COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, January 22, 2014 from 9:30 AM to 3:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To provide an update from the County of Los Angeles Department of Mental Health.
2. To obtain feedback on the Client Congress resolution on peer-based services.
3. To discuss the UREP committee's input for the 3-Year Program and Expenditure Plan.
4. To give a brief update about the SAAC for the 3-Year Program and Expenditure Plan.
5. To begin to prioritize the feedback on the Age Services Continuum and Gaps.
6. To discuss next steps.

MEETING NOTES

Department of Mental Health - Update	***Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health** A. Dr. Southard provided an update on current DMH partnerships. His update included information on SB 82, partnerships with the DA and law enforcement on substance abuse pre-booking diversion program, the developing partnership with SAPC on work related to the alcohol and drug Medicaid benefit. In addition, he discussed the implementation of the Health Neighborhood, the submission of a federal multijurisdictional grant with UCLA, Rand, the Health Department, and Public Health Department. Finally he highlighted the Department's efforts to look at how MHSA fits in with all other parts of the system of care. **FEEDBACK** 1. **Question:** What age group is the target for the expanded drug Medi-Cal money? If individuals are younger than 18 years of age are not included, what is the plan to include them in the future? **Response:** It is Medicaid benefit and has no age limits. In fact, for kids you should think of it as an EPSDT benefit, which has a higher enforcement standard than other parts of Medicaid. The main limits are related to consent and telling the truth about what is really going on. For example, if you listen to what people said then probation youth and foster youth would have lower rates of substance abuse than the general population. It is a recognition issue. We are trying to find appropriate and helpful screening tools that we can use to identify but not punish. 2. **Question:** In Boston they have a Recovery Learning Community. Would this be related to that? Will there be room for us to bring programs from the Alternatives conference and introduce those into this process? **Response:** No. We tried to approach the CHFFA which is the organization that distributes a portion of the SB 82 funding. They require that they be licensed facilities and licensed according to crisis residential program standards. We wanted to lower the costs and improve the efficacy by having different kinds of facilities and we were told, "no".

3. **Question:** You discussed new agencies, PEI funding and how in the future, the outcomes might be geared to neighborhood health centers. How will the EBPs allow for integration of agencies already doing the work and show that they are successful as neighborhood health centers?

   Response: These health neighborhoods are meant not just to provide health, mental health, and substance abuse services, they are meant to deal with what a particular community believes are the social determinants of health outcomes. Our hypothesis is not necessarily that the particular problem that is worked on matters as much as the community working together. That community empowerment by and of itself is a healing element for the community. Communities already have resources and work going on. We would require two things: The EBP defined however it is but also in alignment with the community plan.

4. **Question:** I see a lack of support of funding for our children and families in regards to early intervention. How come they are not being mentioned? We are trying to prevent them from becoming homeless, from being in our jails, and being on our streets every day without medication, without mental health services and being served. The question is, "where is that funding?" Why are we not seeing those children being mentioned? Why are we not seeing our parents being brought up as well? Why are we not seeing our funding coming back to us? Why are we dispersing this funding to other programs instead of early intervention?

   Response: I do not dispute that there is not enough. But I do dispute that it is not going there. As a matter of fact, we are investing heavily in early intervention in a variety of communities. We have a whole set of programs that are aimed specifically at early intervention and innovation for ethnic communities: Latino, API, African American, and the other Europe groups. But with what we have we are doing the best we can. This group is here really to have us say, "Are there ways we can do better and what are those ways?"

5. **Comment:** Since AB 3632 was dissolved, very few people know about the new education mental health related services. The need is very high.

   Response: We agree 3632 and what has not happened with that program is a problem for everybody. It is just not something that we have any role in anymore. We were cut out by the legislature in the funding of that process. So the money that we used to have to do those programs are given to the schools.

6. **Question:** Is there a projected timeline for the rollout for the substance abuse benefits?
   a. **Response:** The new benefits which are inpatient detox and residential services--the state submitted a state plan amendment in mid December to the federal Center for Medicaid and Medicare Services and they are waiting for that approval. Until they approve it the state will not reimburse anybody for those services. But legally, they are in effect.

   b. **Response:** The administration is pressing CMS to get an answer. During our next meeting are the details on the use 'one time' CSS to potentially fund implementation of the Laura's Law expansion that our work group developed as a consensus document and how we would do that. I am in the process of meeting with Board offices to see if they agree with the program and the funding idea for what is necessary that will not be covered by revenue. If those pieces fall into place then I will approach you with a specific inclusion in the 3 year plan about the use of 'one time CSS' over a two year period to cover some of the treatment costs associated with a Laura's Law expansion.

Resolution to Fund Peer-Based Services	Presenter: Ruth Hollman ***Resolution included in the SLT meeting packet.* **FEEDBACK** 1. **Question:** Why 7.5%? 2. **Question:** What is the definition of peer services from your perspective? 3. **Question:** Regarding diversity beyond the UREP communities – will there be monitoring to ensure inclusion of peer support groups particular to Gay and Lesbian groups, deaf, hard of hearing, blind, etc? How might you ensure that such inclusion comes about? 4. **Question:** Does your proposal include cultural competency and disparity elements for peers? 5. **Question:** Does either the Client Congress Advisory Board and/or the Department have a number or percentage for what the allocation is now? Does anybody have data on that? You are seeking to identify 7.5% but what is the baseline? 6. **Comment:** I like how you integrated and explained and defined peer services—"who is a lived experience person". I like the way you incorporated this paragraph. I liked that you incorporated the families, the peers, the parents and the caregivers. 7. **Question:** I am concerned about your statement about accountability and I wanted to know whether the accountability is an issue or whether it is the lack of true peer programs for county operated as well as county contracted services. 8. **Question:** What training do peer advocates receive? 9. **Question:** Did you give your definition of what peer services are supposed to be? The people that are going to administer the service need to know. 10. **Question:** If there is a means other than financial withhold or financial incentive that might be better suited to achieve your goals? 11. **Question:** If you have figured out what the operationalization of what this might be, who would check, how, what? What might that cost? 12. **Question:** I totally agree peers are needed because I have had so many people addicted say, "you did not live it, you do not understand." But how does money solve the problem? I am hearing a different disconnect. I am wondering specifically how the 7.5% money is going to solve the problem of the disconnect?

13. **Question:** Ruth and I were in a meeting yesterday where I believe there were 5 people that were either peers or family. And this question specifically was, "who has experience?" Only 2 of the 5 self identified. That should have been a safe place. So I attribute the money aspect to a deeper problem.

14. **Question:** I would appreciate some data on the ways that the current peer services reflect cultural competency, particularly addressing issues about linguistic barriers, how many groups are in different languages and what languages they are in. Also, how do they represent the different cultural views, for example, regarding support groups? In Asian cultures, the idea of sharing feelings openly is a big barrier.

15. **Question:** What technical support or training the agency is given in regards to getting their buy in to the benefits of peer services?

16. **Question:** I fully support the idea of 7.5% of funds for peer services. I was wondering how we would track that and have some accountability? You mentioned FSP. I know adult [inaudible] is working with wow workers and we are funding that component of it but also there seems to be instances where you have individuals in these positions that do not have any lived experience. Do not forget that we also need our veteran peers in trying to go forward with that too.

17. **Question:** What is the difference between a peer advocate and an individual with lived experience? We have programs where we have no peer advocates but 100% of the program are employees with lived experience. Experience is something that informs our skills. We do not hire people because of their experience. We hire people because of their skills. The lived experience just informs their skills. A difference between a peer advocate, which is someone is out, and you described very well what type of services they give and the differential between the employee with lived experienced which could be any of us.
    a. **Response:** The reason we chose 7.5% is because that was our best estimate of how much is supposed to be going to peer services. We did not want this to be controversial. We did not want it to be a money grab. The idea was to hold the people who are getting the money--both directly operated and contractors--to actually provide the services. They are getting the money for the peer services but it is not being implemented. The people overseeing the contract the same way that they have to make sure that everybody is licensed could also make sure that whoever is supervising also has peer services as opposed to just having hired somebody that they consider a peer with lived experience. It is no different than any other contract.

    b. **Response:** The definition is paragraph 2. Peer services are defined as delivered by someone who is known to the recipient as a peer. Peer services can only be provided by people who have personal lived experience being a parent, consumer, family member, or care giver. This is not something that the client congress has made up. This is evidence based best practices by SAMSHA.

    c. **Response:** In terms of skills and experience I do not know a single job that requires only skills. You need experience as well. As the governor said this morning, "there is no substitute for experience." The idea of the 7.5% is to not create any waves but to just make what was planned the last time, to put a little bit more teeth into it and to make people recognize that in implementing their programs they are supposed to be implementing these programs as well. Support is something that is needed.

18. **Question:** I am still confused about the definition. For example, for older adults there is a very strong evidence for peer counseling per say as a great tool but when you talked earlier it sounded like you did not like peers being hired as case managers?
    a. **Response:** No, not at all. This is not to say that peers should not be used as case managers, as peer counselors and anything else. This is just to say that we need to include peer services which are a very specific type of service that peers provide.

19. **Question:** You are putting peer counseling outside of the realm of peer services?
    a. **Response:** Peer counseling can be included if it is not case management. But case management is not peer services.

    b. **Response:** It is not case management. It is counseling.

    c. **Response:** If it is done with mutuality where together we come to solutions that is one thing. If it is done with, "this is what you need to do and this is how you do it and here are the resources for it" that is not considered peer services.

    d. **Response:** That is an important differentiation.

    e. **Response:** Regarding qualifications people have to have, the department spent a long time coming up with core competencies for peers for people to be trained in. I know that a report was put together with a lot of people working on it in order to get the peer to define it and whatever else. We have a number of peer training courses occurring. There are evidence based best practices in terms of intentional peer support and emotional CPR that also train people to do peer services. The certified peer specialists; some of them do peer services and some of them do case management and stuff. But the idea here is to get this very important evidence based best practice into our system that will help people change quicker and save us a tremendous amount of money.

    f. **Response:** Regarding the issues with support groups not being applicable to the Asian community, I would like to point out to you on page 2 of the references all of the articles on the effects of mutual support groups for Chinese people with schizophrenia and the groups are culturally competent to Chinese. If you go to OACA on page 62 dealing with the Japanese support groups and how they are different and how they do not--for example the largest Japanese support group for stopping alcoholism in Japan is not AA.. It is different strokes for different folks and they are being all over the world. We just need to get those models into our system.

20. **Question:** It sounds like they do not know that there are case managers that are peers. There are doctors that are peers. There are people in all lines in professions that have had a mental illness. That is what you are kind of talking about, are not you?
    Response: When a doctor is a peer a doctor has a particular set of ethical standards that they have to do. The doctor is not going to be able to take an hour and a half to talk about somebody about their experiences being a mental health consumer. The idea here is to have somebody who can provide that support. I think it is wonderful to have doctors, case managers, psychologists, social workers, and everyone else that are peers and there

	should be. What this is a particular service called "peer services." It is not unlike saying, "we need substance abuse services." It does not mean that somebody cannot have a substance abuse problem that they have overcome and is now a case manager. This is a particular sort of evidence based best practice and we are trying to get it integrated into our system. 21. **Comment:** As I listened the discussion, what came through for me most clearly was an opportunity to improve the quality of our peer support services that have been embedded within our FSP programs to, our wellness centers, our client run centers, and our innovation programs as well as our FCCS program. That is going to take time because I think there were different expectations set up in those programs and we have learned a lot since 2005-06. So I think there is an opportunity to inform the services and also to monitor and make sure that providers do have people with lived experience. I did hear you make a distinction though that the department has never made for a variety of reasons. But the distinction was that you are not including, for purposes of this discussion and proposal, staff professionals in the peer employee category. **Response:** Not the peer employee category, it is peer services. Peer services are a different type of service. It is not just anything peer is the same. It is a different type of service. So it is not an urgent care center. It is not a FSP. 22. **Comment:** I understand. Part of what is going to need more discussion--because I have heard the opposite. I have heard peers say 2 things: 1, "we want dedicated services for peers" in much of what you are describing right now. I have also heard peers wanting a career ladder that brings them into professional walls. **Response:** This is not saying that a career ladder is not important. It is just saying that we need to have this category of service that is different than other services and it would make our system a lot better.
UREP Committee Input 3-Year Program & Expenditure Plan	FEEDBACK 1. **Question:** I agree with a lot of the points made. Long Beach has been engaged in Healthy Neighborhoods for a while. Certainly, we have had a strong learning curve in being able to understand. I find, not only a difference in how people might define mental illness, but how people might define being healthy. I think that is a really important component that we have to look at. For some people being healthy might mean staying out of jail. I think we really have to take that into consideration. How are we addressing that particular issue? 2. **Comment:** I especially like your comments about EBPs on slide 15. One of my concerns is with the focus on EBPs that the consumer has to fit the EBP rather than the program fit the consumer. We need to look at promising practices that are also effective. 3. **Question:** We see a lack of support and being inclusive in regards to our parents, youth, and our own people--our peers and consumers. How are children and families being incorporated into the outcomes for UREP? 4. **Question:** How are we going to keep the data and how are we going to implement all of that into the community? The schools I do not see involved in this. Police are not included. I do not see the same involvement--the churches. 5. **Question:** There are 2 other access to care issues. One is the ongoing access to care for indigent clients that are

uninsured. I do not want that to be forgotten in light of the health care reform. The other one is a reality--not a belief system--but a reality of fear within the immigrant population of deportation. That is a huge barrier to access to care. If somebody accepts a government program there is a fear they will be seen, easily deported and separated from their families.

6. **Comment:** I do not think that the deaf and hard of hearing population will ever be included until they recognize our language.

7. **Comment:** We need to change UREP--the concept and include deafness/hard of hearing. No one appreciates more than I do the inclusion here. But for outsiders it is never going to happen until the name is on the table.

8. **Question:** Usually when it comes to access for consumers to mental health services and other physical services it is the doctor's determination to find out the clear symptoms that the clients are manifesting. Therefore it is important for the professionals to document properly and accurately, how they perceive and how they see these symptoms in the equivalency of the service that they should get.

9. **Question:** In terms of connecting people it is important to address the mentally ill coming out of jail in each service area. . That is part of cultural competency too: to really understand what they've been through.

10. **Question:** I am happy to see, as one of the 8 goals, to train staff, contractors, and all individuals involved with delivering the services. When this is taken on will those that are already employed or given services be trained? To me I see that in some areas they never were trained as to where they are servicing.

11. **Comment** Skill and experience are very important. Experience is very important, not just the knowledge.

12. **Comment:** Yesterday in our SAAC meeting it was brought up, "how can we talk about community when the geography is so big?" You have really given me a key that I am going to say, "How do we take all of this information in your minds back to the SAAC?" This is how we identify the underserved and the invisible people.
    a. **Response:** Recognition that each community and culture has different definitions for wellness is important. In developing programs and policy, there is not a cookie cutter approach. One of our innovation programs is the Integrated Service Management model that we have for the Samoan community. We created this design, where they needed to meet certain criteria such as severe mental illness, substance abuse, as well as either a co-occurring physical illness. It is an enrolled program like FSP. The Samoan community was not ready to access those services. There needs to be other things in it. We missed the mark there. The services need to be designed differently for what the community really needs rather than what we think they need.

    b. **Response:** Many EBPs are designed to study specific types of diagnoses and illnesses. They design practices based on evidence to treat particular disorders such as: anxiety disorder, mood disorder, major depression. We are not saying that in and of itself is bad. We question whether or not they can be adapted to serve our communities. In working with some of these developers we offered to pay for the translation of those materials but we did not get any response. When we take a look at EBPs we need to ensure that they are sustainable and

scalable for us but also are they culturally flexible? We may need to rely more on community EBPs as well as promising practices. The Department is not opposed to going beyond EBPs. We encourage those practices as well.

c. **Response:** Regarding the issue of children and access, I want to share a challenge we found in the Asian population. We have not been successful in getting children enrolled even though we have indigent funding and we get the older adults. We discovered that the staff that we hired in our community-based organizations did not have a clear understanding on what symptoms they should be looking for. We have recognized the fear that if a parent comes forward that their child will be taken away. We are working on flyers and educating our staff so that they can spot the symptoms and rephrase them in a non threatening way.

13. **Comment:** I think we are always going to favor our own. I am a community member. I am a voice of the community first and foremost. When I hear discussion about perhaps Boyle Heights as an ideal community there is about as many Black folk in Boyle Heights as there as in this room. Knowing that the historical trauma and the fact that no American system was designed to support non whites and those challenges that have affected our community if we are not intimately involved in that process then there will be a lack of commitment from our community. A healthy community cannot just be divided by east or west and most certainly cannot be designated to one population, we have to think above and beyond ourselves in order to be successful moving forward.

14. **Comment:** It is important that we ask for a paradigm shift in how we do business. That requires us to look at the community as the focal point. We need to connect to and organize the community. Ultimately, our clients that are served by this system go back to the community and to their families. We must develop a broader strategy that says, "Ok, when you come here you have a need. We are going to help you. But we are also going to link you back things in the community that will sustain you and support you. Dr. Southard already talked about the fact that government does not pay for everything. That requires us to look at things to strategize, to strengthen, to network, to connect to existing things that are going on and help communities if they need to develop work groups or groups that are self help groups within themselves. 'Healthy communities' must be defined by the community.

15. **Question:** Your presentation and recommendations are wonderful. I think they take cultural competency to a level where it starts to become embedded in our services. My question is, "What recommendations do you have to make your recommendations actionable?" What I mean by that specifically is, "How can we incorporate these recommendations concretely and specifically into our 3 Year Program and Expenditure Plan?"
    a. **Response:** That is our next step. We wanted to present this and realized that a lot of these things are very specific and some are very general. We need to operationalize things better and come up with some concrete recommendations.

    b. **Response:** I just wanted to add to that. Dennis said that we will come back and provide more concrete recommendations. But what we wanted to make sure is that we were all on the same page regarding, "What is culture?" and "What is cultural competency?" When we talk about cultural competency how important it is that our staff and efforts are truly culturally competent. What exactly does that mean? We need to be culturally competent so that we can be culturally sensitive. We need to be culturally sensitive so that we can provide

culturally relevant services. That is what our goal is.

16. **Comment**: I am listening to the presentation and hearing a lot of universal recommendations that apply not just to one cultural group but all cultural groups including the majority cultural group. Each culture, including the majority culture, actually needs to deal with each one of these recommendations.

17. **Comment:** I was an ad hoc member of the committee and I wanted to address one of the issues that came up around fear of immigrant services. If you look on page 4 under slide 7, number 6, this does again cut across various racial, ethnic communities. Homelessness is a sub-culture that really needs to be addressed. People are generationally homeless. We need to look at these things: disparities that cut across all racial, ethnic populations and all neighborhoods.

    Response: There are a lot of myths and misunderstandings that are out there now. But there are some things that people really need to be informed about. For example, for the immigrant population the issue of public charge and what that means; people were afraid to disclose a mental health need because they were worried that protective services will take their children or that they would be deported.

18. **Comment:** From all of the groups that we are talking about, Gay and Lesbian, Asian and so forth there is one specific group that lacks funding. Because of the lack of funding there is lack of services to access and that is the undocumented immigrant. If you are serving indigents that are undocumented you are not going to have any savings in your program. So to be fair, that all of savings that Medicaid expansion come back to the county and be redistributed to providers that are serving in high numbers of undocumented immigrants.

19. **Comment:** A really great documentation of what the different UREP groups have been talking about needs to be done for the state and they reference recommendations that are in line with what we are doing. So it is not individualized and we actually share a lot of things. If you have an idea or you know something that works that will do that send it forward to Rigo and our group so we can take that into account and see how it fits.

20. **Comment:** I have here on the table copies of the API, the Native American, the Latino, the African America, and the LGBT CRDP reports. These are state mandates. The mandates that came in place from 2012 are here and are a support from the UREP, the Cultural Competency Committee--the overall working on how the state of California wants mental health services to be delivered. These were community members giving their input in each of the 5 different reports that covered the needs that are considered to be unmet. I am asking individuals and the system to look at these items completely and thoroughly. My biggest position by being a community member is the thought of wellness, holistic approach, and a better life. What is happening as being the largest mental health jurisdiction in the nation we are responsible to make sure the nation follows through. If we do not get it together within a timely manner many individuals lose out. This is a time for willing partners. Right now what I am concerned about is that state of California reducing disparities. The CRDP that covers 5 populations that the information gathered reflects all of our hopes, wants, dreams, and desires for the movement

SAAC Discussions on 3-Year Program and Expenditure Plan	**SAAC 8** 1. Comment: In December, Debbie presented information on the 3 year plan. Our executive committee with our SAAC is meeting at the end of the month. We are going to coordinate and strategize in terms of how we want to give feedback to the 3 year plan through our SAAC. Our executive committee is meeting next week to get that organized and then our February SAAC will be definitely addressing those issues. Just to let you know for our January SAAC meeting we actually did a family engagement workshop to talk about how we can better engage family not only in the treatment process but in the SAAC process. I am very proud to say we have a lot of family engagement and attendance in our SAAC and we want to be able to maximize that more. **SAAC 2** 1. Comment: Dr. Innes-Gomberg is going to be coming out to our next meeting in February to talk about the 3 year plan. In our last meeting we had the mental health alternative court come out, the court liaison program, and speak about how to keep people from going to jail and getting treatment instead. Everyone agreed that we need to have more money devoted to that program and to other alternative courts to try and stop mentally ill people from being incarcerated. Also, we have established a committee to look into the criminal justice system in service area 2. **SAAC 5** 1. Comment: Debbie came out in November and gave us the presentation. In December, we had a combined meeting with the west side mental health network and essentially took December off. In January we had 2 blue ribbon planning committee meetings where we talked in the first meeting about the details and in the 2nd meeting we really focused on the big picture. 2. Comment: We kept reminding ourselves if we are falling into the details we need the data and we did not have that in front of us at the table so it was, "What is it in the big picture? What is our ideal?" What we have come up with is a really interesting framework of an ideal that we might go forward with. It is much more than just one conversation but a conversation that will be ongoing I hope at least quarterly, if not, monthly. 3. Comment: One of the things about this round is that there is not a lot of new money. So we need to figure out ways of using existing resources in better ways. One of the main things that we took away from Debbie's presentation was the lack of employment that over the years of data that we have with FSPs that only 2% of all the people who have ever been in FSPs have actually attained employment. 4. Comment: If we do not have flow going through the system it is not going to work. That is where we need to figure out better ways of doing flow and better ways of getting people connected. 5. Comment: Another idea is just to a lot more coordination between the various, different groups. In service area 5 we have the highest suicide rate amongst seniors for white males. Service area 5 has been a bellwether to begin. We had

the first school shootings and things like that and teen suicides. We want to work on that as well.

6. Comment: So as you can see from the details we have got a lot of back story that we are attempting--using this meeting, the SLT--we are teaching the back story to the people that are on the SAAC to our members. Then we are talking about our ideal system. What is happening in SAAC 5 is that we are starting discussions and learning how to talk to each other. We are discovering that we have a lot more to do in order to have deep conversations.

SAAC 6

1. Comment: In the spirit of transparency I am really excited because there is a transformation going on between or at least a strengthening of the communication between the SLT and the SAAC and again with many of the efforts here and many of the voices that have expressed the importance of doing that. Debbie presented to us in December as we gear up for the 3 year plan. That led to discussion on the data and outcomes that she presented to us and in particular what is unique to service area 6 in South LA.

2. Comment: This led again to a robust discussion in January as we identified service gaps and issues that are unique to our area but also some recommendations that we can put those forward and in writing to Dr. Gomberg. One of the questions that came up with our members was the issue of the definition of resilience. We talked about, "How does the DMH define resilience?" which may be at odds with how a consumer or community member defines resilience. The implications to those obviously are more on the issues of then, "How do you provide prevention and/or early intervention?"

SAAC 7

1. Comment: I have the TAY and Children report and also the adults and older adults. A TAY drop in center needed in service area 7 specifically in the underrepresented area of Huntington Park. This TAY center would provide peer advocate services as well and link to referrals. Our area remains with no resources, especially for TAY housing. We would like to see TAY housing in the Huntington Park area. The current area has rather restrictive criteria. We want to see wraparound services for DMH providers--can assist youth in job training, trade school placement, pursue a higher education etc.

2. Comment: TAY age youth in SPA 7 needs an emergency enhanced shelter for ages 16-24 to be located again at Huntington Park. It is detrimental to TAY and older adults to be placed in the general homeless population because of the high risk of being exploited. TAY to receive psychiatric hospitalization--they need a transition team from the hospital back to the community so they can hand off to the provider, educate family in the TAY and so forth, assist TAY women with children with wraparound services as in housing, job placement, parenting classes, support group etc. Juvenile Hall TAY: Parents desperately need support to navigate the system and Promatoras Salud Mental for TAY as well.

3. Comment: Subsidize housing options for undocumented individuals including those that are not in FSPs, create profiles of hope of videos of permanent Latinos in Spanish to be played on Latino TV, radio, and social media, create housing options for mental health consumers who may be still taking medication; so pretty much supportive housing. Service area 7 has a lot of homeless shelters and some Section 8 housing but there is nothing in between, empower client run

centers, recommend providers to include self help groups in discharge treatment plans and also outreach efforts to the API population especially Koreans and Chinese around Cerritos area.

4. Comment: For the children the recommendations was that we do not forget the community kids. We are doing a lot for the DCFS kids which is wonderful and needed. But if you forget the community kids then they end up in DCFS or probation.

SAAC 4

1. Comment: We did talk a lot about the underserved populations and tried to tease that out. Who are they? How can we outreach to them in our community? Like Service Area 6 we also talked about the program, gaps, and recommendations. For example, in regards to people with depression it was primarily treatment focused. Some of the gaps were adults in various ethnic communities need access to treatment for depression. We also came up with recommendations. We'll submit that in our report.

2. Comment: A couple of other areas that we covered are FSP needs, more long term housing and also in regards to FCCS funds for housing in terms of transitioning people to a lower level of care, and also the PEI program, we talked about some of the difficulties with that program. Too many clients rushed in and out of treatment or not culturally responsive to the needs of the different ethnic populations out there.

SAAC 3

1. Comment: We recently met to review the gaps and recommendations to serve the needs in our area. Some of the things we identified kind of connect with what was talked about today. In the older adult area they are being underserved. There is a lot of money allocated for treatment. Many felt that some of that money needs to be earmarked for outreach. There was talk of placing mental health workers in community centers. In one of our local cities, Alhambra, on their own the community center partnered with USC and has a mental health worker that comes out there and provides services two days out of the week.

2. Comment: With the FCCS program they are designed to be field capable. They are designed to treat a group that has difficulty accessing the clinics. We have no medication support in the home. We have no psychiatrists providing medication management. They are expected to come into the clinic and there are clients that cannot. The proposal was that a dedicated nurse practitioner be designed to each team and their job is to provide the medication management in the home.

3. Comment: Another area that was identified as far as the PEI is that ours are being stuck too long. They are getting 2 years maybe of a couple groups a week, weekly one on one psychotherapy--and then what do you do with them? We considered differentiation between specialized mental health care and non specialized mental health care. We have to find a better way to identify PEI clients that can be transitioned back to their primary care physicians if all they need is medication support or something like that or if they still even need medication support or needed it in the beginning.

	4. **Comment**: Across the board housing was a big issue. In our service area affordable housing is next to non existent. There is no subsidized housing to speak of anymore. One of the big problems is with the MHSA flex funds that are earmarked for housing. We used to be able to use it to help with furniture. We cannot do that anymore. It is only going to the homeless clients. We have to fix that. 5. **Comment**: To connect with the employment issues brought in on those numbers they were not very good. We focus on the TAY. Nobody is being employed. Part of that is not because of the system. It is because our economy has been transformed over the last several decades. There is no support from the broader economy. Until there is a jobs program and the tax structure changes, jobs are going to be a problem. They spoke of FSP clients not being employed. That is a group that needed 24/7 support. Do you expect them to be employed after a year or two of service? I do not think so unless something is done in the broader economy. 6. **Comment**: One of things that we did want to do we wanted to clarify some of the things that were said. The first thing related to housing money. One thing we needed to let everybody know is that unfortunately right now the MHSA regulations prohibit the use of rental subsidies in CSS programs that are not FSP and not outreach engagement. We are working to get that changed. Even if DHCS said yes to that tomorrow it would still take maybe close to a year. 7. **Comment**: Housing it is so critical. Each of the FSPs does have Client Supportive Services that can be used for housing. Transition age youth recently--the SLT voted recently--to transition some of those funds to services so there is less for TAY now. But I would really encourage you where housing is a struggle to use those funds strategically. That is a source and oftentimes providers do not use all of those funds. 8. **Comment:** Well what I heard the man from Service Area 3 say is that the FSP flex funds were given over to the housing department and now cannot use them. 9. **Comment:** [inaudible--off mic] He was a wellness client. The only way we could help him was to connect him with an FSP outreach and engagement even though he's still a wellness client. That was the only way we could get housing support. 10. **Comment:** What you just described was what Debbie was talking about. Some of the regulations at the state level prohibit us to put Client Supportive Service funds for housing into our FCCS and wellness center programs. For years now we have been trying to get that regulation changed. We have sent letters and it has not changed. It is a problem, we agree. We will keep working on that. 11. **Comment:** The California Mental Health Directors' Association (CMHDA) today in about an hour is talking with the legislature about this issue. It looks like there will be some movement on it. Finally, someone mentioned PEI and some clients in PEI for 2 years. We would be interested to know a little bit more about examples of that because if someone's receiving services and it is not a first break service, for example, but if they are receiving services in PEI for 2 years we need to understand why that is happening because that is not the intention of PEI.
Analyzing Input on Age Continuum	A. I want to explain what we have done with all of our input so we are clear of how we are going to be proceeding for today. First, you will see that we preserved the basic continuum that should be familiar to you now to see what kinds of programs, What we did was look at all of the different ideas and needs that you identified and realized that they fell

Feedback Framework	pretty nicely under not just prevention and early intervention but also some of your ideas had to do with improving access, service quality and in some cases community integration. Finally, some of your proposals had to do with cross systems and then finally infrastructure. On page 8 and on page 5. Infrastructure deals with training. How do we make sure we have the work force to deliver on the prevention service or the service that will increase access? Some of your recommendations cut across systems. B. This is now a grid that we have developed to make sure that we have captured all of the different ideas and proposals. When we get the perspectives from the SAACs we are going to try to see if this framework can help us organize the ideas. The worst thing we want to do is ask you for input and not have a way of capturing your input. This matrix is being used across all of the age groups to make sure we have placed your idea in the right location. C. When you gave input it was of 2 types: Sometimes you identified a need, for example, the lack of support for parents. And sometimes you gave us input in the form of a solution: "Provide a program that..." So to make the language consistent we moved everything into solution language. Whenever we saw a statement in the form of a need like the lack of a parent program we translated that into provide a program for parents. D. One of the difficulties we had was levels of abstraction. Sometimes you would mention an actual program or sometimes it was just a prevention program for parents. We realize we have some work to do there. We tried to shift all of this language into solution based language. E. You'll notice that in italics under each of these proposals, if you look at column A (Prevention), row 1 (access to services), then letter A you'll see "increase outreach and engagement services for parents" and right under that you'll see in italics that this has to do with potentially with expanding or restructuring existing programs. The age groups attempted, wherever relevant to know what it entails?. F. There were some proposals that were not that clear when they were written down. We did our best. But if you were the ones who proposed that today you'll have a chance to tell us what it meant.
Public Comments	1. **Comment**: Redundancy and vagueness in the choices provided in the Age Continuum Framework activity. 2. **Announcement**: Flyer: Clergy Academy Launching. RSVP by Jan 24 at the latest.