COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, October 30, 2013 from 9:30 AM to 4:00 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

REASONS FOR MEETING

1. To understand the architecture of key state-mandated regulations and locally developed policies for the MHSA plans as foundation for the Three-Year Program and Expenditure (3YPE) Plan planning Process.
2. To provide an update on SB 82-Wellness Act of 2013 and its implications.
3. To provide an update on Laura's Law and obtain feedback.
4. To discuss Transition Age Youth proposal to re-distribute TAY flex (client supportive services) funds and issue a recommendation.
5. To provide an update on re-distribution of funds with the MHSA Technological Needs Plan.
6. To understand the service continuum for each age group at the countywide level and provide feedback on gaps and issues by age group for the 3YPE Plan planning process.
7. To clarify next steps with regards to the 3YPE Plan planning process.

MEETING NOTES[i]

MHSA 101 Foundation	*Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes Division,* County of Los Angeles, Department of Mental Health ***PowerPoint presentation included in meeting packet.* **FEEDBACK** 1. **Question:** When CSS and PEI program funding are finished, does this mean they will no longer be doing PEI or is that just a threshold for years to come? **Response:** Funding received during this Fiscal Year (FY) must be spent within 3 FYs, so by FY 15/16. If not, we must consider putting it in the Prudent Reserve. We monitor expenditures very carefully and if considering placing funds in the Prudent Reserve would come back to the SLT with some recommendations. 2. **Question:** Last year some money that was reverted back to the state. How much was that? In Service Area 4 there were $46.1 million that was taken from the prudent reserve and put into housing. Which housing did you put it in? Can you please explain? **Response:** It takes several years to determine whether funds actually remain unspent due to claims entered after the end of the Fiscal Year, late settlements and cost reports. To my knowledge, we have not reverted any money. We did not actually have to access the prudent reserve because of some unspent dollars that we were unable to use to cover investments. 3. **Question:** If we have money that is not spent, can it be used for other services? a. **Response:** We carry over unspent funds, and in particular need to do that this year since MHSA funds dipped this

year from last year.

b. **Response:** We can also dip into our prudent reserve for that but it makes sense to use the unspent funds first. Sometimes you do not know they are unspent for several months after the end of the fiscal year.

4. **Comment:** Will AB47 make MHSA more compatible with ACA?
   Response: The tie in is that were specific individuals or entities that need to be a part of planning processes. It calls out drug and alcohol providers or, in our case, SAPC and health care organizations.

5. **Question:** The prudent reserve: (page 5, slide 10) does it take a certain percentage of the CSS funds and the PEI funds and automatically sets this aside for a length of time?-Is a certain amount put in a reserve just in case the money does not come?
   a. **Response:** The prudent reserve should be 50% of the CSS plan and then it is uncapped. The State DMH gave us a certain time frame and then they extended a year to put money into the prudent reserve. We think about it like a bank account to hold money until we need it. .

   b. **Response:** Accessing the Prudent Reserve requires a plan that is vetted through stakeholders. It must be vetted, approved, and submitted as part of our annual update, 3 Year Program and Expenditure Plan or as a mid-year update to one of those plans. Use of the Prudent Reserve is meant to be a time-limited bridge to continue services in years when funds reduce.

   c. **Response:** the State DMH gave us a lot of guidance on the prudent reserve through info notices. Some of it was inconsistent. DHCS is reviewing the current regulations and info notices. In the next year or so, we will have more clarity on all of this.

6. **Question:** How are health records being integrated under the Affordable Care Act? Are you using capitol funds to upgrade both of the DMH and health providers' health records? Are we doing something as to integrate these other two avenues that are now expanding the care to health, mental health, and drug?
   Response: Our current IT plan does not address the question you are raising. All it does is fund electronic health records for us and provides money to contractors to do very specific things around data transmission of their own electronic health records. But it does not go beyond that.

7. **Comment:** Debbie is trying to stick to the facts. Your question is to what extent is this investment in the electronic records compatible with the Affordable Care Act? This becomes a question that we need to ask in the planning process.

8. **Question:** How much is in the prudent reserve right now? Is that interest accrued annually? Biannually? If there is an overage and interest accruing over 10 years is there a way for that interest that has been accrued to be used in or for communities?
9. **Comment:** There are two questions. One is, "How much money is there?" and the second is, "Is there an interest and what happens with the money that accrues from the interest?" On the first question we will provide you with that information during the planning process.

Response: I cannot speak specifically to the prudent reserve but any interest accrued from MHSA funds gets put into the available funds for our program on a yearly basis. We will get you the exact amounts. There are two parts of the prudent reserve. One is for CSS and the other is for PEI. Prudent Reserve funding is reported annually via the budget section of the Annual Update or 3 Year Program and Expenditure Plan.

10. **Question:** If the government shuts down—does that affect the money that is coming in?

11. **Comment:** The money comes in quarterly. Millionaires are required to pay quarterly taxes. That money goes to the State's Mental Health Fund. Counties get allocations monthly. A government shut down does not impact that at all.

12. **Comment:** A federal government shut down would not affect it because these are state collected dollars.

13. **Question:** You said monies from the MHSA cannot be used for parolees. I have concerns about that. There are several states that do certified specialist trainings in the jails.

14. **Comment:** Concerns can be raised through the planning process. I want to make sure that we are clear about the facts.
    Response: With the MHSA we cannot fund any services that are in jails, juvenile halls, or state prisons. What we do fund is after care services; services that are focused on transitioning clients out of those entities.

15. **Comment:** AB 109 is a special class that we can serve because they are probationers, not parolees. That's a special class.

16. **Question:** You said MHSA money cannot be used in juvenile halls, jails, and prisons. However, if I remember correctly, MHSA dollars specifically could be used for kids in juvenile hall but not used in jails. Did something change since we first started this process?
    Response: I need to be a little clearer. The distinction of juvenile halls relates to legal status I think. It focuses more on the transitioning, after care planning, as opposed to services within the juvenile hall.

17. **Question:** How did they come up with the name Systems Leadership Team? Is that a name we have outgrown or maybe it is time to think of a more innovate name, perhaps?
    a. **Response:** Initially, we wanted to make a distinction between a much larger body of stakeholders called delegates and a smaller group. The delegates group was responsible mostly for planning.

    b. **Response:** The distinction is that this SLT was going to make recommendations around the implementation--not just the planning--but the implementation of MHSA. This more active body would make recommendations around implementation.

18. **Comment:** The other part is that your role of the systems leadership is to look over the full system and not just advocate for one particular perspective. So it is also the importance of balancing different needs and interests but as a full system.

19. **Question:** Is the statute silent on the groups to be served under Innovation?
    Response: Yes. There are 4 different focal populations or approaches that you can use for the Innovations project

that could apply to any and all age groups. You do not need to include all age groups in your project or any particular one. You can generalize it.

20. **Question:** What is the distinction between a serious emotional disorder and a serious mental illness?
    Response: They are defined in the Welfare and Institution Codes. Serious emotional disturbance refers to children, for the most part, and the serious mental illness refers to adults.

21. **Question:** Is the emotional disorder considered 'mental illness?'
    a. **Response:** Yes, something that is diagnosable.

    b. **Response:** I am interested in it in terms of PEI versus other program support.

    c. **Response**: With Prevention you do not need to be diagnosed with a mental illness but can be at risk of developing one, either Serious Emotional Disturbance (SED) or Serious Mental Illness (SMI). Early Intervention refers to being early in the course of an illness. There may be signs and symptoms of psychosis, depression, or anxiety, impact of trauma, or PTSD.

22. **Question:** On slide 24, what is SPMI?
    Response: A: Serious and Persistent Mental Illness. The 'P' has dropped off over time. So, it is SMI.

23. **Question:** Do sections of the Mental Health Services Act evolve or change as we gain better understandings of practices through research? For example, on slide 21, the last bullet point says, "Child youth who is involved with probation, is on psychotropic medication and is transitioning back into a less structured home/community setting." We hear more and more about the effects of psychotropic medication on very young children, especially children who may be in foster care situations. As we understand the impact of medication – if a child is not on medication but still involved with probation and transitioning into less does that qualify them for a full service partnership?
    Response: Yes. These were informed by stakeholders and promulgated by the Department in 2005. We learned a little bit since then in terms of the key focal populations that seem to use FSPs the most.

24. **Question:** For adults, there are some programs that are really working and they are not funded. In 'older adults' there are only a few funded programs. Can you please explain?
    Response: We do not have new money. The money has been allocated. We need to carefully look at the service array for each age group, where we have resources for the future for example or where we want to change things now.
25. **Question:** Indigenous populations were not mentioned in underserved and unserved, many seem 'near homelessness' or not receiving appropriate mental health services. I did not hear what funds might be available to those families or individuals; just to the fact that there are a lot of those individuals--indigents that are going to the mental health services and they being put on the back burner and not being served.

26. **Comment:** You are referring to people who are indigent who do not have a payer source for the service that they need? The question is where do indigents fall in the focal populations?

	a. **Response:** Many of our programs initially set a target. Innovation is probably the best example of this. They set a target for a percentage of clients that a provider would have that would be unfunded for reasons such as being undocumented or they do not have benefits yet. We wanted to focus on a population, that, going back to the regulations, would be underserved or unserved, and in LA we came up with a third category–inappropriately served –people can get services but perhaps not the right services. b. **Response:** For FSPs, for example, DMH stipulated that a certain percentage of clients enter the program without funding and a certain percentage of clients would obtain funding over time. c. **Response:** In some of the program descriptions we address the issue of folks who are insured. There are the uninsured and the uninsurable which is increasingly important to look at because not everyone will be covered by the ACA.
SB 82 Update and Implications	*Susan Rajlal, Legislative Analyst*, County of Los Angeles, Department of Mental Health ***Two handouts on SB82 were given to the SLT during the presentation.* **FEEDBACK** 1. **Question:** Is DMH in the process of submitting or writing the grant proposal? **Response:** Not yet. I believe some of you may be participating in that process. 2. **Question:** What is the participation process? How would you like to get feedback or information? a. **Response:** We are on a really short time line. We are talking about the TRIAGE, the mobile team. On the mobile response team, these are going to be applications submitted to either the state, the OAC (which is the mobile response team). This is due on November 3rd. b. **Response:** We are trying to generate a proposal that gives us enough flexibility to implement things. Once approved by the OAC a part of this is going to be contracted out. So we will go through a local solicitation process. We are trying to write an application that will be accepted by the committee that will give us the flexibility to implement these things locally through a solicitation process. 3. **Question:** I am wondering what a TRIAGE worker is. Is it something we already have in the system? Is it a new job category? What is it parallel to? a. **Response:** It is not parallel exactly to the navigators, although the idea is related to the navigators. We envisioned that it would be more than navigators. These will be individuals who conduct more service, case management, as well as other types. The emphasis of this is hiring peers and paraprofessionals. 4. **Question:** You made reference to using these funds to leverage other dollars. What type of dollars? a. **Response:** I think the initial assumptions provided by the OAC are that most of these dollars would be leveraged. We see a limited ability to match these funds to Medi-Cal.

	5. **Question:** The reference was for the county match requirement for state or federal dollars? **Response:** Right. It would be using these dollars to generate Medi-Cal revenue. 6. **Question:** Can a consumer/client endorse a stakeholder or collaborator and get a percentage out of the allocated fund? **Response:** The funds can only be accessed by county plans; essentially, the county mental health department. Once they receive their grant they can consider whether to contract out services. 7. **Question:** I have got a question concerning consumers that are going to be hired--people with lived experience. Are they in recovery? Will they be trained in emotional CPR for example? **Response:** There will be training. The people hired will be well trained for the situation they work in and have supervision and continual training. 8. **Question:** You mentioned peer certification and peers. Does this include peer advocates and parent partners? **Response:** There is a place for parent advocates in this process, particularly when working with children. It would be necessary.
Laura's Law Update and Feedback	*Dr. Rod Shaner, Medical Director*, County of Los Angeles, Department of Mental Health *** Dr. Shaner's PowerPoint was emailed to the SLT.* **FEEDBACK** 1. **Question:** How much is Nevada County spending on their program for 70 people? Will we spend similar amounts here? a. **Response:** In terms of costs, one component of these costs is the mental health system, FSP has an AOT team. But there are also costs for the court, county counsel, and public defender. We talked with the judge, the county counsel, and the public defender and they all indicated that they did not have a separate budget because they believe that the costs offset b. **Response:** We did not ask about costs for their treatment program. We just asked what it cost them. They just said it is the same. It is their FSP costs. They have 70 slots. The only reason they have 70, they said, is because that is how many they need right now. They said if they needed more they would probably do that and devote slots. The cost for their AOT outreach program was a half time person, her other half time directing the FSP program. I am not sure how we could simply do a multiplier for LA County. 2. **Question:** 7 years later, does Nevada County have any quality of life outcomes that they are able to report on? **Response:** They did not have specific measures. They indicated that the people in their program do well. They did not have many dropouts. People told them anecdotally that they felt treatment was valuable. They have offered to send us information on outcomes but they did not have any ready at the time--what they also noticed is that the number of incarcerations in their jail for people with mental illness dropped remarkably. The numbers of LPS conservatorships also dropped. They feel that indicates that the program was useful. 3. **Question:** My question has to do with the 'unlikely to survive community without supervision.' There is an asterisk that says "unable to provide for food, clothing, or shelter in a manner consistent with preservation and reasonable physical

health and safety." Is this similar to 'gravely disabled' with 'adults.' Can you clarify how the two are different?

Response: We looked at their procedures and tried operationalize all of it. We wanted to know how they operationalize that 'in danger of serious deterioration." They looked at our operational definition and said, "LA--we just say 'gravely disabled light.'" That would not work here. We had a sub-group try to come up with an operational definition so that it is operationalized as precisely as possible. In the court proceedings when the person is questioned they will ask specific questions related to the definition. We operationalized it a bit broader than 'grave disability' but to make it clear had to do with surviving safely and we defined what that would be.

4. **Question:** Regarding the new program and outreach. Some of the clients need medication, others do not. Is there a way to check to see if they take their medicine?

   Response: The requirements to the process require obtaining a lot of information, but there are some limits. For example, we can get access to hospital records if people permit that. Another issue is having the capability. We will have a nurse and a psychiatrist on the team, who can ascertain meds and prescribe in the field. That is one of the reasons for having some prescribing abilities on the team. So we will be able to check that.

5. **Question:** Many former clients are opposed to Laura's Law. Can you comment on consumers' objection to Laura's Law?
   a. **Response:** The first thing is while we may be opposed to various laws, if they are on the books we cannot like them--but they are there. Our focus is that if Laura's Law were to be implemented consistent with the law what would the procedures be and how would they be structured? It is not the DMH's choice whether or not those programs are put into effect. It is a governmental choice on a county level.

   b. **Response:** There are a 'core' people and there is a potential in Laura's Law to detain people, not on 5150 but on 5846, because you can detain in order to evaluate for inpatient care. It is a concern but it is a small portion.

6. **Question:** The guy who has both jobs--does not that show a conflict of interest?

   Response: Their county counsel was there from Nevada County when they were describing it. We have a separate outreach and engagement team. We thought that given the many FSPs that we will need a centralized, departmental way of evaluating need and finding places for people should they meet criteria.

7. **Question:** One of the factors that would hit me immediately is the housing issue in LA--that would create more circular processes here where people would be less stable because housing is much tougher to come by and assure for a stable lifestyle.
   a. **Response:** Clearly, housing is critical. Within the 300 slots were 60 immediate beds. Is that the right number? I do not know if anyone can be certain. I do not know--step down. They were not IMD beds. We hope to have people be able to spend that much time and then be stabilized and then go into other systems.

   b. **Response:** The last thing to say about beds is that you cannot require someone to go into AOT. One of the things that a judge must ascertain is that you have the resource that they need. The size of the AOT program, by the law, is limited by it being able to have the resources to meet those needs.

8. **Question:** Are cultural factors and language differences being taken into consideration at the beginning of your planning

	for this? **Response:** It is a critical issue for Los Angeles. We know that as we construct both the AOT team, but more importantly too, the FSPs--we have talked about how they have to be culturally, geographically, diverse to meet the needs of whatever population is in AOT. 9. **Comment:** The question about housing--when asked that question in Nevada County they said, "If somebody needs housing they get housing." Part of what was being offered in the program was housing to those people who need it. That's potentially a piece of a FSP; providing housing. If it is not available they have to figure out how to make it available. Secondly, about the clients' objections and medications, they made it very clear in Nevada County they did not forcibly inject anybody. Our procedures for LA, that we have written, are explicit. In Laura's Law no medication can be forcibly administered.
Transitional Age Youth Proposal to Redistribute Flex Funds	*Terri Boykins, District Chief*, County of Los Angeles, Department of Mental Health ***A copy of Terri Boykin's presentation was included in the meeting packet.* **FEEDBACK** 1. **Question:** What is the relationship of flex funds to housing? My understanding was that housing needs were supposed to come out of flex funds if somebody was not housed. Are all of the folks in the TAY program housed? **Response:** Yes. In terms of the housing, we track all of the flex fund expenditures for TAY. The single largest utilization is for housing. The providers are all following through so that we do not have homeless TAY remaining homeless when they are in a FSP program. They do the housing for them. 2. **Question:** We need to increase EESP capacity. When you have unused flex funds used is that because those young people are not yet in the FSP program? **Response:** Yes. The EESP is broader in general, but it is a direct highway to our FSP programs for those young people who want to establish the partnership expected in an FSP. A lot of young people do not want to establish the partnership. But we can house them in our shelter EESP program while we link them to other less intensive services. 3. **Question:** Where would the one additional TAY drop-in center be? Is it going to serve a particular area? Is it countywide? **Response:** For all of the Drop In centers we conducted a solicitation because that is the fair way to do it. The thing that we have done is that where we have a drop in center, in terms of a service area, we do not solicit for another one in that service area. Our most recent solicitation is for a Drop In center, not in Service Areas 3 or 4, because we already have centers we are funding there. Our recent solicitation was for any of the other remaining of the 8. 4. **Question:** I do not know where there is room for a particular focus but 60% of the young women in sex trafficking in LA are foster care youth. There was a hearing in Washington last week. They said that their single biggest problem was housing. I would just ask that your efforts coordinate with the county task force looking at trafficking. **Response:** We are part of that county effort.

5. **Question:** Your document shows that you want to harvest $1.3 million. Your estimate shows $978,000. What is the remaining amount of funding going to be used for?
   Response: At this point we just wanted to keep it at unallocated status until we can come up with something we can all use it for. These are our most pressing needs. We wanted to identify those.

6. **Question:** The additional EESP capacity--where is that going to be?
   Response: The way the EESP capacity works is that we have an open solicitation that we advertise on the county's website as well as the DMH website. We have potential providers that can apply if they meet requirements then we buy beds on an as needed basis. Right now we have been working with our Service Area management team, Service Area District Chiefs, to begin to identify potential EESP providers in the various service areas where we are looking for providers. But because of the way that this money flows we have a broad range of options that we can fill holes on the EESP. It is not legal entity type contractors.

7. **Question:** Some of this will include the SPA 6 needs as well?
   Response: Yes, as well as domestic violence. We have a domestic provider as well.

8. **Question:** Where do we stand with the partnership regarding the LA County educational schools? When you say funding I haven't heard anything about where these young people, especially the undocumented youth, are you going to be providing as a target population?
   Response: We currently do.

9. **Question:** Will be doing that in Antelope Valley?
   Response: Yes.

10. **Question:** I know in Carson they have a Drop In or a hot spot center with TAY. Is that a little bit different from what you are talking about here?
    Response: It is the same kind of concept. It is what we call a low demand, high tolerance setting where young people can go and sometimes hang out. Generally, they get basic services. They can get clean clothes, take a shower, get a meal, talk to someone about some needs you might have, get a referral. .

11. **Question:** The children's providers that have TAY FSP do not have adult Medi-Cal dollars in their contracts. For when the TAY turn 21 and they are in a children's clinic they can no longer stay at that FSP program. It is a real disruption of their treatment. Is there a way to put in some adult Medi-Cal dollars into the children's FSP providers so that they can continue to see their kids that are aging out?
    Response: We will take that back to our department leadership and let you know what's possible.

12. **Question:** With regard to flex funds, could the problem be that the changing of the teams when TAY is in service, being promised things, and then a new group comes in and does not follow through--it is happened to various youth in the TAY program. When a youth was promised a mattress he did not get it because another team said he did not qualify. Are the agencies aware that this is for flex funds and they could use them? They cannot just promise people stuff and that is why

they are not using their flex funds.

a. **Response:** In terms of the flex funds, I know the terminology is interesting about 'promising'. It is based on need. The FSP team partners with the youth. If there is family involved they do that. They decide what things that client needs. They also decide what resources the client already has and has access to get those needs met.

b. **Response:** The flex funds cannot be used for everything. It is just not possible. But also the FSP provider should be working with the client to determine what the needs are, what the client's assets are, what resources are available to come up with whatever it is.

c. **Response:** We buy mattresses all of the time. I sign every invoice that comes through, for the last 5 or 6 years, because these are manual invoices. . Different agencies buy different things. When an agency has an issue about something they can purchase or not they call or send us. That has been my or our experience.

13. **Question:** I understand what flex funds are for. The flex funds are not being used because teams are not following through.
    Response: That I cannot speak to. I would have to follow up on because you are talking about different team.

14. **Question:** I see that you presented an average. What is the high and low in use of flex funds for different agencies and 'county directly operated?'
    Response: The County 'directly operated' has a different process. They are not given a flex fund allocation because the county 'directly operated' generally pays for their staff. We fund a program including a staff, the services and supplies. But our 'directly operated' spend a lot less because of some of the barriers with county purchasing. In terms of percentage, each agency has a different amount. Our highest agency has almost $700,000 of flex funds. Our lowest agency has about $15,000. It is hard for us to do that for client because it is allocated at the agency level, not at the provider level.

15. **Question:** Have the various agencies that provide these services been consulted on this taking, as it were?
    Response: We have had some discussions, for at least the last year--we informed them that we were heading in this direction. Some agencies have been wanting to, and we have been allowing them, to shift their dollars to provide additional clinical services. This is an issue in terms of expending this money for a couple of fiscal years.

16. **Question:** Before making a decision to reallocate funding, can you provide some reasons for why the money is not being expended? Is there some kind of problem in either the referral process and eligibility criteria that make it difficult to expend all of the funding?
    Response: No, The agencies appear to be doing a very good job in getting benefits established for these folks in providing them with the resources they need to live in the community that way.

17. **Comment:** There are already funds to support the client. But on top of that there is a certain amount on top for 'flex'; called flex funds?
    Response: So within these FSP programs we know we have the dollars in the clinical part, most of it is Medi-Cal,

	you can pay for clinical services. For the other things that clients need to live and function independently in the community, Medi-Cal does not pay for, so to speak. These flex funds pay for that portion. It is specifically for the youth and young adults, 16-25, who are enrolled in the FSP program. 18. **Comment:** I think this is a 'no brainer' personally. It is flex money that's sitting there and not being used. It can be allocated to something good. The Antelope Valley has the highest percentage, per capita, of people with mental illness than any other area in the country--not the state--the country. 19. **Comment:** For the folks who deal with TAY. I am not trying to advocate for Obamacare but the issue is that the importance of the ACA is the 19-20 year old folks or even those folks who are the older party of TAY, 21-25; traditionally there has been no Medi-Cal aid for them to enroll in except for SSI or [inaudible] parents. We encourage you, even during this transition period; they are still enrolling people to Healthy Way LA until December 31st. At the end of December 31st, they get transitioned into Medi-Cal. We encourage you, even at this time, to enroll them, if they are eligible, into Healthy Way LA and then they will be in Medi-Cal on January 1st. It is very important because the problem with serving that population--they had no benefits that they were previously eligible for. Now they will. 20. **VOTING RESULTS:** SLT recommends reallocation of flex funds. 57% strongly support, 36% support, 7% support with some reservations. No one is blocking the recommendation.
SAAC Representation	A. Last month the SLT approved expanding the number of members from 50 to 60 on a temporary basis for this planning process. Because we have 5 current vacancies, plus the other 10, that goes from 50 to 60, we are recruiting 15 individuals who will then fulfill certain diversity targets that we set. The diversity targets are all in that handouts from last month's meeting. B. We are recruiting 15. Of those 15, we want to make sure we have a formal representative from the SAAC on the SLT. We already have two SAAC representatives from Service Area 6 and 8. We are targeting 6 more service area committee representatives. The other 9 are the 9 we will still be recruiting to be able to amplify the diversity in the group. The issue is how do we recruit representatives from the SAAC to make sure that we are part of this planning process? C. The Mental Health Services Act is supposed to be client and family driven. SAAC representation is really important because it is one of the few places that any consumer, parent, or family member can go and speak and be heard. Because of that, it is really important that those voices get from the SAAC to the SLT to be a part of what is going on. D. In the past, when we have done this in stakeholders we came up with a system whereby different SAACs were assigned to send consumer or family member or parent, etc. I am proposing that the 6 members of the various SAACs that are not being represented sufficiently yet at the SLT, that at least two of them be consumers and at least two of them be family or parent members so that those voices of our family and consumer driven system get heard at the SLT. E. **Comment:** That is the proposal. In terms of how to implement that I want to clarify two things. The first is that we have 15 slots that we are going to use to yield as much diversity as possible. If you look at last month's slides in your packets it tells you that we are targeting family members, consumers, etc. We will try to yield as much of that diversity of family members, consumers etc from the SAACs. We have 15 slots, 6 of which are for the SAACs, but for the other 9 we are also

	going to try to yield as much diversity from that. F. Comment: Second, in terms of process we were going to ask that the next step would be to go to the District Chief meeting (next week) and engage them in a discussion to see if we can yield as much of the diversity that Ruth refers to through the engagement with the district chiefs and then take it from there. G. Comment: I think each SAAC can be told what needs to be done. But I think each SAAC has to make its own determination–not have any classification imposed on it. The second Tuesday of each month the SAAC chairs and co-chairs meet with at least one or two Mental Health commission members. This can be put on the agenda. As a parent of a child born with mental health problems I do want parents to be treated as I want other siblings of the ill child to be treated. But I think that may be known to the co-chairs. But I think each SAAC needs to make its own decision. H. Comment: The shared interest here is to bring the SAAC representatives here, make sure they are constantly interacting with the SAACs, and that we yield as much diversity from the SAAC representatives that speak to family consumers, caregivers, etc. I. Comment: I Knowing group dynamics and depending on what the SAACs are doing, given voice and choice to consumers and parent is a daunting thing for some parents and consumes. Unless we encourage them and recommend to the SAAC--people who are already empowered do not need to be empowered. If you do not empower these people enough. You are not going to see them here.
MHSA Technical Needs Plan	*Bob Greenless, Deputy Director*, County of Los Angeles, Department of Mental Health ** Presentation included in the meeting packet.
Age Group Service Continuums: Adults and Older Adults	**Continuum of Care documents included in the meeting packet.
Age Group Continuum: Feedback from Small Tables.	1. Comment: Our group believes we need a 5th category: "systemic". Systemic issues occur in each age group. It includes issues such as finding housing, providing family supports, dealing with multiple disabilities, having specialty navigators in all Service Areas, needing to bridge trainings of peers at all age levels, culturally competent training and services at all age levels. For the adult continuum we are concerned with the lack of housing options. In FCCS, we want community integration support to check in as needed for graduates of FSP and wellness. We need an expansion of Promotoras in our 'older adult.' We have 187 service centers with mental health components and no connection with DMH. Navigators need more training on older adult issues and we need more navigators. We need older adult specialists and adult wellness centers, we need an education component across all age groups. Children service continuum: we need to address needs of indigent youth and families with no Medi-Cal because they tend to fall through the cracks. We need a training staff with some budget with sustainability of EBPs. A huge gap for kids in the middle: who are in the community and not in fostercare. If you are in foster care you tend to get services. If you are not, you tend to not get seconds. As far as the TAY continuum is concerned what leaped out at us is 20% of the people in the UCCs are TAY. Co-occurring and substance abuse services do not get addressed. We need people to take a look at the systemic issue, that county funds went away, were transformed to PEI, and therefore we have a very small amount of CSS outpatient services available for TAY.

2. **Comment:** Under adult services what resonated with us was the need to increase culturally sensitive suicide prevention and anti-stigma in API communities. APIs continue to have high rates of mental health issues and suicide. We like intensive community services as seen by FSP and want to see more of them. In terms of gaps and services for adults, there is a gap for dually diagnosed adults with developmental disabilities. Is there a way to create a continuum of services rather than siloing the services? Services should be more holistic. We should rethink Navigation system to be more robust and expansive to provide clients with everything he or she needs. For older adults wellness centers seemed to compete with existing older adults' centers, things like ADHCs and senior service centers. It might be better to use existing senior centers and integrate wellness services there to be more efficient. What is the justification for increasing staff for older adult suicide prevention team? What is that data to support this? We are not necessarily against it. We wanted to see a distinction between services for older adults who are on the young end of the spectrum versus the older end of the spectrum because their services and needs are different and similarly target sub groups within older adults based on their needs. For sedentary older adults it might be very different than for active older adults. What is a wellness center? For children: we like that there is more focus on PEI under the MHSA. We endorse using EBPs and full continuum of services including intensive services, not just PEIs. Gaps include a lack of mention of being culturally sensitive to Europe groups, or kids in the juvenile justice system, lack of mention for children with developmental disabilities, need more robust services in juvenile justice systems, need for more holistic services beyond just strict mental health treatment. For TAY: we liked the talk about supportive employment services. Gaps included: having wellness centers--focus more on integrating school based services or co locating services there. For kids who are in the juvenile justice systems or for teens transitioning into adulthood we need to develop services specific to them.

3. **Comment:** Things that stood out across for all groups were wellness, client run, peer providers, Promotoras, mentoring of older kids to younger kids, as well as other mentoring, younger seniors, helping out with older seniors, and service extenders. All age groups needed real employment with real jobs and using EBPs to get employment. What we need are EBPs that are culturally responsive. We also need housing. We can no longer do just Section 8 housing. We really need to expand the possibilities of housing and use some of the evidence based best practice models for providing supportive housing The other is reducing stigma both within DMH and the provider community where we have an incredible amount. We have more stigma within the provider community than we do in the general population. We also need to reduce stigma in the community and we need better branding of service names. It was pointed out in wellness centers are used to mean 6 different things in Los Angeles at this point. One of the big issues that came up was people who go through the EBPs. It is a 3-month practice. They get out of it but now they are on medication and there is a gap in helping them continue getting medication. For TAY: linkages to community colleges and getting community colleges--that is where a lot of TAY is going to show up. We need the equivalent of wellness centers for children, maybe like family centers where self-help is going on but there are resources where kids can meet other kids in a good environment. For the older adults: becoming more culturally competent.

4. **Comment:** On the 'adults' continuum everyone resonated strongly with the need for more housing, a better flow from FSP to FCSS, and on the gaps, employment was outlined as a big unmet need. We need a wellness recovery action plan. EBPs should be used throughout the continuum, not just in the wellness column. We need a better way of measuring outcomes, defining and measuring outcomes in community based services for adults. We need more help for caregivers of people living with dementia and those with foster children. For older adults: the word that resonated with us was

'neglect.' There is a great deal of overall neglect, not enough funding; not enough programs. We are neglecting the older group and APIs were pointed out as a very neglected group. In the older adult gap category, co-location of health services, especially with Cal Medi-Connect, more intensive services; have geriatricians working more with mental health providers. With dual diagnosis we need more help with co-morbidity, alcoholism and prescription drug misuse. For wellness without walls programs we have existing programs but need more from homebound seniors. For children, we need better collaboration with 211 and DCFS hotline so that where kids needs are identified; mental health services are more readily accessible. We need to have a system to ensure that psychosocial rehabilitation is used before psychosocial meds, more overlap and continuity for providers of foster youth where their care gets interrupted.

5. **Comment:** Our group felt that there needed to be more sensitivity training for cultural mental health issues, physical health issues across all age groups, and the idea of wellness fairs was thrown out for that, law enforcement training, utilizing consumers, if possible, to decrease stigma across all age groups, services for vets for TAY through older adults, specifically to their developmental needs since those may be different depending on what war they were in, normal development as well as normal development compounded by whatever trauma may have happened during wars. Similar to having a specific focal population of birth to 5 for children, our group felt we should develop a specific population for older adults. I think the term elderly was suggested. For those that are 80 years old and older, because natural supports may diminish tremendously, spouses may pass away, and their needs become more and more unique the older they get. Increase training on decreasing stigma, that's age specific, and including some vocational and non-vocational needs, increasing the outreach and education we do specific to the ACA, and increasing suicide prevention services with specific knowledge to developmental needs and helping people tease out the mental health issues that could look like physical health issues or the physical issues that could look like mental health issues to help our providers gear up for ACA.

6. **Comment:** In the interest of time, we had a lot of shared similarities, comments, and gaps with the other groups so I want to identify those that were not discussed. For the children: a gap was EBPs for non-PEI services. That really resonated with us. In terms of CSS, we need EBPs in that category. There is a need for 0-3 training. We thought that for the 0-5 need there tends to be a focus on ages 4-5 but not 0-3. Also, for those children that did not meet medical necessity there should be a focus, again, on some preventative approaches, namely best practices, promising practices, and community defined practices for underrepresented ethnic populations. Lastly, to provide mental health training to school based professionals where school based mental health services are not offered and probably to those professionals who are not familiar with mental health but are impacted by mental health problems. For TAY: it resonated with us that the department recognized the additional needs of our LGBTQ population and the need for additional peer support services as well as other underrepresented groups including hearing impaired and blind populations; also the importance of peer run TAY wellness centers and employment and housing. Lastly, continued support for TAY when they transition out of the TAY age group.

7. **Comment:** Everything that was shared resonated with our table as well. One of the things that resonated with us was the outreach and engagement component for all age groups; that they need training to do consistent outreach and engagement. It is not a one point in time, but it is a process and relationship in collaboration with agencies outside of the mental health world. For adults--what resonated with us was the specialized programs for specialized populations that were available; some of the gaps and issues where some of the criteria and the eligibility requirements can act as a barrier for some. For older adults: what resonated with us were the less services and programs for older adults as

	opposed to the other age groups. Some of the gaps and issues are due to some of the funding and coverage issues with Medicare and private insurance and the need for outreach navigators and all service areas specific to the older adult population. For children: what resonated was that the services in the schools tended to focus on prevention, services focusing on interventions at the schools was a gap, as well as children who were completing EBPs--where do they go afterwards for continued support and services? For TAY: What resonated with us was the pull between children's system of care for the early age TAY to the adult age group for the adult age TAY group.
Next Steps	A. You will receive an email with electronic copies of the material we will summarize all of the information from the tables and send it over to the SLT Ad Hoc committee and the SLT group. B. November 14th is the meeting of the SLT Ad Hoc group. We have a November 20th meeting of the SLT to which you all are invited, again 9:30AM to 4PM. C. Please study all of the documents so that on November 20th we will start with an orientation part 2 and then move over into the service area level discussions. You will receive information in November related to the service area level. **FEEDBACK** 1. **Question:** First we should take a look at the folks that were nominated and then take a look at their representation, right? Was that part of what you were talking about? a. **Response:** There were folks that were nominated and folks that could be nominated so we want to yield both.

[i] The public participated equally in table discussions. Therefore, we did not have a public comment section during this meeting.