assisting this population to reach their maximum potential and eventually transition back to the community rather than continue their involvement in the criminal justice system as adults.

"Prodrome (Prodromal Syndrome)" means the period in the course of a disorder when some signs and symptoms are present but the full-blown criteria are not yet met. Typically, the prodrome can be defined only retrospectively, after the individual has met the full criteria for the disorder.

"Professional Services Unit" the Administrative unit of managed care division in the DMH Office of the Medical Director that oversees the Central Authorization Unit and manages the credentialing of Fee-for-Service Network Medi-Cal providers.

"Program Head" a program head oversees personal, budget, and hiring of their specific program.

"Project 50" as known as the Homeless Initiative Act, targets 50 of the most vulnerable homeless individuals on Skid Row and provided them with supportive services including housing and mental health. As of late 2008, 49 of the 50 individuals had been located and linked to housing and supportive services.

"Projects for Assistance in Transition from Homelessness Federal grant funds (PATH)" is a program that provides services to individuals who have a severe mental illness or who have co-occurring severe mental illness and substance abuse disorders, and who are homeless or at imminent risk of becoming homeless.

“Project Management Methodology (PMM)” is a highly detailed description of the procedures to be followed in a project life cycle. Often includes forms, charts, checklists, and templates to ensure structure and consistency.

“Promising Practice” means programs and strategies that have some quantitative or qualitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. A promising practice has an evaluation design in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes. These practices have support from communities or providers. In addition, promising practices are especially relevant in ethnic communities that do not have the means to perform research studies to support their practices.

“Promotores de Salud” are volunteer and paid community health workers who are trusted members of and/or have an unusually close understanding of the community served. Promotores de Salud generally share the ethnicity, language, socioeconomic status, and life experiences of the community members they serve.

“Proposition 63 (Prop. 63)” is the ballot initiative which passed in November 2004, and became the Mental Health Services Act (MHSA) of 2004.

“Protected Health Information (PHI)” is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. This is interpreted rather broadly and includes any part of a patient's medical record or payment history.

“Protection and Advocacy Inc (PAI)” this is an organization of lawyers that advocate for the disenfranchised. This organization has been involved in suing the state to ensure funding for specific programs, including mental health programs.

“Proselytize” To induce someone to convert to one's faith or spiritual beliefs.

“Provider” A person or entity who is licensed, certified, or otherwise recognized or authorized under state law governing the healing arts to provide specialty mental health services and who meets the standards for participation in the Medi-Cal program as described in CCR, Title 9, Chapter 11 and in Division 3, Subdivision 1 of Title 22. Provider includes licensed mental health professionals, clinics, hospital outpatient departments, certified day treatment facilities, certified residential treatment facilities, skilled nursing facilities, psychiatric health facilities, and hospitals. The MHP is a provider when direct services are provided to clients by employees of the MHP.

“Provider Director” identified at the Billing Provider level, this is the person who has administrative and financial responsibility as listed on the Provider File Adjustment Request (PFAR) Form and also on the “LAC-DMH Head of Service Directory.”

“Prudent Reserve” The Mental Health Services Act requires that some of the funding not be spent but instead be put in a special account that can be used at a later date when other funding sources are cut. For example, before the MHSA, counties would spend all the money they were given in a year because if they did not spend it, it would be absorbed back into the state budget and they would lose it. This would then leave counties vulnerable without any extra money to fall back on during years when state or federal budgets for mental health were cut. The Prudent Reserve is like a savings account for a rainy day for mental health and that money can stay in each county’s account for 3 years after which it is absorbed into a statewide account that is controlled by the CDMH.

“PsyD” refers to Doctor of Clinical Psychology.

“Psychotropic Medication Authorization (PMA)” is a web application that allows doctors and clerks to enter medical and background information on Child and Transition Age Youth clients which require prescribed medications. The information is sent to the Courts for their approval.

“Psychiatric Advance Directive” is an Advance Directive specific to healthcare concerns associated with a psychiatric condition and the care provided for that condition. See Advance Directive.

“Psychiatric Health Facility (PHF)” is a health facility licensed by the State Department of Mental Health,that provides 24 hour acute inpatient care on either a voluntary or involuntary basis to mentally ill persons. This care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.

“Psychiatric Mobile Response Team (PMRT)” is a field-based, directly-operated service delivery programs that provides evaluations and interventions (including the initiation of an involuntary psychiatric hold, if indicated) of clients experiencing a psychiatric crisis in the community. These programs operate under the DMH Emergency Outreach Bureau. Similar field based programs (MET, SMART, HOPE) pair DMH staff with local law enforcement agencies.

"Public Guardian" The Los Angeles County Office of the Public Guardian was established in 1945 - the first in the state. Initially, the primary responsibility was for the finances of persons civilly committed to psychiatric facilities. As society evolved and the laws changed to meet new social challenges, the role of the Public Guardian broadened to include more responsibility for the care of the individual. The landmark LPS Act of 1969 and subsequent changes to the Probate Code meant that the Public Guardian became the substitute decision maker for vulnerable populations of the county, such as the frail elderly and persons with serious mental illness. The Los Angeles County Office of the Public Guardian is organizationally located within the Department of Mental Health. Dr. Marvin Southard, Director of the Department of Mental Health has been appointed by the Board of Supervisors as the Public Guardian and County Conservatorship Investigator. Office of the Public Guardian operations is managed by Deputy Director Connie D. Draxler.

"Public Guardian Office (PGO)" this office receives referrals from mental health professionals who wish to evaluate clients for both "grave disability" and mental disorder. The Director of the Los Angeles County Public Guardian Office acts as the conservator for individuals and their estate when the court has determined—based on the results of the evaluation—that the individual cannot provide for their basic needs of food, clothing, and shelter.

Q

"Quality Assurance Activities" are indirect activities defined by the Federal government that assist a Local Mental Health Plan in insuring and improving the quality of care delivered by its organization that are not provided as a service to or in relation to a specific client of the Department. Claiming for these services is currently paperbased. Only licensed professionals may claim for QA activity.

"Quality Improvement Program" is a DMH program involving DMH leadership, management, staff, consumers and family members intended to create and sustain a culture of system wide involvement and continuous improvement to the delivery of care.

"Qualified Proposer" is a bidder, lawfully able to conduct business in the state, which is solvent, not in financial distress, and is willing and able to meet the requirements of the RFP.

R

"RCL Certification Unit" is a unit of the Childrens' Countywide Case Management division within the DMH Child, Youth and Family Programs Administration that issues placement certifications to residential care facilities to provide care for youth in need of this level of care. The unit also monitors the care being provided in these facilities.

"Re-alignment Money" In the 1960s, mental hospitals were closed with the promise that community based services would be provided. However, there was no funding for these services and so they failed to materialize. In 1992, the State of California passed a law that allocated a percentage of the vehicle license tax and sales tax to be given to support mental health services. This tax was "re-aligned" to mental health to guarantee funding for services. This funding became known as "re-alignment money."

"Recovery" refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. We believe that recovery is possible and we are committed to providing meaningful and appropriate support to individuals and families at every step along the pathway to recovery and wellness. We are committed to providing education about mental health issues and how they affect individuals and families; and teach and promote self-advocacy. We are also committed to encouraging individuals, families, and communities to share responsibility to support one another.

"Recovery Model" is a goal for mental health care, in which consumers are able to self direct their lives in a positive manner outside of a mental health system. Recovery will be individualized for every person.

"Referral" means the process of sending an individual from one practitioner to another for health care, mental health or other services and supports.

"Religion" A set of beliefs and practices designed to help an individual or group express and carry out their spirituality. (Provided by the DMH Clergy Advisory Committee.)

"Rendering Provider" Staff who provide services to clients (i.e.., psychiatrist, psychologist, psychiatric social worker, case manager, therapist, etc.)

"RFI" stands for Request for Information. LACDMH uses the RFI when they want to solicit ideas about possible ways to address needs in the County and they are unsure of how to best meet these needs. Agencies are invited to submit their ideas for possible programs which are then reviewed and a program strategy is selected.

"RFP" stands for Request for Proposal. LACDMH creates a Request for Proposal when they are seeking a new program or working with a new contracted agency. An RFP is the way the LACDMH advertises to the community that they would like to contract a

new program and agencies are invited to submit a proposal (similar to an application) to provide the program and receive the funding.

“RFS” stands for Request for Services. An RFS is a solicitation based on proposed solutions in response to a defined need of the County. After evaluation of submitted Proposals, Contract(s) are recommended for award to the Proposer(s) who submits the Proposal deemed to be in the overall best interest of the County (generally the highest-ranking Proposer). An RFS is used when the county wants to add an additional service to an already existing program or contract agency.

“RFSQ” stands for Request for Statement of Qualification. LACDMH receives many Requests for Services from agencies seeking funding but many of the agencies do not meet the requirements of the proposal. Therefore, LACDMH created a filtering process or a pre-application process in which agencies submit a short statement verifying that they can meet the requirements (financial stability, staff, facilities, etc.) before they can submit the much longer RFP or RFS.

“Residential & Bridging Services” provide DMH program liaisons and peer advocates to assist in the coordination of psychiatric services and supports for individuals being discharged from County Hospital Psychiatric Emergency Services, Urgent Care Centers (UCCs), Institutions for Mental Disease (IMD), and crisis residential, supportive residential, substance abuse, and other specialized programs.

“Resilience” is defined as the ability to recover from or adjust easily to significant challenges such as misfortune or change.

S

“**SAMHSA**” stands for Substance Abuse and Mental Health Services Administration. SAMHSA is a division of the United States Department of Health and Human Services. SAMHSA provides federal funding (known as the SAMHSA Block Grant) to counties for mental health programs. SAMSHA’s vision is: “a life in the community for everyone, based upon the principle that people of all ages with or at risk for substance abuse disorders and mental illnesses should have the opportunity for a fulfilling life that includes a job, a home, and meaningful relationships with family and friends.”

“Schiff Cardenas Crime Prevention Act” is the State Assembly Bill 1913 administered as the Juvenile Justice Crime Prevention Act, providing a source of funding for community-based solutions to locally identified juvenile crime prevention needs.

“School-based Interventions” means a unifying intervention framework and strategic plan for school-based Prevention and Early Intervention programs. The framework and plan must encompass a comprehensive approach to enhance regular classroom

strategies to enable learning; support students during vulnerable periods of transition (e.g., to a new school or to a new class); increase and strengthen home and school connections; identify and support trauma-exposed students; respond to and prevent crises; increase and strengthen community involvement and support (e.g., health services, tutoring, volunteer programs, mentoring programs, family resource centers); and facilitate student and family access to effective services and special assistance as needed.

"School Failure" means the process of an individual experiencing continued lack of academic success and achievement based on learning disabilities, emotional disorders, family stress, and/or other conditions that, if not resolved, may result in suspension, truancy, and/or expulsion.

"School Threat Assessment and Response Team (START)" provides training, early screening and identification, assessment, intervention, case management and monitoring services in collaboration with school districts, colleges, universities and technical school, and in partnership with local and federal law enforcement agencies. The program's services are designed to prevent targeted school violence.

"Screening" means a process used to identify individuals with an increased risk of having mental health disorders that warrant immediate attention, intervention, or more comprehensive review.

"SD" stands for Supervisory District. There are five Supervisors in Los Angeles County and each has their own district. *(See Board of Supervisors above)*

"SDMH" stands for California State Department of Mental Health.

"Serious Emotional Disturbance (SED)" refers to a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

"Serious Mental Illness (SMI) or Disorder" means a mental disorder that is severe in degree and persistent in duration and that may cause behavioral disorder or impair unctioning so as to interfere substantially with activities of daily living. Serious mental disorders include schizophrenia, major affective disorders, and other severely disabling mental disorders.

“Service Area Advisory Council (SAAC)” represents each of the eight service areas in LA County have an advisory council of stakeholders and community members that meet to advise LACDMH on current and future policies and practices (*See SAAC chart attached for contact information*).

“Service Area District Chief” is a middle management position within the Los Angeles County Department of Mental Health that provides administrative oversight of directly-operated and contracted mental health service providers within one of Los Angeles County DMH’s eight Service Areas. These individuals report to a Deputy Director.

“Service Coordination Inquiries” are inquiries regarding coordination of services or clinical issues regarding a client from sources such as line-level staff within the LAC-DMH System of Care or other direct-service providers in the community.

“Service Extenders” Service Extenders are volunteer peer counselors who work with licensed mental health professionals to find and help older adults with mental illness whose needs aren’t being met. Minimizing the social isolation felt by many seniors, Service Extenders deliver services in community settings where older adults congregate—such as health clinics, faith-based institutions and senior centers. To meet with seniors who have trouble getting out, Service Extenders also visit senior housing complexes and even seniors’ own homes. Since many older adults are affected by the stigma of mental illness and will not go to mental health clinics, Service Extenders are always out trolling the field.

“Service Function Code (SFC)” as defined by Director, for a particular type of mental health service, and/or Title XIX Medi-Cal administrative claiming activity.

“Service Area Navigators” The County of Los Angeles - Department of Mental Health Stakeholder group unanimously supported the creation of Service Area Navigator Teams that would, across age groups, assist individuals and families in accessing mental health and other supportive services and network with community-based organizations in order to strengthen the array of services available to clients of the mental health system. Such networking would create portals of entry in a variety of settings that would make the Department’s long-standing goal of no wrong door achievable.

“Service Planning Areas (SPA)” Los Angeles County is administratively divided into eight (8) geographically-based Service Planning Areas, also referred to as “Service Areas”. This organizational structure facilitates closer coordination among agencies providing services in that geographic area.

"Share of Cost" is a monthly dollar amount some Medi-Cal recipients must pay, or agree to pay, toward their medical expenses before they qualify for Medi-Cal benefits. A Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible.

"Short-Doyle Act" was implemented in 1957. The act was designed to organize and finance community mental health services for persons with mental illness through locally administered and locally controlled community health programs.

"Single Fixed Point of Responsibility (SFPR)" is a specifically designated individual or team within a clinic or agency who has responsibility for maintaining the Client Care Coordination Plan and for coordinating and authorizing services provided to clients who are receiving ongoing mental health services.

"Skilled Nursing Facility (SNF-STP)" is a facility licensed by the State Department of Health Services, with an added Special Treatment Program certified by the State Department of Mental Health.

"Sliding Fee Schedule" is the charge for services based upon the income and family size of the individual or family requesting services.

"Small County" means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance.

"SMART" is the Los Angeles City Police Department System-wide Mental Assessment Response Team. This team responds to 911 or other calls requesting help with psychotic, suicidal or homicidal persons. They are authorized to hospitalize people against their will if they are too ill for outpatient treatment.

"SOC" stands for system of care. **CSOC** refers to Children System of Care, **ASOC** refers to Adult System of Care and **OASOC** refers to Older Adult System of Care.

"Social Inclusion" is the full participation of consumers in social relationships, housing, employment, and education without regard to their status as consumers of mental health services.

“Specialized Intensive Foster Care” is a community-based alternative placement for children who require out-of-home care along with therapy and specialized services including those children who are emotionally and behaviorally disturbed, developmentally disabled, and medically disabled. Specialized Intensive Foster Care programs involve the application of specific evidence-based practices designed to treat this population.

“Spirituality” is a person’s deepest sense of belonging and connection to a higher power or transcendent life philosophy which may not necessarily be related to an organized religious institution (Adapted from California Mental Health & Spirituality Initiative). Spirituality is a process of pursuing meaning and purpose in life.

“SSDI” is Social Security Disability Income.

“SSI” is Supplemental Security Income.

“Stakeholder” is either a person or group of people who impacts or is directly impacted by mental health services or, a person who represents others’ interests relative to mental health services.

“State General Fund (SGF)” California SGF used as FFP match.

“Statement of Qualifications (SOQ)” stands for a contractor’s response to an RFSQ.

“Statement of Work (SOW)” is a written description of services desired by County for a specific work order.

“Stigma and Discrimination” is a mark of shame or discredit. A sign of social unacceptability that is often attributed to those suffering from mental health related issues. Research suggests that stigma can be an obstacle to help seeking and recovery for those who need mental health support. Discrimination means the unlawful and intentional action take to deprive individuals of their rights to mental health services, based on feelings and reactions to stigma.

“Substance Abuse” The addiction to illegal and legal substances including alcohol and prescription and non-prescription drugs.

“Supportive Residential Programs (Enriched Residential and IMD Step-Down)” Provide supportive on-site mental health services at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing, or

other independent living situations to serve persons being discharged from IMD, acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care.

“Supportive and Therapeutic Options Program (STOP)” a program for children who do not qualify for any other type of funding for a particular service or support. The main goal of intervention or support is to help bring the child home, maintain the child in the home, or return the child to his/her community.

“System for Treatment Authorization Request (STAR)” tracks inpatient days approved and denied TAR. County anticipates to fully replacing this application with the IBHIS System.

“System Leadership Team (SLT)” this team was created by the Delegates (see above) during the first MHSA plan, the Community Supports and Services (CSS) plan in order to have a smaller decision making body to address specific concerns. The SLT is made up of Delegates, stakeholders and LACDMH staff. Currently, the SLT serves as an oversight committee for the implementation and revision of the CSS plan and eventually the other MHSA plans once they are put into practice.

“System of Care” stands for a partnership of mental health, education, child welfare and juvenile justice agencies as well as teachers, children with serious emotional disturbances and their families and other caregivers. These agencies and individuals work together to ensure children with mental, emotional and behavioral problems and their families have access to the services and supports they need to succeed. Together, this team creates an individualized plan that builds on the unique strengths of each child and each family. The plan is then implemented in a way that is consistent with the family’s culture and language.

T

“Tarasoff” *Tarasoff v. Regents of the University of California* was a case in which the Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual. On June 21, 2001, Geno Colello asked his father to loan him a gun. When his father refused, Colello said he would get another gun and "kill" the "kid" who was then dating his ex-girlfriend. Colello's father relayed this threat to Goldstein, his son’s psychotherapist, who urged him to take Colello to Northridge Hospital Medical Center. Later that evening a hospital social worker evaluated Colello. Colello's father told the evaluator about his son's threat. Colello was admitted to the hospital as a voluntary patient but discharged the

next day. The following day he shot and killed Ewing and then himself. The California Court of Appeal concluded in *Ewing v. Goldstein* and *Ewing v. Northridge Hospital Medical Center* that the defendants' duty to warn could have been triggered by the statements Collelo's father made to Goldstein and the social worker regarding his son's threats. The court saw no difference between threats conveyed directly by the patient and those related by an immediate family member of the patient.

"**TAY**" means Transition Age Youth. This term applies to youth and young adults between the age 16 and 25. This age group became a focus of treatment in the MHSA.

"Target Community" means a subset of the priority service population, such as those residing in a geographic area or school catchment area, or a countywide target population (e.g., children and youth in foster care) that will be the focus for a PEI project

"The Project-Based Operational Subsidy" The Project-Based Operational Subsidy funds provide subsidies for Unit-based Permanent Supportive Housing programs and "Youth-Oriented" board and care-type (non-licensed) programs to address the longterm housing needs of SED/SPMI TAY who are eligible for Full Service Partnerships (FSP) and others coming directly from transitional housing programs or directly from foster care or group homes.

"Therapeutic Behavioral Services (TBS)" TBS is a short-term intensive intervention that may be included as one component of a comprehensive mental health service plan. TBS provides one-to-one support for full scope Medi-Cal children and youth under the age of twenty one (21) years, who are experiencing a life crisis or when a life crisis is imminent, who need additional support to transition from a higher to lower level placement or to prevent movement to a higher level of care. In Los Angeles County, these services must be authorized by the Central Authorization Unit.

"Threshold Language" The California Department of Mental Health tracks how many people are served in each county in mental health. If a county has 3,000 Medi-Cal consumers that speak a certain language then that language becomes a "threshold language" and the county is required to provide services and written materials in that language. Los Angeles County has 13 threshold languages; most counties in California have 1-3 languages. These languages are Armenian, Cambodian/Khmer, Cantonese, Farsi, Korean, Mandarin, other- Chinese, Russian, Spanish, Tagalog, Arabic and Vietnamese.

"Title IV" Title IV of the Social Security Act, 42 United States Code Section 601et seq.; XX. "Title XIX" means Title XIX of the Social Security Act, 42 United States Code Section 1396 et seq.

“Title XXI” Title XXI of the Social Security Act, 42 United States Code Section 1396 et seq.

“Traditionally Underserved Populations” any group of individuals with mental health needs, who because of mental health issues, geographic location, race, ethnicity, gender, sex, sexual orientation, spiritual/religious, age, socio-economic status, or disability status, have not historically sought, been eligible for, or received mental health services.

“Transformation” is applied to the overall change in the mental health system that now focuses not just on providing services but seeing outcomes. There is now a system of accountability in place to measure the effectiveness of our services to ensure that we are employing the recovery model and seeing positive results. Evidence based practices (EBP) and Full service partnerships (FSP) are two ways that transformation of the system is evident.

“Trauma-exposed Individuals” means those who are exposed to traumatic events or prolonged traumatic conditions, including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

“Treatment Authorization Request (TAR)” is a request submitted to DMH administration requesting authorization for the provision of a particular service or type of service of medication.

“Triage” is a process for sorting injured people into groups based on their need for immediate medical treatment.

U

“Underserved/Inappropriately Served” is an individual who has been diagnosed with serious mental illness or serious emotional disturbance, and their families who are receiving some service, but whose services do not provide the necessary opportunities to move forward and pursue their wellness/recovery goals.

“Undocumented Youth” (also see AB540 student) an immigrant youth who does not possess an immigrant visa, legal permanent residency card (i.e. “green card”) or U.S. citizenship to legally reside in the United States.

“Uniform Bill-04 (UB-04)” a standardized form from the Centers for Medicare and Medicaid Services used to electronically submit claims for health care received in an institutional setting to payers.

"Uniform Bill-92 (UB-92)" Starting May 23, 2007, all of paper claims must use the UB-04 since the UB-92 will no longer be acceptable. See Uniform Bill-04.

"Uniform Method of Determining Ability to Pay (UMDAP)" is the process by which annual liability is determined.

"Unit of Service" is the increment unit of time used to capture the quantity of services provided (e.g. 1 minute = 1 Unit of Service) during mental health service procedure. Claims are generated based upon service provided and multiplied by the rate for that procedure.

"Unserved" is an individual in need of mental health services but does not receive services due to various social, personal, institutional and environmental factors.

"UREP" stands for Under Represented Ethnic Populations. Examples of these populations are American Indian/Alaskan Native, Eastern European/Middle Easter, African/African-American, Latina/o/ Hispanic, Asian/Pacific Islander, Refugee groups, Lesbian/Gay/Bisexual/Transgender/Queer & Questioning/Intersex/Asexual.

"Urgent Care Centers (UCCs)"Provide intensive crisis services to individuals who otherwise would be brought to emergency rooms for up to 23 hours of immediate care and linkage to community-based solutions. UCCs provide crisis intervention services, including integrated services for co-occurring substance abuse disorders and are geographically located throughout the County. UCCs focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment.

V

"Very Small County" means a county in California with a total population of less than 100,000 according to the annual projections published by the Department of Finance.

"Vision" refers to the Los Angeles County Department of Mental Health vision statement: Partnering with clients, families and communities to create hope, wellness and recovery.

W

"Welfare and Institutions Code (WIC)" is the code enacted to insure the rights or physical, mental or moral welfare of children are not violated or threatened by their present

circumstances or environment. WIC establishes programs and services designed to provide protection, support or care of children and provides protective services to the fullest extent deemed necessary by the juvenile court, probation department or other public agencies designated by the Board of Supervisors to perform the duties prescribed by this code.

"Wellness Center" is MHSA-funded and designed to infuse our entire system with the philosophy and principles of recovery. Multicultural and welcoming environments, Wellness Centers provide a place where clients help one another achieve community reintegration, wellness and meaningful social connections. These "consumer-driven" or "client-run" centers try to increase people's self-reliance and community involvement by providing a comprehensive array of self-help, educational, social, and recreational activities.

"WET" stands for Workforce, Education and Training. This is one of the five plans of the Mental Health Services Act that focuses on improving the capacity of mental health professionals in implementing the recovery model and transforming the mental health system.

"Whatever It Takes" refers to a wide array of clinical and supportive services beyond mental health care, such as housing and employment services, for individuals with a serious mental illness or a serious emotional disturbance to support recovery and/or resilience. The approach helps individual and families regain their lives. For most clients, full recovery requires more than clinical interventions.

"WRAP" Wellness Recovery Action Plan. A client centered plan that includes a daily maintenance plan, triggers and action plan, early warning signs, crisis plan, and post crisis plan. Ideally, WRAP concepts are modeled by clinicians who are working with consumers who are also working on their WRAP.

"Wraparound" stands for the process of providing individualized, comprehensive, community-based services and supports to children and youth with serious emotional and/or behavioral disturbances so they can be reunited and/or remain with their families and communities. Wraparound helps families develop an effective support network, increase their competence, and teaches new skills for managing the specials needs of their child. Wraparound is one of the effective services that children's MHSA-funded programs are built upon.

X
Y
Z

The Los Angeles County Department of Mental Health

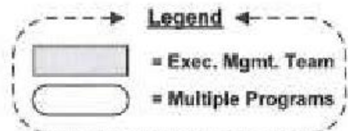
Service Areas

- SA 1 (Antelope Valley)
- SA 2 (San Fernando)
- SA 3 (San Gabriel)
- SA 4 (Metro)
- SA 5 (West)
- SA 6 (South)
- SA 7 (East)
- SA 8 (South Bay/Harbor)

Los Angeles County
Department of Mental Health
Integrated Behavioral Health Information System (IBHIS)

ATTACHMENT RFP 1 - DMH FUNCTIONAL ORGANIZATIONAL CHART

- **Director of Mental Health**
  - Mental Health Commission
  - Office of the Medical Director
    - Pharmacy Services
    - Managed Care
    - COD/HIV Programs
  - Empowerment & Advocacy
  - Community & Government Relations
  - Patients' Rights
  - Emergency Outreach Bureau
    - Service Area 4 Svcs
    - Service Area 7 Svcs
    - Countywide Svcs.
    - MHSA
  - Older Adult Program Admin
    - Service Area 2 Svcs
    - Service Area 5 Svcs
    - Countywide Svcs.
    - MHSA
  - Adult SOC Bureau
    - Service Area 6 Svcs
    - Service Area 8 Svcs
    - Countywide Svcs.
    - Jail Mental Health
    - MHSA
  - Child/Youth & Family Program Admin.
    - Service Area 1 Svcs
    - Service Area 3 Svcs
    - Countywide Svcs
    - MHSA
  - Special Children & Youth Svcs Bureau
    - Special Foster Care
    - Juvenile Justice
    - MHSA
  - **Chief Deputy Director**
    - Compliance Program Office
    - Chief Information Office Bureau
    - Program Support Bureau
      - Standards & Records
      - Planning
      - Quality & Outcome
      - Training
      - Cultural Competency
      - MHSA
    - Public Guardian/ Conservator
      - LPS
      - Probate
    - Office of Administrative Deputy
      - Finance
      - Contracts
      - Administrative Services
      - Revenue Management
      - Human Resources



ATTACHMENT RFP 1 - DMH Functional Organization Chart

County of Los Angeles – Department of Mental Health
MHSA Implementation and Outcomes Division
Acronyms

AAA	African/African American
AB	Assembly Bill
ACHSA	Association of Community Health Services Agencies
ACT	Assertive Community Treatment
ADAMHA	Alcohol, Drug Abuse and Mental health Administration (Federal)
AI	American Indian
API	Asian Pacific Islander
ATCMS	Adult Targeted Case Management Services
B&C	Board & Care
BOS	Board of Supervisors
CAC	Citizens Advisory Council
CALHFA	California Housing & Finance Agency
CAMI	Calif Alliance for the Mentally Ill (formaly CAFMD)
CAO	County Administrative Officer
CASRA	California Association of Social Rehabilitation Agencies
CBO	Community Based Organization
CCAC	Childrens' Citizen Advisory Committee
CCALAC	Community Clinic Association of LA County
CCF	Community Care Facility
CCLMHD	California Conference of Local Mental Health Directors
CCP	Community Corrections Partnership
CCR	California Code Regulation
CDF	Community Defined Evidences
CE & I	Consultation, Education and Information
CEIU	Crisis Evaluation Intervention Unit
CEO	Chief Executive Office
CET	Consumer Employment & Training
CF	Capital Facilities
CIAC, IAC	Countywide Interagency Committee
CIMH	California Institute for Mental Health
CMHC	Community Mental Health Center
CMHDA	California Mental Health Director's Association
CNMHC	California Network of Mental Health Clients

WELLNESS • RECOVERY • RESILIENCE

COLA	Cost of Living Allowance
CO & O	Community Organization and Outreach
COS	Community Outreach Services
CPPP	Community Program Planning Process
CPRP	Certified Psychiatric Rehabilitation Practitioner
CR/DC	Cost Reporting/Data Collection (System)
CRTS	Community Residential Treatment System (AB 3052)
CSAC	County Supervisors Association of California
CSOC	Children's System Of Care
CSP	Community Support Program
CSS	Community Services Supports
CTF	Community Treatment Facility
CWS	Child Welfare System
C/Y	Children and Youth
DCFS	Department of Children's Services
DD	Developmental Disabilities
DHHS	Department of Health and human Services (Federal)
DMH	Department of Mental Health (State)
DO	Directly Operated
DPSS	Department of Public Social Services
DS	Direct Services
EAD	Employment & Advocacy Division
EBP	Evidence Based Practices
EE/ME	Eastern European/Middle Eastern
EPSDT	Early Periodic Screening, Diagnosis and Treatment
FCCS	Field Capable Clinical Services
FFS	Fee for Service
FQHC	Federally Qualified Health Centers
FSP	Full Service Partnership
FSS	Family Support Services
FFP	Federal Financial Participation
FTE	Full Time Equivalent (Staff Position)
FY	Fiscal Year
GP	Growth Plan
HUD	(Department of) Housing and Urban Development (Federal)
HWLA	Healthy Way L.A.
IBHIS	Integrated Behavioral Health Information System
IC	Institutional Care

WELLNESS • RECOVERY • RESILIENCE

IMD	Institution for Mental Disease
INN	Mental Health Services Act (MHSA) Innovation Plan
IP	Implementation Plan
IT	Information Technology
JCAH	Joint Commission on Accreditation of Hospitals
LACCC	Los Angeles County Client Coalition
LACDMH	Los Angeles County Dept. of Mental Health
LAHPDA	L.A. Health Planning and Development Agency
LPS	Lanterman Petris Short Act
LTC	Long Term Care
LVN	Licensed Vocational Nurse
M-C	Medi-Cal
MD	Mental Disabilites
MDO	Mentally Disordered Offender
MFCC	Marriage, Family, and Child Counselor
MH	Mental health
MHA	Mental Health Association
MHAB	Mental Health Advisory Board
MHAC	Mental Health Association in California
MHC	Mental Health Commission
MHMC	Mental Health Managed Care
MHP	Mental Health Plan
MHS	Mental Health Services
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight Accountability Commission
MIA	Medically Indigent Adult
MIS	Management Information System
NAMI	National Alliance for Mental Illness
NIMH	Nation Institute of Mental Health (Federal)
NMHA	National Mental Health Association
O&E	Outreach & Engagement
OA	Older Adult
OCDD	Office of the Chief Deputy Director
OMD	Office of the Medical Director
OMHAB	Organization of Mental Health Advisory Boards
OMHSS	Office of Mental health Social Services
OOD	Office of the Director
PEI	Prevention's Early Intervention

PES	Psychiatric Emergency Services
PHF	Psychiatric Health Facility
PPPs	Public Private Partnerships
PPs	Promising Practices
PR	Public Review
PS&S	Plan Status and Review (Report)
PSW	Psychiatric Social Worker
RCF	Residential Care Facility
RFP	Request for Proposal
RFA	Request for Application
RFI	Request for Information
RFS	Request for Service
SA	Service Area
SA 1	Antelope Valley Area
SA 2	San Fernando Valley Area
SA 3	San Gabriel Valley Area
SA 4	Los Angeles Metro Area
SA 5	West
SA 6	South
SA 7	East
SA 8	South/Harbor Long Beach
SAAC	Service Area Advisory Committee
SAMHSA	Substance Abuse Mental Health Services Administration
SB	Senate Bill
SED	Severe Emotional Disturbance
S-D	Short-Doyle (Legislation)
SD/MC	Short-Doyle/Medi-Cal
SDMH	State Department of Mental Health
SFCP	Specialized Foster Care Program
SGF	State General Fund
SH	State Hospital
SLT	System Leadership Team
SM I	Severe Mental Illness
SNF	Skilled Nursing Facility
SPA	Service Planning Area
SSA	Social Security Administration (Federal)
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income

WELLNESS • RECOVERY • RESILIENCE

TAY	Transitional Age Youth
TRC	Therapeutic Residential Center
UMDAP	Uniform Method of Determining Ability to Pay
UREP	Under Represented Ethnic Populations
USPRA	United States Psychiatric Rehabilitation Association (CA Chapter)
W & I	Welfare and Institutions Code
WET	Workforce Education & Training
WIC	Welfare Institution Code
WRAP	Wellness Recovery Action Plan