COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING

Wednesday, February 19, 2014 from 9:30 AM to 4:00 PM

St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. To deliberate and approve the recommended goals for each age group.
2. To listen to input and recommendations from additional stakeholders.
3. To identify common ground and divergence on key strategies to achieve goals for each age group.
4. To be clear about next steps.

MEETING NOTES

Meeting Opening	**Rigoberto Rodriguez, Facilitator** A. In August, the Mental Health Services Oversight and Accountability Commission (MHSOAC) issued the 3 Year Program and Expenditure Plan guidelines. The guidelines were skeletal and tried not to impose too many policies on communities. In September, the SLT, Service Area Advisory Committees (SAACs) and Department began a review of existing MHSA programs and services. To meet a July 1, 2014 implementation date for the 3 Year Program and Expenditure Plan, planning needs to be completed in March, 2014. We set an ambitious and aggressive timeline to complete this process in 5 months. B. Since this plan covers 3 years the SLT Ad Hoc recommended, and the SLT agreed, to focus year 1 priorities on the Mental Health Services Act (MHSA); making sure the various components are well structured and integrated. In years 2 and 3 we will focus on integration beyond just MHSA plans, looking at the broader public mental health system and other systems as well. That does not mean you cannot make recommendations beyond the first year. The focus is on making sure MHSA funded services meet the needs of the communities served. Stakeholder participation is critical to this process. C. Foundational knowledge of the group was developed and/or enhanced by ensuring everyone had a base level of information about MHSA to help inform decisions and recommendations.. From October thru February, input was gathered from SLT, Service Area Advisory Committees, and other stakeholder groups. During February and March, service gaps and recommendations were refined. The approach involved first reviewing existing MHSA funded services, including service information, focal populations served and outcomes. D. An SLT Ad Hoc group was formed, which integrates feedback, receives information, and makes initial recommendations to the SLT. E. Foundational knowledge was increased through a review of MHSA programs, the Act itself and existing regulations. The Department also conducted several briefings on the structure of the MHSA budget, spending trends and essential

	budget-related regulations. (i.e., At least 51% of the CSS expenditures must be from FSP or associated with FSP). F. MHSA service continuums developed by the MHSA Age Group leads were refined, prioritized based on goal and strategy identification. SAAC input was then incorporated into these plans. G. Between February 20th and March 15th the Ad Hoc will develop a proposal. They will review today's session and tighten up recommendations on the goals and strategies. They will propose a budget framework that will be sent to the EMT. The EMT will weigh in with their comments, which will be sent back to the SLT Ad Hoc group. The SLT will issue a final recommendation on the plan at the March 19, 2014 SLT meeting. H. Today we begin with a proposal and have one round of questions of understanding. During that round you can offer a friendly amendment. In a friendly amendment you can propose a word change. If the person proposing agrees, you can make the change. This is a very important moment because in the questions of clarification we are making sure we are on the same page. In the 2nd round we begin the deliberation. During the deliberation you can still offer friendly amendments. But in the end we have to issue a recommendation and test for agreement.
Age-Specific Categories, Goals and Strategies	***4 handouts outlining Categories, Goals, and Strategies were handed out.* A. Each age group lead provided a short five minute overview of the age group document.
Dr. Southard's Response to Age-Specific Categories, Goals, and Strategies.	***Marvin J. Southard, Director*, County of Los Angeles, Department of Mental Health** A. There is a new and changing context for our deliberations --the implementation of the Affordable Care Act (ACA) and what that means for everything we do. In California, ACA implementation moved some Medicaid services for mental health particularly for mild and moderate conditions, to the health plans. Those conditions are now the responsibility of the health plans. B. In California, we had a robust discussions with the health plans to determine how that interface will happen. We approach these discussions from the point of view of, "How do people get services in the way that they need to get services with as little disruption as possible in the referral process?" In the past we used the characterization of tier 1, 2, and 3? Tier 1 are people disabled by their mental illness. Tier 3 are people who can be managed by their primary care physician for their medication services. Tier 2 is in between, including those early in the course of a mental illness. C. Statewide we are debating where the boundary between specialty and non-specialty mental health should be. Specialty mental health is our responsibility. Non-specialty mental health is the responsibility of the health plans. Some, mostly in northern California, want the boundary to be as close to tier 1 as possible. Others, especially us in Southern California, want the boundary to be as low in tier 2 as possible so that we encompass the vast majority of people in our system and have a greater continuity of care. D. In the long run, the Department will probably run our PEI services with more focus on prevention and less early intervention. Some things we did as early intervention will become the responsibility of the health plans in all age

	groups. It is an issue for all age groups about how that plays out. There is no final decision on this. It is a policy issue that is very live.
Age-Specific Goals	**FEEDBACK** 1. **Question:** There is a perception that information from the SAAC meetings is not really being used, that the department does not care, and that the decisions area already made. I would like clarification for all of us. 2. **Question:** I am concerned about the onsite school based integrated mental health services (goal 5). It excludes kids attending early Head Start, Head Start, and State child development centers where a great number of kids are being expelled because of behavior. 3. **Question:** Cultural competency across all age groups: This seems too narrow. Is it just talking about increase linguistic capability of staff? Creating a geographically based wellness center? UREP had a robust discussion where the group agrees it goes beyond language. It talks about the belief systems, and understanding the cultural gaps that go on within the age groups of the community. This includes understanding their belief systems, their next generation of kids, and history. It is more than language. How will we integrate different belief systems and be culturally respectful of those understandings? My amendment is that it should be a more robust discussion. 4. **Question:** About cultural specific services for underrepresented ethnic and cultural groups, I wanted to clarify under adult goal 1, number 3, can Lesbian Gay, Bisexual, Transgender (LGBT) be specifically listed. Also its parallel with older adults under 'access to services.' In addition, there are folks who are HIV positive and not necessarily within the HIV/Aids or the LGBT communities. More folks who are aging as a result of HIV/Aids becoming a chronic disease. Those particular areas need clarification. 5. **Question:** Across the board there is no focus or attention to co-occurring disorders, a key and critical component that seems to have been overlooked. a. **Response:** Do we need to add more robust strategies or is it about modifying the goals? b. **Response:** There are implications on both ends. The use of psychoactive substances is so woven into the addressing of mental health issues that it needs to be a goal. Reduction of psychoactive substance use needs to be a goal. Strategies to reduce the frequency of co-occurring circumstances also need to be dealt with. c. **Response:** From your perspective it rises to the level of a goal? d. **Response:** Yes. 6. **Question:** Across age groups, I want to include physical disabilities and challenges. 7. **Question:** I second your motion about specifying underrepresented cultural groups. Additionally, most deaf people do

not consider themselves people with physical disabilities. Can we include that separately?

8. **Question:** The other recommendation is to include family for 'adults'; there is very little about how to include the family on the treatment team and interact with the family for support.
    a. **Response:** On the 2nd item, including the family in the treatment team seems to be a strategy. We do have a goal around one of the groups for incorporating peers and families. Does that make sense?

    b. **Response:** It is really important to do peers and families. There is nothing exclusively talking about family support as part of the process.

9. **Question:** Under adult, I do not see a goal for reducing hospitalization.

10. **Question:** This is for all age groups. I want to see it clearly stated that the smaller ethnic groups will receive more attention this round. There is a gap and they have not been included in many programs.

11. **Question:** Across age groups, I did not see a spirituality component as a service to be provided to any of the age groups or the family.

12. **Dr. Southard's Question:** By way of a technical clarification, for adults, the goal of increasing employment opportunities within the mental health system for peers might be doubling as a goal in the peer and family roles section. Can this be consolidated? Under employment goal 5 is increase employment opportunities in the mental health system for peers. In peer and family roles there was "increasing peer involvement in the mental health system" with a bunch of strategies that were going to be discussed later. It just might be more elegant to address them in one place rather than in two.

13. **Comment:** Regarding cultural competency, we discussed more than language--the culture of the people, what their beliefs are. We also discussed ways that stigma keeps people from getting services and that in some families that if somebody is mentally ill they do not want it known publically.

14. **Question:** A point of clarification, in older adults, access to services, number 5 it discusses "wellness centers without walls." Goal number 2 and number 1 say "provide older adult specialists at adult wellness centers." These seem like 2 different things. The improved transition to a proper level of care (goal 2) by improving older adult specialists to me seems like something we have done for awhile; providing specialists for the clinics and educating adult navigators about older adult things. Is the access to service for people who do not have services?
    a. **Response:** We distinguished between a goal which is more of a desired result, a condition of well-being that we are striving for of some kind versus a strategy which is, "How do we get there?" A strategy refers to programs like FSP, FCCS, a service modality such as individual or group therapy, and/or an actual intervention like an EBP. A goal is broader and something we are striving toward. The also see a set of columns on the right hand side next to each of the strategies that maps out if the services are new or existing.

b. **Response:** "Are these two different strategies to achieve the same goal?"

c. **Response:** One through four are strategies that seek to achieve goal 2.

d. **Response:** Therefore, we are looking at two different groups. Goal 1 is to expand for those who do not have services and expand services for them. Goal 2 is for people in the system and transitioned to different levels of care.

15. **Question:** There is not enough focus on the parents. When they have language barriers, they use the children to interpret.
    Response: Point well taken. In some communities the parents have a different function. For all age groups--when we use underrepresented groups, is it ok if we specifically include LGBT, deaf and hard of hearing and physical disabilities? We want to be specific about the groups we are targeting. With older adults is that ok as a friendly amendment?

    Response: [All age group leads approved off microphone].

16. **Question:** We have the 4 major ethnic groups that we keep talking about but we also have the smaller ethnic groups classified under the White category. These groups need more attention.
    a. **Response:** Let me ask for UREP groups, my understanding is that the smaller ethnic groups that we see in each of the larger categories, was included under the concept of underrepresented ethnic populations. That we have not done enough to address smaller ethnic groups is a point well taken. The concept includes smaller ethnic groups, correct?

    b. **Response:** That is right. I am asking for a little more emphasis for those ethnic groups.

    c. **Response:** We will write down that, "strategies should reflect the importance of addressing needs of smaller ethnic populations."

17. **Comment:** Part of the issue is that there is a data limitation on our part right in terms of selecting ethnic specific information that fall under White. My understanding is that when we adopt items, our electronic health record, hopefully we have the ability to collect at that level but I am not sure.
    Response: Rather than a new goal, we want to ensure that the strategies under the reduction of disparities address directly the needs of the smaller ethnic populations.

18. **Question:** Age group leads, how do you see the co-occurring piece? It is not mentioned explicitly in the goals. Any reflections on that?

19. **Comment:** You asked if I felt this should be applied across the age group categories and I do. The proviso is that the

strategies employed in different age groups would be different. For example have more prevention with youth and early intervention with TAY and on down the line.

20. **Comment:** Any reflections from the age groups? Was that discussed in your groups? If you do not have comments no worries. We will then have to tackle that together around how this rises to a goal level or not, and if so, how do we state the goal? Then that enables us to line up strategies around that.

21. **Question:** On the funding section I see there are the A, B, and C's. Are we going to talk about the funding now or some other time?
    Response: The funding is related to the strategies. We will discuss that in the afternoon.

22. **Question:** I propose that we put a co-occurring goal in each of the 4 age groups.
    Response: We will name it right now. When we get into the decision-making we will include that.

    Response: With the co-occurring disorders; we will put a placeholder for now. Then after the stakeholder input I will convene the age group leads and include it across all age groups.

23. **Question:** How many people remember the peer services resolution from last time? People services are evidence based best practices. It is a type of service not unlike FSP's or DBT.
    Response: The proposal is to devote 7.5% of the MHSA budget to peer services. We chose that number because that is what was originally written into the plan but it has not been implemented. This is a way of keeping the plan true to this evidence based best practice. Does anyone have any questions about the proposal?

24. **Question:** Do you have a dollar amount?
    Response: It is 7.5%. I believe it works out to around $30 million. I tried to get a dollar amount from those that know the budget better. That was the best that I could come up with.

25. **Question:** Would that be included in the amount of funds that are already allocated for peer services? There are already some significant amounts already.
    Response: This is not new money. This is what was written into the plan the first time around but has not happened where people in FSP's are supposed to have a peer providing peer services to them and yet many FSP's are not providing those services. They may have a peer employed on their team but that peer is not doing peer services and often is not even known to the people they are serving as a peer. The idea is to get peer services, which reduces hospitalization by 50%, the medication that people need to take, increase employment. They are not being implemented because we have not named them as peer services.

26. **Question:** In your $30 million is it for all age groups?
    a. **Response:** All age groups.

	b. **Response:** In my experience we may have at times overestimated the amount of dollars--not the amount of service needed in the older adult realm; that is because there is a limit to the amount that people can get paid and keep their straight social security benefits. We should have them calculate that. I do not think we are lacking the services. c. **Response:** The concept was to take the budget and pick out all of the peer services that were planned in it last time. That would be the wellness centers, the client run centers, and the FSP's having peer providers. What is different is that the people are not providing peer services.
Vote on Goals	**1. Proposal: Adopt the proposed goals for all age groups, including the goal for co-occurring disorders.** **2. Vote Results:** **a. 17 Strongly Agree** **b. 15 Agree** **c. 1 Agree with Reservations**
Stakeholder Recommendations	**Romalis Taylor (UREP Presentation)** A. It is very important when looking at this change that we talk about and open up and broaden the definition of what outreach and engagement means from a culturally respectful manner. Some of the disparities that go on in the system are due to the cultural barriers within the communities. B. We need to understand the people and how they think and how to help them transition into what we call the American mindset of how we help each other out. C. Cultural competency for all communities is about understanding who they are and where they are whether they be black, blue, green, or purple it. You have to engage people where they are and what it means for them. D. We want to make sure that all the different groups are addressed. We discussed a systemic change that we want to see. The gap that we see is in the front end and in the back end of the system. How do we help people so that they do not come back into the system? How do we give the community support so they can help themselves and when they cannot they know where to go and how to get it? That is important. E. There were some very good recommendations made when we met on all these different groups. We wanted to make sure that cultural touch is there and go beyond just language. **FEEDBACK** 1. **Comment:** In the minutes there were probably about 15 different questions and/or comments related to Ruth's presentation last month, some were answered and some were not. I wanted all of you to recall that you asked questions and made comments that may have not been addressed here in the last 10 minutes that might need to be.

Response: There are also questions about UREP last time that are in the meeting notes so review those.

Sylvia Drew Ivie, Commission on Children and Families' Presentation
***The Commission documents were included in the SLT meeting packet.*

A. I will summarize the commission's reflections on their priority concerns, which were based on the letter sent out in May 2013, key studies the Commission is reviewing in regards to Children and TAY, and finally the age group documents from the Ad Hoc group.

B. We are supportive of the goals that the Ad Hoc committee presented for TAY and Children. The issue is how to reach those goals? Some of the strategies are not exactly a bulls-eye from our perspective. We have concerns based on the studies shared with you.

C. For children, we are worried about the 0-5 population because 42% of the kids coming into the DCFS system are 0-5. We have got to work with that group. The 'what' is to work with them on using our best EBP's, using EBSDT, working more with faith based centers, WIC centers, wellness centers, and best start communities.

D. We want to work with the children of parenting teens. A USC study on parenting teens says that 40% of teen mothers have previously been reported to DCFS. This is a high-risk group. Out of f those 40%, 20% were victims of abuse and neglect. If they were victims of abuse and neglect the chances of their children being abused are twice as high as the children of teen mothers who are not victims of abuse and neglect. We have 300 teen parents in DCFS right now. We expect that to double with kids who are staying in the system under AB 12. They can now stay until they are 21.

E. The third area of focus for children is the community kids who are not eligible for EPSDT. In our Ad Hoc group it was mentioned that the people in the schools have to choose between children for services in terms of whether they have EPSDT or not. We want the children from the community to stay in the community and get the care that they need. The commission wants to keep people out of the system because our numbers are going up and we cannot service those numbers.

F. With respect to TAY, again parenting teens to get help. We are very happy to see crossover being continued. A USC study on crossover kids who are part of both probation and DCFS face numerous issues. They go to jail, are drug addicted, and their lives are really in the worst possible shape for young people.

G. The kids exiting probation and DCFS need more after care services. We want to catch them if we can on the front end but if we do not catch them on the front end there are a lot of things that we can do when they step out of our county services. We need to do what has been proposed in terms of more drop in centers, wellness centers, collaboration with faith based entities in the community, substance abuse support, and help for kids who are involved in sex trafficking.

H. I am delighted that the Ad Hoc group added sex trafficking as a target strategy. This group can be helped in 4 categories;

housing, supportive services for mothers who fight with their daughters, runaway kids and the children who have been detained, and victims of sexual abuse at home. These four groups are at risk of being caught in sex trafficking.

I. Kids who are on probation but not in the system are a high risk group that we can help and keep out of going into formal probation. Teens who are not eligible for EPSDT just as the children are out there, en masse, in the schools; we find them in the teen clinics and the community health clinics. Let's identify their mental health needs in health care settings, in school settings, and help them to keep from coming into the system.

FEEDBACK

1. **Question:** Define crossover kids?
   Response: Crossover kids are kids who cross from DCFS into the criminal justice system. They get out and exit DCFS and then they are picked up for crimes.

2. **Question:** On this document you mentioned that children were not up and running at the outset of our MHSA implementation as they were for adults and older adults. I want to clarify that there was FSP for children and TAY up and running.
   a. **Response:** No, we are not saying there were zero. But I think the process of preparation to deal with prevention for very young families is an ongoing. Would you agree with that?

   b. **Response:** Yes. I am clarifying the funding. There is PEI funding but there was also community services funding. In the community services funding there was FSP funding significant for children and TAY.

3. **Question:** What do you have in mind for kids without EPSDT?
   a. **Response:** Undocumented children who are not covered by any program who need the same services as the kids eligible for Medi-Cal.

   b. **Response:** That is good because non-EPSDT would include all of those kids who have private insurance. They do not have EPSDT. I hoped your focus was on the undocumented and not anybody with EPSDT.

   c. **Response:** No. It is undocumented.

4. **Question:** Your focus on the children with the sex trafficking; what about all the children in domestic violent homes, who are married at a younger age and being sexually abused by their boyfriends, husbands, whatever, their early partner, who are going through a tremendous amount of pressure and issues, mentally, physically, and everything and they could be also at the same mothers?
   a. **Response:** I did mention that the families where the children who have been sexually abused are a high risk child for future involvement in the sex trade.

b. **Response:** I am thinking beyond the sex trade, about those who face a lot of domestic violence and are abused at home. They do not have to be traded outside. There are issues at home.

c. **Response:** Right. Some of those children are in that 42% who are coming in who are in the 0-5 group. We are emphasizing 0-5., teen parents and breaking the cycle.

d. **Response:** This program will cover their services?

e. **Response:** Yes.

f. **Response:** With or without sexual abuse?

g. **Response:** With or without.

5. **Question:** I want to see a strong effort from DCFS -- outreaching and educating the general public about what is abuse and what is not abuse. There has been no concerted, across the board, departmental effort to let people know; especially when you go to underrepresented communities. My thing is prevention. A partnership with First 5 and yourselves around this kind of education is important.
   Response: Best Start and the wellness centers are a good place for that kind of dialogue and community education.

TJ Hill (ACHSA Presentation)
****The ACHSA Proposal and Presentation was included in the SLT Meeting packet.*

ACHSA Proposal FEEDBACK

1. **Question:** I love the idea of having a place that somebody can get just medication and have other peer services going on. There were supposed to places where all these peer services happened. Instead they became outpatient clinics. What keeps us from changing this into what we already have?
   a. **Response:** The strategy is to provide actual funding for those services that are needed and what wellness centers are providing-- allowing for more of those intended wellness centers to serve as a mid-level space that bridges recovery into wellness.

   b. **Response:** Will this happen at existing wellness centers or are you seeing all new centers setting up?

   c. **Response:** That something farther down, I do not think it is conceptualized yet.

2. **Comment:** The adult system of care worked on a concept called clinic redesign, which is inline with ideas that you expressed today. Second, I want to throw out the idea of a peer run wellness center, which embodies a lot of what you

discussed.

3. **Question:** I have a question about what Dr. Southard said earlier that with the health plans who will treat those with the more mild and moderate impairment. What would be the pros and cons in your proposal about keeping this population within specialty mental health versus having them transition into healthcare plans with kind of a supportive package in that way?

   Response: We envision this as a transition to those health plans. At this point the jump across the gap is too large. Stated in the proposal, one of the things observed was a lot of people trying to make that bridge end up recycling back into our system but at the highest levels of care. So they are coming back into our system at FSP.

Debbie Innes-Gomberg, Los Angeles County Department of Mental Health
SAAC Feedback Presentation.
***SAAC Summary Document included in SLT meeting packet.*

A. Part of this planning process is incorporating the best of CSS and PEI. What that resulted in is meaningful feedback and participation of the SAACs. This required making sure SAACs were as informed about the MHSA, the programs in their service area, and any outcomes that those programs achieved.

B. We put together a 42-page document, which the SLT, the service area District Chiefs and SAAC Chairs received in October. I presented that information, took questions, and then the service area District Chiefs and SAAC co-chairs engaged in a planning process. We gave them a template that the SAACs were incredibly creative around using, going beyond what was asked of them.

C. The job now is to take the feedback from the SAACs and incorporate it into the work of the Ad Hoc committee and the SLT. The document is my best attempt at summarizing the identified gaps and the recommendations. First I categorized the recommendations and the gaps by age group and then by MHSA component. You will see some overlap there and that is intentional.

D. First I want highlight some of the things that I think are important for you to take a look at by age group. For SAAC 6, under children, new programs and services, we need culturally relevant school based programs for children ages 4-12. As it relates to children and PEI, many SAACs discussed the 0-5 population.

E. A SAAC recommended increased identification of trauma before impairment and functioning occurs. That is consistent with the Children's Commission recommendation. There is a recommendation to implement family resource centers. We need to further define what a family resource center is, whether it is a prevention or early intervention program or CSS program.

F. Two SAACs recommended developing infant development screening and linkage services.

	G. Under focal populations, SAACs emphasized the 0-5 population. One of the goals of programs and services was decreasing juvenile hall involvement of children enrolled in FSP programs. One SAAC looked at the days in juvenile hall and the number of TAY and children in juvenile hall and noted that work is needed in that area, either around data quality or around practices that are effective in reducing juvenile hall involvement in clients that are enrolled in FSP programs. H. In TAY some new programs and services I want to highlight include a recommendation from SAAC 3 on emotion regulation skills training and schools. Another is, "identifying treatment models that work well with pregnant teens." Increase countywide housing, employment, education, and resource division services, and funding to TAY to promote scholarships, college bound programs, attainment of certifications, degrees, or diplomas needed for employment. In this program, they talked about providing CSS dollars to pay for financial aid, college applications, registration fees, SAT prep courses, etc. This program is consistent with interesting work occurring in Alameda County that is funded under WET and is consistent with TAY transition goals. I. SAAC service expansion recommendations across the age groups focused on work or housing needs. There was an emphasis on employment services and housing services across CSS and PEI. J. For adult, SAACs discussed leveraging MHSA funding to permanently house more low income and GR income only adults with mental illness. Some SAACs gave very specific recommendations in this area. They discussed wellness centers utilizing life coaches to increase community engagement and life skills and wellness and client run centers, as a suggestion from SAAC 4. K. For Older Adults one SAAC recommended field-based older adult outreach teams that need training to better discern or screen clients for mental health and health concerns. This is another theme that came out in several of the age groups. That is the importance of maybe refining our outreach and engagement and thinking about it very specifically in specific communities. In other words, "Who do want to outreach and engage to and how do we want to do that?" This also came up as it related to UREP several times. L. In terms of service expansion, creating older adult wellness centers: One service area called it “wellness centers without walls.” It talked about suicide prevention services, particularly for older adults, building collaborative with nontraditional organizations that serve older adults to reduce the stigma of mental health issues for the older adult population. M. By component, WET; recruiting more Spanish speaking clinicians. There were many training recommendations including recommendations for training symposiums at service area 8 community colleges. N. There are numerous recommendations under PEI. Two I want to highlight: outreach and engagement to teen victims of domestic violence and promote protective factors for clients who are at risk of becoming victims of teen domestic violence and presumably they would become mentally ill.

O. Then there is a general category that includes "establishing a coalition of housing providers." "Incorporate CRDP" which is the CA Reducing Disparities Project, recommendations into use of EBP's and then substance use needs to be addressed needed to be added to outcomes.

P. In addition, SAAC 7's recommendations were not included. I received them yesterday. They recommended promotoras to outreach to monolingual Spanish speaking families, the use of the Latino media to promote services to Latinos to find stigma and improve access, giving providers more flexibility on the financial buckets so they can create flow between programs, and allowing schools to supply the match and bill EPSDT directly to expand services. There was a focus on indigent funding for foreign born, undocumented kids, parents, and grandparents. Other recommendations were: using tele-psychiatry when possible to avoid long commutes for disabled seniors and then co-locating services at senior centers.

MARIA FUNK – HOUSING
***Presentation included in SLT meeting packet.*

FEEDBACK

1. **Question:** If we were to approve these amounts where would that money come from?
    a. **Response:** Right now the money comes out of CSS. The two alternatives are wrapping it into ongoing funding through CSS, which is preferred. The second option is one-time money that may be available to fund it now.

    b. **Response:** We are going to spend $120,000 per unit thereabouts. Is it cheaper to buy houses? If we just provided the supportive services as opposed to building we could house many more of the 20,000 people who are homeless rather than just housing a few hundred.

2. **Question:** With the housing that is already there, how do providers know what housing is available and what kind of waiting lists there are and how do even family members find out housing is available?
    Response: If you look at the DMH website under services and then housing there is a whole page that is constantly updated when there are vacancies in the projects. There is a process when they come through the department where we certify our clients. We give the developers the referrals to fill their units. We try to make sure that this resource is preserved for the clients and try to make sure people are aware when the projects are opening. We have a network of case managers and housing liaisons and specialists and all of that that come to our meetings and we sent notices out every single time. We are open to other ideas.

3. **Question:** My question is on the housing trust fund program. The proposal is to make a one time allocation of $20 million. Does that mean that the providers who are selected will have a multiyear contract?
    Response: It would be similar to the contracts we currently have. If there is one time money available now like there was with the original plan, than it would be a five year contract with a onetime allocation.

4. **Question:** We have an older adult population that is increasing in terms of homelessness that requires a lot of wraparound services. It is important that we continue to evaluate the allocation toward that age group. The second concern is the multiple challenges of getting people into housing but also keeping people in housing. Services that are directed in that area also need to be allocated.
   Response: We have many projects targeting older adults. We have funding principles that the housing advisory board uses to make recommendations on which projects to fund. One is age group distribution and service area distribution, etc. In those discussions that age groups like older adults and TAY are often prioritized because of that principle.

5. **Question:** I want to make sure that whatever you are doing is culturally relevant and that the disparities that are out there are being dealt with for all age groups.

6. **Question:** The MHSA housing program goes through California Housing Finance Agency (CalHFA). I assume that CalFHA is part of the rationale to continue to ask for funds. Can you briefly talk about the experience with CalHFA?
   Response: When we allocate money to the MHSA housing program, we assign the money to CALHFA. They are a statewide organization with expertise in administering housing funds for the development of housing. It is an expertise that we in the DMH really do not have so we leverage and rely upon that. A lot of these deals also, at least before the recession happened, had funding from CalHFA. They help make sure deals are viable. They do the fiscal monitoring over the years. These projects that we are investing in are for 15-20 years but often it is actually 55 years of commitment to this project and population because their other funding requires it. It is a long term investment that ensures that the units are set aside for the intended population.

7. **Question:** If you are able to leverage as much as you do and we have a demand for housing -why are we not considering a larger investment?
   Response: If that is your recommendation we will go with that. We were trying to be realistic knowing that there many requests. Even though we can fund up to $120,000 per unit, which can be no more than a third of the cost of the unit many times we invest a lot less than that. A lot of times we are not investing that much. The last several expressions of interest--we prioritize projects that ask for a lot less money than the full amount allowed. We try to maximize the leveraging.

8. **Question:** Did you say something about outreach or is it part of your project?

9. **Question:** Outreach to people who are homeless or outreach to developers?
   a. **Response:** Outreach to the communities to know that you have those facilities for your homeless. And how culturally relevant is your outreach?

   b. **Response:** Whenever a new project starts to be developed we, along with the age group leads and the Service Areas look for a service partner in the community to work with. We make sure that the community is aware as

	it is closer to the time that the project is opening so they can help their clients apply for the units and not miss the opportunity. When you are developing a project you and the developers do outreach to your community and try to gain community support and political support for the project or often the project will not go anywhere if you do not have that. c. **Response:** I would like that to be also very culturally relevant. d. **Response:** In terms of cost effectiveness we get the incredible leverage by connecting to the larger system for affordable housing production primarily low income housing tax credits. Some may say maybe there is a way to do this cheaper, but you would not get the leverage because that whole system is built to create affordable housing. We are targeting a very vulnerable group of individuals with this program. Like the SAMHSA said it really needs stable, safe, secure housing and that is linked to onsite supportive services. It is really crucial that we are building at a scale where we can have service coordinators and case managers as well as other support professionals onsite. Many studies show that we actually save tremendous amounts of money when we help people connect to permanent supportive housing because when they are on the streets they are using emergency rooms, they are sadly cycling through jails, and actually it costs about 50% as much as leaving folks on the street when we put them into housing. It is very cost effective model.
Public Comments	1. **Comment:** Recovery Learning Communities in Massachusetts. Advocacy to develop a similar program in Los Angeles County 2. **Question:** As you know there are a lot of young girls and boys, who are lonely, especially in mental illness, and they go on the internet and start looking for friendships and there are a lot of predators in that. Is there any way we can get some education about girls being attacked by predators on the internet. We should have that for girls with mental disabilities. 3. **Question:** When you looked at sex trafficking as a priority is this part of the work that you all are doing in terms of how some girls or boys are more vulnerable, particular to that? **Response:** In terms of strategies regarding sex trafficking I am sure that we are going to encompass all areas. 4. **Question:** Right in your backyard by [inaudible] there are a lot of homeless people. You see more everyday, especially on the weekend.
Common Ground on Age-Group Strategies	***TAY AGE LEAD REPORT*** A. For goal 1 under the category of engagement, enhance TAY's personal recovery and wellness, we added "resiliency." We felt that was a very important part of anyone's recovery and wellness within mental health. We did have a consensus among almost all of our top priorities in terms of strategies. B. The first priority under that goal was to incorporate peer support services into existing TAY services to reduce stigma. The second priority is that we reverted one of the strategies to identify specific based outreach and engagement

strategies to engage TAY into service and support. For example, utilizing social media and technology. The third priority was to increase anti stigma and discrimination and suicide prevention trainings.

FEEDBACK

1. **Question:** Under goal 2 what were some highlights there?
   Response: We combined a couple of the strategies. There was some redundancy in the wording. We also wanted to make very specific that the TAY included not just young adults but those 16 and 17 year olds.

2. **Question:** Under school-based services, goal 3 and 4, what stood out there?
   Response: That was consensus because there were only a few strategies under those goals which incorporated into previous goals.

3. **Question:** It sounds like the group had a very spirited and wonderful discussion and seemed to come to the consensus around the goals and strategies. With 'Access to Service' did the group break down at that point?
   Response: We had two strategies that were difficult to choose between. We decided to give them both our first priority which was numbers 3 and 4, expanding mental health services to ensure that youth involved in and exiting from probation services receive appropriate services and increasing opportunities to leverage resources for services and supports to crossover youth including parenting teens.

C. Goal 6: We came to a consensus of increasing FSP and FCC capacity for TAY was a first priority and we did adopt the co-occurring substance abuse to include alcohol, different types of addictions, and mental health services as a goal and the strategy of the provision of ongoing work force development to increase the knowledge, skills, and abilities in the provision of those services especially with our TAY population where it is like everyday there is a substance that TAY are experimenting with.

FEEDBACK

1. **Question:** You have goal 7 at least with one strategy there under access to services?
   Response: Yes.

CHILDREN AGE LEAD REPORT

A. We had a total 8 goals. So we added 2 more goals. For the first goal we prioritized strategies 1, developing family wellness centers, we wanted to leave it more general instead of specific to children 0-5 and their families.

B. We changed the wording for strategy 3 which is another priority. We said “expand and develop services, focus on community reintegration” We also prioritized "improve coordination services between DCFS and/or probation and/or DMH for clients moving between systems.

C. For the second category it will say "cultural competency/disparities". We prioritized the first strategy, the second strategy and included a new strategy that is going to be prioritized in our top 3. It is going to say, "Incorporate implementation of CRDP recommendations into use of EBP's."

D. Under the category of indigent services we prioritized and reworded strategy 1 to say, "Expand services for uninsurable children and families (for example, mental health services for parents and caregivers) in the community." We prioritized "increase onsite, school based integrated mental health services and will include Nina's friendly amendment about expanding that to include early education and state funded child development centers, etc. We also prioritized strategy 4, "use savings from ACA and other funding sources to fund services to uninsurable children and families."

E. Under continuum of care, the fourth goal, we prioritized one, two, and four. There are no changes. The new goal 5 is going to be co-occurring disorders (COD); the ensure availability of COD services and resources for children and families in need. We identified new including a provision of ongoing workforce development to increase knowledge, skills, and abilities in the provision of COD services as well as another strategy of ensuring the integration of COD treatment into mental health services for children and families.

F. Under goal 6, increase support and services to children and families not involved with DCFS or probation we prioritized developing family wellness centers. We purposefully put that under 2 goals because so it encompasses not just youth coming out of DCFS and probation systems but also community children and families. We prioritized strategy 3. It is going to change to say "provide respite services for families and children receiving mental health services" and we are crossing out the "i.e. FSP and/or FCCS." We prioritized strategy 6, increasing number of parent advocates.

G. Our last goal, which is now goal 8 –"increase services to prevent children from entering the child welfare and/or probation systems." We prioritized strategy 3, strategy 4, and adding regional centers; so it is DMH, DHS and regional center. We also prioritized 6, which will now read, "develop specific services for children and families affected by human/sex trafficking and/or domestic violence and/or sexual abuse."

H. There are going to be 3 goals under services for community children and families rather than just the two that we currently have. The new goal is about housing. Our goal is to expand supportive housing for homeless families with mental health consumers, which could be adult or children. The two strategies we identified under that is to dedicate 25% of funding for housing for families and ensure equitable funding by service area for housing for families.

FEEDBACK

1. **Comment:** That last goal was the goal that was added after the ones that you all endorsed. So for now the SLT has not endorsed that 8th goal but let's hold that and we can come back to that.

2. **Question:** I did not realize we could put percentages on the funding. That is a good point.

Response: We are not at the level of budgets just yet we want to make clear what the strategy is.

3. **Comment:** Leslie said that we took out the emphasis of 0-5 and that is also true with anywhere it says "develop family wellness centers." We do not want it so closed.
    a. **Response:** It is inclusive of 0-5 but not limited to.

    b. **Response:** Right.

ADULT TEAM LEAD REPORT

A. I will start with the co-occurring disorder goal. We went ahead and put that under the availability of services. More specifically we added a strategy under that approved goal which was ensure the provision of ongoing workforce development, increase knowledge, skills and abilities in the provision of COD services.

B. For the availability of the services we combined one and two because they are kind of part of the same process. Under continuity of care added a strategy for integrated services. It just said, "Implement strategies to ensure integration of health, mental health and substance abuse services."

C. For disparities, we combined 2 and 3. Number 2 is ensuring service availability for underrepresented ethnic and cultural groups by increasing the number of staff to meet language needs. As a strategy to do that we have, "expand the Promatoras program."

D. For employment, this was one where we just did some more clarification to address one of Dr. Southard's concerns this morning. For goal 5 we changed the wording to, "Increase employment opportunities within the mental health system for persons with lived experience" and then strategy 1 is, "Employ peers who can provide health and mental health services including health navigation as well as peer services." And then goal 6 will be, "Increasing effectiveness of education and employment services in mental health programs."

E. Housing we left alone. For peer and family's roles, this is where half of the work was done within the group. We combined 1 and 2 under an umbrella of just increasing and expanding peer services. Under that we want to expand client run centers, the availability of self-help groups and peer-run groups within the county.

F. Number 3 we changed because "expand the definition of peers"; to ensure the inclusion of individuals with community lived experience and ensure they have a role in services, again, particularly with specific outreach to cultural groups. The life coaches go under wellness centers again.

FEEDBACK

1. **Question:** Can you explain the community lived experience; how you are defining that?

a. **Response:** It is broadly defined. We want to ensure there is a place for individuals with cultural lived experience who may be community leaders where maybe there is more responsiveness to that in outreach and engagement.

b. **Response:** I wanted clarification on whether it was a cultural community or a geographic community.

c. **Response:** Cultural community is really what we are speaking to. As we are talking about the definition of cultural community too I think that could probably expand to disabilities and LGBT.

2. **Comment:** There was one more suggestion that regarding cultural competence and the broad definition of cultural competence that we want to use. It might be a nice place to define that.

OLDER ADULT AGE LEAD REPORT

A. With regard to goal number 1 we combined strategies 2 and 3 into a single strategy which is basically increase FSP and FCCS services; including in that the option of funding for indigent where needed. A second strategy was the use of technology for service delivery and to expand that to include tele-therapy. Third, was to increase the number of service extenders.

B. With regard to goal 2 we collapsed number 1; the adult wellness centers and the 5 from the previous one about wellness client run centers into that transition would be improved with the inclusion of wellness centers of all types for older adults. We did endorse the notion of continued expansion of the FSP and FCCS integration project.

C. We want to increase senior housing options and increase sensitivity with our community partners so they are better equipped to work with older adults with mental illness. We want to expand the notion of providing services for veterans as well. We want to move beyond just DMH programs; to be more inclusive of serving older adults who are veterans and/or consulting with anybody who does.

D. With regard to cultural competency, we want to encourage increased linguistic capacity because that is foundational to the work that we do. We want to expand cultural competency for staff and look into notion of wellness centers and technology and looking at the idea of creating culturally sensitive and non-geographically based wellness centers based on the idea that technology and specialization can create culturally specific wellness focused centers. With regard to workforce we will continue to train staff, developing a specialized training, continue to train service extenders, and hoarding specialists.

FEEDBACK

1. **Question:** I am looking for the hospital diversion. I got left with that as an issue that we brought up that it was across all of the--I do not see--we have not mentioned that.

	a. **Response:** I thought we addressed that though as an outcome measure. b. **Response:** No, reducing hospitalization was but having a program that is an alternative to hospitalization is a strategy and that is what we needed to integrate. So can we agree to integrate it? c. **Response:** Does that fall within the SB 82, the triage teams. We will be creating these triage teams, the idea being which to avoid hospitalization and divert--provide prevention services at the level that it does not require hospitalization or emergency room. 2. **Comment:** James is talking about SB 82, the grant that we got funded for service area mobile triage teams. At the service area level the priority is on older adults, veterans, and the homeless and mentally ill. That is not an alternative to a step down program--that is a triage program. 3. **Comment:** We discussed having places people can go when they recognize that they are beginning to decompensate they have got a place to go where they can have respite away from everything to prevent hospitalization. 4. **Question:** Rather than making a decision I suggest is if that strategy were to be included somewhere what category would it fall under in terms of this? Would it be the, "access to services", "community integration", "improve transitions", where do you see it fall into this? a. **Response:** Probably "improve transitions." b. **Response:** So why do not put that strategy in the mix and when we get together in the Ad Hoc group we can do another review and also hear what the department is also going to be presenting. So let's put a placeholder there. 5. **Question:** Would an example of that strategy being played out be the 23 hour centers? a. **Response:** Right. There is talk of crisis stabilization services, right? b. **Response:** Yes, the other component of SB 82 which is the crisis stabilization and crisis residential programs. That is an expansion. In the proposal they plan on having a [inaudible] in at least every service area and also crisis residential center countywide for every service area.
Public Comments	1. **Comment**: Chair of the Asian Coalition: Annual training at California endowment called "Health Reform in our Communities" on March 27th 9AM-4PM. Contact Nami Roberts at 310-904-3144.