COUNTY OF LOS ANGELES–DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, October 21, 2015 from 9:00 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

REASONS FOR MEETING

1. Provide an update from the County of Los Angeles Department of Mental Health.
2. Inform the SLT on state legislative and budget items.
3. Follow up on MHSA-related issues.
4. Issue a recommendation on proposed changes to MHSA work plan.

MEETING NOTES

Department of Mental Health Update	**Dr. Marvin J. Southard, Director, County of Los Angeles, Department of Mental Health** ▪ **1115 Waiver** – California proposed about $17 billion worth of additional resources through the 1115 waiver, but the Feds approved about $7 billion. We will focus on a more modest proposal focused on how to support public hospitals as the 'disproportionate share' of funding goes away. ▪ **State Statement on MHSA Growth** – The State's statement was finally received and DMH is in the process of negotiating the distribution formula among counties. ▪ **Alcohol and Drug Waiver Implementation** – With all of CMS approvals in place for the Alcohol and Drug Waiver, the key issues pertain to its implementation throughout California. Los Angeles has been moved up to the first group of counties for implementation. A robust implementation of the substance abuse benefit will be essential to making diversion possible, homelessness better, and child welfare smaller and to reducing pressure on emergency rooms. Many who come into emergency rooms have substance abuse crises. The substance abuse benefit will be a game changer in every area of public policy. A complicated implementation piece is how to put into place an organized system of care. The Department of Public Health is gathering stakeholder feedback and our input has focused on designing a system with inter-operability that connects the mental health and child welfare system from the beginning. ▪ **Parole Outpatient System** – Efforts to integrate the parole outpatient system with the county operated systems have started and one key issue is that parolees now are eligible for the coverage under Medicaid under the Affordable Care Act. They therefore have access to the mental health, substance abuse and primary care treatment that is entitled under Medicaid. Previously, parolees had separate systems for mental health and the substance abuse and had separate payer sources. We are trying to renegotiate what the mental health system will take on here in Los Angeles County. However, who pays for the non-Medicaid services that are associated with parolees, such as a state hospital or IMD coverage. This is

not covered by Medicaid. The state parole system would take responsibility for those costs to prevent cost shifting.

- The substance abuse side is more complicated. The parole system had a network of substance abuse providers giving care for the parolees in the community but provider quality varied. Under the ACA, the county is responsible for the substance abuse benefit. The CDCR's intention is to keep the money that was previously used for contracting for substance use in the system and redirect it for housing and vocational services. The money would be augmented by federal funds paying for substance abuse treatment via a new mechanism.

- **Wraparound System –** As directed by the Board of Supervisors, we are completing the transfer of the Wraparound system from DCFS to DMH. The Katie A. Settlement expert panel believes it is important for kids to get high intensity and high quality services, if they need them. The services are measured to ensure the expenditures are producing the results. They are not concerned if it is called Wraparound or Full Service Partnership.

Discussion: Questions, Comments and Responses

Q1: *With Wraparound, does the expert panel want mainly a mental health focus on the child and not on the family?*

- **Response:** There is the issue of engaging families and caregivers in the process of making the child's situation more manageable, which often includes more than offering mental health services. We are trying to incorporate the substance abuse treatment in the family context as well as with individual kids in the long term. The expert panel wants to know that kids are doing better.

Comment: *It is concerning hearing someone describe intensive field based clinical services as 'Wrap without flex funds.' Flex funds are really significant to provide all those other services that are critical to support the family.*

Comment: *We really admire and are grateful for DMH's leadership on the Wrap transition and look forward to new opportunities that will help Wrap be more clinically focused and for Wrap agencies to learn a lot more about intensive care coordination.*

Q2: *When do we anticipate the drug and alcohol benefit rolling out? Where is the planning for that happening? Does it have family, consumer, and parent input into that planning?*

- **Response:** DMH is working to have the benefit come into play in the next fiscal year, with a focus this year on establishing network availability and real services available in a robust way in next fiscal year. There probably will be some early implementation, but getting residential treatment, detox treatment, etc., is going to take some time. The stakeholder process is ongoing through the Department of Public Health. I think more family and client input would be welcomed.

Q3: *Regarding NAMI South Bay Area of UCLA Harbor Hospital, we were told we would be moved out and relocated to an Urgent Care Center. We were assured a smooth transition and plenty of notification for our clients and family members. We would like to address this on another date to formally meet to ensure a proper transition of our programs there for the community.*

- **Response:** I am aware of the situation. The commitment that DMH and the Board office have made is that we will make the transition in a fashion that does not affect the wellbeing of the clients and families that have been there. This would not have been DMH's first choice for the location process but there is a commitment to producing the best outcome for those involved.

Q4: *Governor Brown signed AB 1197, which basically says that when somebody's being considered for a 5150 they do not have to be imminently dangerous to themselves or others and that history must be considered in terms of making that decision. What is DMH's stance and are you going to educate the different facilities on this?*

- **Response:** The legislation clarifies an urban legend because the actual statute does not say anything about imminent danger. It is merely a clarification as to the status of the law as it exists. The standard for imminent danger has not been a part of the DMH training for 5150s before. However, many people in the system believed that it was a requirement. Therefore we will be reinforcing our previous position, which is that imminent danger to self or others is not the issue. As you might imagine, 'imminent' is a standard that could be interpreted in a variety of ways and not all of those are useful.

Q5: *Regarding integrated parole with the mental health and substance abuse, you mentioned that there was going to be funds moved from substance abuse to housing and vocational. Is that right?*

- **Response:** No. Historically the state parole department has not provided abuse treatment directly like they did for mental illness. They contracted with community providers throughout the state. Now their position is since the vast majority of individuals who would be receiving that treatment would have an entitlement under the Affordable Care Act, they should not have to pay with pure state money. Services should be paid by federal money. Therefore, the money that they do not have to spend, because somebody else is paying for it, could be dedicated for a better purpose.

Comment: *In the beginning, Wraparound was about the whole family because children go back to their families. But, I hear that many times the agencies hiring parent partners do what they feel is necessary: billing. And many things that parent partners do cannot be billed. So, if they are being mandated to bill 30 hours a week, where do they get time to do actually their job? I am also concerned about the reduction of flex funds. How can a family concentrate on helping a child if it is worried about a bill or no refrigerator or whatever? That is what flex funds were supposed to be for, to help that family be able to deal with the family crisis or the child.*

Q6: *Regarding the transition after the Board motion creating an agency, and specifically in the area of the creation of the Office of Diversion, how is DMH working with that Office in terms of the diversion of people with mental disabilities out of*

	the criminal justice system? And where are we in terms of the creation of the agency? • **Response:** The appointment of an agency director was on the closed session agenda yesterday but I do not know what the Board decided to do. The three Department heads and the chief deputies have been meeting on a regular basis to try to figure out how we move forward with the new agency. We have finalized the agency mission, which will be released this week. I imagine the next steps for the agency would be that the Board would decide who would be the interim director of the Department of Mental Health on November 6, 2015. I'm assuming and hoping that would be Dr. Kay. Then there would be some kind of process for choosing the DMH director. Statutorily, that process requires input from the Mental Health Commission before the Board takes a final vote. I think the ordinance says that the Board is the appointing entity for the Department heads. • The Office of diversion is still in its formative stages but the work of diversion has been going on by the Departments involved. Mary Marx has been working on all of the diversion projects for the misdemeanor incompetence. We have also been growing our law enforcement mental health teams and clarifying the responsibilities for aftercare (e.g., what will be the responsibilities of DMH, MHSA funded staff as opposed to the staff that will be working for health services within the jail). We are also a broken record about the need for the addiction treatment being a major component of the diversion process because far more of the inmates in the jails suffer from an addiction than suffer from a mental health issue. Almost all who suffer from a mental health issue also suffer from an addiction issue. We need to systematically include the addiction treatment if we are going to be successful on diversion and preventing recidivism. **Q7:** *Is the piece from the 1115 waiver that went through for the 'whole person care' project?* • **Response:** No. It is for a bunch of different things, but the primary thing is for stabilizing—trying to redirect the disproportionate share of hospital funding towards an outpatient basis to support people to avoid or reduce intensive hospital stays. It is about rebooting the relationship of what hospitals and outpatient centers do to integrate the indigent system into the overall Medicaid system. **Q8:** *I would like to know more about the make up and the frequency of meetings of the advisory committee for the new agency?* • **Response:** We are in the process of figuring out what the advisory committee is going to be and how it is going to do its work. The Mental Health Commission selected the mental health clients and the two Mental Health Commissioners for the advisory committee. DMH will be providing some stipend support for the consumers involved in committee to guide and give feedback on the actual implementation as it takes place.
State Legislative and Budget Items	**Susan Rajlal, Legislative Analyst, County of Los Angeles, Department of Mental Health** **No discussion on this topic.** See handout for details of bills.

USC Telehealth Pilot Project Proposal	**Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** There is a proposal today that is time sensitive brought to DMH by the USC School of Social Work and one of the Board officers. The Board of Supervisors and the CEO are interested in DMH's use of technology to expand its services. Concurrently, the USC School of Social Work has developed a tele-mental health platform through which faculty and students are delivering services to individuals needing mental health interventions. This is a two-year proposal that would involve the use of one-time PEI funding to explore the use of tele-mental health to deliver some of the PEI Evidence Based Practices (EBPs) that are already in our plan. This is an opportunity to explore whether two of our EBPs (BRC Cores Model, Crisis Oriented Treatment and Seeking Safety, and potentially in the future, CBT) can be beneficially delivered using a technology platform. (See handout for full details of the proposal.) **Discussion: Questions, Comments and Responses** **Q1:** *Are you saying that we are going to 'explore' this with USC? We have already done some planning here and would like to see what you anticipate with this project, so that it is not just an exploration.* • **Response:** We believe we can accomplish the expansion of our EBPs under PEI using tele-mental health, which means a computer is in the family's home and a computer is with the therapist. Instead of having an in-person, in-clinic session, the session is done using tele-technology. **Q2:** *My concern is from the basic humanistic perspective of providing mental health services and health care via computer somehow does not resonate in my spirit and soul. I understand the outreach and engagement need but I, myself, still stress out in front of a computer.* • **Response:** We are not going to add to the emotional distress that people are experiencing. The Department has done a fair amount of tele-psychiatry and, actually, we have clients that are not only comfortable with it, they really like it. So just as anything else, it is the connection between the therapist and the client, whether it is done in person or via technology. **Q3:** *Is the service is going to be provided by USC professors and students?* • **Response:** Yes. **Q4:** *Is there a plan to connect those service providers with the rest of the TAY serving community in case there is a need to transition the child to a different program because this is not working out?* • **Response:** Yes, in the same way that we do with any other clinic or program. If at any time a child or a family does not feel that the treatment is working, the department will give people an option to get back in touch with the staff to be reassigned, just as we would if people were being seen in a clinic.

Comment: *I would hate to see certain kids caught in this program for research purposes as opposed to some protocol to evaluate, 'Is this the best way to be serving this child?'*

- **Response:** We will always give people the chance, whether it is from the perspective of the clinician or the client, to be reassigned if it is not working.

Q5: *My concern would be the capacity to observe nuances if kids are getting into that really deep part of being suicidal and they are distant and we cannot bring in the security to say, 'Can we do an assessment?' 'Do we need to hospitalize?'*

- **Response:** To be clear, USC already has set up this platform. If a client that is displaying behavioral changes or mention suicide, a licensed clinical supervisor can be immediately contacted and enter the session via the use of the same technology. There is somebody standing by at all times, just the same way if the service were at a clinic location.

Q6: *My understanding is that this is funded with PEI money so it is basically early intervention, not actually mental health services on an ongoing basis. Also, is this basically like FaceTime?*

- **Response:** This is for youth who have experienced some trauma. We are offering two of the existing EBPs (Crisis Oriented Therapy, which is up to six visits, and Seeking Safety, which can be delivered over a longer period of time). If DMH staff member doing the initial screening in the Hub determines that a client needs more intensive therapy, then he or she would not be a candidate for this program. Also, USC has a secure platform developed specifically for tele-health. It is similar to a conference with breakout rooms. You can create a separate room on the platform to communicate with your supervisor if something emerges while still being present with a client. Both people see each other in real time.

Q7: *Assuming that there is a trauma-induced problem, could they be referred for further services in another way?*

- **Response:** Yes. If it is Seeking Safety, which is focused on trauma as well, if it cannot be resolved through that practice or needs a higher level of service or more intensity, the clinician will be making an appropriate referral.

Q8: *You mentioned that family would also be involved in Seeking Safety? Is that in keeping with fidelity to Seeking Safety?*

- **Response:** Crisis-oriented therapy can be done with families in Seeking Safety.

Q9: *Is this the same thing already being implemented at West Central Mental Health Wellness Center? I see clients there and no one else is allowed and the computer screen is there.*

- **Response:** It is not exactly the same but the idea is basically the same. In our case, DMH is just it for telepsychiatry.

Q10: *I am in favor of tele-therapy and tele-medicine. But I really want to see the experimental design. I am confused about why we would try to experiment with one of the most vulnerable populations, such as kids going MLK and foster care. Also, is there a control group?*

- **Response:** It is not for foster kids, only kids for whom all the screening has been done, who are non-detained, and who remain with their family of origin. It is an expectation that we expressly screen out children in the foster care system. There is no control group.

Q11: *Since we need to guarantee the privacy of the treatment for children, then the iPad is concerning to me, especially unsafe things that can be done with iPads. I personally would prefer to see it done on an adult population first. Also, what about internet access?*

- **Response:** We will have to follow up with USC people about the first two issues. Regarding internet access, the iPads will be able to facilitate that internet access. So it will be a conduit for the tele-health.

Q12: *Regarding the proposed $400,000, it includes the costs of the iPads. But does it pay for the billing? Will it take from current services? What is the estimated number of clients to be served?*

- **Response:** We are still looking at the rate structure so we put in a round number of $400,000. It will be less than that and will come out of one-time PEI. The funds largely pay for the licensed faculty person who will be delivering some services and the supervision cost for the students. The iPads are being furnished by the USC as part of their commitment to the project along with a whole host of other costs. PEI funding also covers the cost of two navigators who are the essential links between the Hub, the families, and the home. Approximately 200 youth would be served per year.

Q13: *Will there be a staff member trained not just in technology but in helping the family member feel comfortable with this technology? If they do not feel comfortable, will they have the option of having someone see them in person?*

- **Response:** They will always have the option of coming back and seeing us in person. We will make sure that that information is clearly communicated to the family. USC will have an individual who is trained in the technology and who also works for their mental health clinic that is equipped to help explain the technology, walk people through it. At any point if it does not work we will make sure that people get a different type of treatment in person.

Q14: *Will there be a bilingual partnership there for people with different languages?*

- **Response:** We are going to start with English and Spanish.

Q15: Will there be recordings of the sessions?

- **Response:** No. In essence, it is no different than if an intern was seeing someone in a clinic. They do keep notes about their visits and they do get supervised. But we do not record sessions.

Q16: *Is any of this going to be billable to Medi-Cal? Is there going to be any match in it?*

- **Response:** For the pilot program, no, because it is not Medi-Cal reimbursable. Until we get more experience with this, we elected not to claim it to Medi-Cal.

	Q17: *One of my concerns is that this is $800,000 in onetime money that we are handing out here. What else is in the budget? What portion of the budget is going for evaluation? Are we paying for interns?* • **Response:** We are not paying for evaluation. There will be done evaluation by USC. USC is dedicating one full time licensed staff person to deliver services. We are paying for the time of that full time licensed person for some supervision and quality assurance, for two navigators who will get the consents and then go to the homes and guide people through those initial set up and sessions, and coordinate the contact with the Department. We are also paying for training just the same we do for contract agencies. There are some other miniscule administrative costs.
MHSA Related Items	**Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** Dr. Innes-Gomberg informed the SLT that the Board of Supervisors adopted the Annual Update on Tuesday and explained the documents contained in a folder, including the MHSA continuum of care and updates on the Three-Year Program and Expenditure Plan and the $84 MHSA Expansion Plan. (See handouts for additional details) • The SLT requested a digital file of these documents to share with their SAACs. Dennis Murata also provided an update on the Mental Health Loan Assumption program, indicating that it is open to all eligible DMH directly operated staff and their supervisors, contractors, and also subcontractors of our legal entities. This was something added this year. And also it does not necessarily have to be clinicians but it also could be direct service staff who are providing outreach.
A Proposed Change to MHSA Three-Year Plan	**Debbie Innes-Gomberg, Ph.D., District Chief, MHSA Implementation and Outcomes Division, County of Los Angeles, Department of Mental Health** • Dr. Innes-Gomberg introduced Kalene Gilbert and Kanchana Tate to discuss a proposed change to the Three Year Plan in the Children's area. What we want is, they want to present the proposed change and then have a workgroup. (See handouts for presentation details.) At the end of the presentation, Ms. Gilbert invited SLT members to participate in future meetings of a work group. The intention of this work group is to return in December 2015 with a request for a vote to expand the definition of the wellness plan.
Public Comments and Announcement	**Ms. Lamon:** *Are TAY centers closed at 5:00?* **Dr. Innes-Gomberg:** Regardless of age, shelters open up at a certain period and then close during the day. During the day residents are expected to engage in activities outside the shelter. I think what I am going to do is have that question be addressed by TAY and Adults so that we can get a sense of what those supportive services are and how they are connected to the shelters.